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‘Illuminating the Past to Make the Future Safer?’ Exploring the Potential and Peril of Domestic Homicide Reviews as a Mechanism for Change

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A thesis submitted for the degree of Doctor of Philosophy in Gender Studies

(Social Sciences)

December 2022

Declaration

I hereby declare that this thesis has not been and will not be, submitted in whole or in part to another University for the award of any other degree.

Signature: JH Rowlands

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Abstract

UNIVERSITY OF SUSSEX

JAMES ROWLANDS

DOCTOR OF PHILOSOPHY IN SOCIOLOGY (GENDER STUDIES)

‘ILLUMINATING THE PAST TO MAKE THE FUTURE SAFER?’ EXPLORING THE POTENTIAL AND PERIL OF DOMESTIC HOMICIDE REVIEWS AS A MECHANISM FOR CHANGE

Since 2011, domestic abuse (DA)-related deaths in England and Wales have been subject to a ‘Domestic Homicide Review’ (DHR). A DHR brings together a range of stakeholders – including representatives from organisations that had contact with a victim, as well as those who knew them – to build a picture of case circumstances and identify learning to improve practice, policy, and systems. To date, DHRs have been seen as enabling efforts to improve responses to DA and contributing to the prevention of future deaths. Reflecting this, research has focused on DHR findings. As a result, the doing of DHRs – including the operational, discursive, and symbolic practices involved – have been largely unexamined, both for DHRs as individual case examinations but also collectively as a state-mandated counting mechanism. Drawing on interviews with stakeholders, as well as published DHR reports and the results of a web-based survey, this research examines DHRs as a process, product, and a system.

This thesis approaches DHRs as a technology of power, doing so through the prism of use by examining what DHR is for, what is used by and in DHR, and how DHRs are themselves used. This thesis goes on to argue that DHRs have potential as one way of accounting for a victim’s experiences and generating knowledge to bring about changes to practice, policy, and systems. However, this thesis also argues that, as a technology, DHRs are marked by complexity and tension in their establishment and doing that can be perilous, with this being to the detriment of learning, stakeholder experience, and the story told about a victim’s death. This thesis concludes by identifying the implications for policy, practice, research, and theory, and makes a call to broaden approaches to DHRs by seeking to deliver both procedural and outcome justice.

Dedication

I dedicate this thesis to those who have died, directly or indirectly, at the hands of a former or current intimate partner, family member, or household member.

As an act of memorialisation, I have produced the i-poem overleaf, inspired by the anthology produced by Homicide | Abuse | Learning | Together (HALT) (2022). The i-poem is constructed from accounts by family or friends of their loved ones as recorded in the Domestic Homicide Reviews (DHRs) I collected. To produce the i-poem, I used excerpts – where available – which started with she/he/they. I do not include details of the death, nor the learning identified.

By producing an i-poem, I seek to centre the individuals whose lives and deaths are the focus of my research. My intention is that this dedication might represent, however imperfectly, something of each victim's lived experience and be a reminder of our shared humanity.

She had a heart of gold
A bubbly, loving person
A popular young woman with many friends
He was a well-liked, affable character
He would do anything for anybody
She was happy go lucky, a person who loved to travel and never wanted to stay at home
Fun loving, chatty and beautiful. She was a lover of life and a free spirit
She was a forthright person who would ‘name the elephant in the room’
Gregarious and open, with a very outgoing personality
She was a lovely person, but private
She was laid back
She was a bright woman. Extremely intelligent
Energetic, diligent, and bright
He was a loving father
Very family-oriented, she always put the children first
She was happiest with her grandchildren in her arms
He cared about the safety of his family
She was a strong person, a matriarch
She was a hero
She was a loyal friend who touched the lives of so many people
She was a talented artist
She was a much-loved teacher
She gave a lot to looking after those she loved
She had the ability to empathise with others' struggles
He was trying to be a better person
She was taking control of her life
She was an active member of her local church; he was a devout Muslim who attended the local Mosque
Her appearance would be immaculate
They were angels.

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What a journey. I want to thank everyone who has played some part in helping me reach this point. That includes the teachers who have inspired me over the years, not least Mrs Mercer and Mrs Jones who helped a young boy who struggled to read to discover a passion for words. Thank you to my father (who sadly did not live to see me start my PhD), my mother, as well as my sister and brother. Thanks also to my wider family too, especially the Fords, whose home in Brighton has often provided a respite and a fulsome meal. Thank you too to Sam Oliver, who helped me recognise that a return to study was a possibility, and who also provided support during the early years of my PhD. The team at the South East Network for Social Sciences (SeNSS), the local Economic and Social Research Council (ESRC) training partnership, have also been hugely encouraging while, of course, securing a studentship made a huge difference.

Along the way, I have met some amazing scholars, including Professor Neil Websdale, who has given generously of his time. I have also been privileged to work and write with others, not least Dr Lizzie Cook and Dr Kelly Bracewell. Thanks also to my PhD workspace buddies in the Freeman Building. You have shared treats, and provided much needed distraction, as well as wisdom. Additionally, Elif and Laurenne, thank you for your part in our reciprocal proof-reading pact, which I will honour in turn. Thank you to my supervisors – Professor Alison Phipps, Dr Tanya Palmer, and Dr Paul McGuinness – for their feedback, encouragement, and humour. Furthermore, special thanks to my examiners, Professor Sandra Walklate and Dr. Hannah Mason-Bish.

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Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
AFH	Adult Family Homicide
CCG	Clinical Commissioning Group
CCR	Coordinated Community Response
CJ[S]	Criminal Justice [System]
CSP	Community Safety Partnership
DA	Domestic Abuse
DAC	Domestic Abuse Coordinator
DARDR	Domestic Abuse-Related Death Review
DARVO	Deny, Attack, Reverse Victim and Offender
DHR	Domestic Homicide Review
DVCVA	Domestic Violence, Crime and Victims Act 2004
DVFR	Domestic Violence Fatality Review
ESRC	Economic and Social Research Council
FLO	Family Liaison Officer
FOI	Freedom of Information
GP	General Practitioner
HALT	Homicide | Abuse | Learning | Together
IMR	Individual Management Review
IDVA	Independent Domestic Violence Advisor
ITR	Interviewee Transcript Review
IPH	Intimate Partner Homicide
LGBTQ	Lesbian, Gay, Bisexual, Trans, and Queer
MARAC	Multi Agency Risk Assessment Conference
NGO	Non-Governmental Organisation
NHS	National Health Service

ONS	Office for National Statistics
PCC	Police and Crime Commissioner
PIN	Personal Identification Number
QA	[National] Quality Assurance [Panel]
SeNSS	South East Network for Social Sciences
SMART	Specific, Measurable, Achievable, Relevant, and Timely
SUSR	Single Unified Safeguarding Review
ToR	Terms of Reference
U.K.	United Kingdom
U.S.	United States
UNODC	United Nations Office on Drugs and Crime
VAW[G]	Violence Against Women [and Girls]
VSHS	Victim Support Homicide Service

Chapter 1: Introduction

> Death, on the other hand, is the final silence. And that might be coming quickly, now, without regard for whether I had ever spoken what needed to be said, or had only betrayed myself into small silences, while I planned someday to speak, or waited for someone else's words (Lorde, 2007/1984, p. 30).

Writing these words after a health scare, Lorde's ruminations about her mortality led her to ask what, as a Black woman, she had been silent about and why. Lorde went on to describe how silence could be transformed by speaking, connecting, and acting with others. Lorde's account is a stark reminder of the sociological challenge of death. That is, death is a universal condition with which all must wrestle. Yet, death falls unevenly and is mediated by structural inequalities and power (Foster and Woodthorpe, 2016), which can mean some deaths are more grievable than others (Butler, 2004). Finally, after death the dead can no longer speak, thus becoming the absent subject (Gamino, Hogan and Sewell, 2002).

Yet even in their absence, the body, identity, and memory of the dead remain, raising numerous sociological questions. At a minimum, a 'legal regime' is sparked following death (Conway, 2016, p. 34), particularly if someone dies unexpectedly or in suspicious circumstances. In these cases, the potential harm to society as a whole – e.g., in the event of a homicide – means death becomes a collective concern (Jones, 2018). Consequently, the state takes ownership of the response to such deaths (Christie, 1977). This concern can be retrospective (in terms of the detection and successful prosecution of offenders), but also prospective (that is, in seeking to prevent such killings in the future) (Brookman and Innes, 2013). However, the state's interest can be to the detriment of a family who, despite being potentially deeply affected by a sudden death (Cook, 2022), may be relegated to the status of observers (Armour, 2002; Englebrecht, Mason and Adams, 2014).

Yet, in the context of a death, a body, identity, and memory can become contested (Hockey and Draper, 2005; Troyer, 2020). In this way, the dead can have a 'posthumous career', wherein traces of their lives are used by others (Penfold-Mounce, 2020, p. 491). Equally, a death may also become a site of 'affective investment' (Krishnan, 2019, p. 1516) as families, the state, the state's own and other organisations, and the media seek to make sense of and respond to these tragedies, perhaps with different and conflicting agendas (Sedley, 1989). Finally, the dead can retain an attenuated agency as they can continue to 'provoke actions and reactions' (Horsley, 2012, p. 545). Thus, an examination of death can illuminate issues like the nature of the relationship between the individual and society, what is private and public, as well as the importance of gender (Clark, 1993).

Domestic homicides are illustrative of these sociological questions. I define domestic homicide as when someone is killed by a current or former intimate partner (Intimate Partner Homicide, IPH) or a family member (Adult Family Homicide, AFH).[1,2] Such killings are not a specific offence in England and Wales and, as homicides, are prosecuted as either murder or manslaughter (Brookman, Jones and Pike, 2017). I refer to domestic homicide to reflect the literature (explored in subsequent chapters), the statutory definition of these killings (set out below), and the wider domestic abuse (DA) policy context in England and Wales.[3]

However, reflecting on the sociological questions above, first, the term 'domestic homicide' is more complex than it appears. This is because domestic

[1] Domestic homicide definitions vary internationally (Truong *et al.*, 2022). My use of IPH and AFH follows existing research convention (Home Office, 2016a; Sharp-Jeffs and Kelly, 2016).
[2] In England and Wales, as I shall explain below, killings by a non-intimate/familial household member are also included in this definition.
[3] Notably, DA is now defined in statute as physical or sexual, but also emotional, coercive or controlling, or economic abuse between two people aged 16 or over who are 'personally connected' (*Domestic Abuse Act 202*1).

homicide is not a singular or fixed phenomenon (Websdale, 1999) and understandings of, and responses to, such killings have changed over time (Liem and Koenraadt, 2018). Indeed, as a socially constructed phenomenon, these changes reflect if and how such killings are categorised in terms of lawfulness and perceived gravity (Brookman, 2005). This also leads to practical difficulties like how such killings are defined and/or data about them is captured (Walby *et al.*, 2017).

Second, and despite these challenges, it is clear that domestic homicide is gendered (Liem and Koenraadt, 2018), with most victims being women and, in turn, women being disproportionately killed by men.[4] Men die too, albeit more often at the hands of other men than women.[5] Thus, globally, one out of every five homicides is perpetrated by an intimate partner or family member, with women and girls accounting for some 64% of these victims (United Nations Office on Drugs and Crime [UNODC], 2019). In England and Wales, there were 362 domestic homicides recorded by police between April 2017 and March 2020, with most victims being women (276 or 76%) (Office for National Statistics [ONS], 2021).[6]

Third, while domestic homicides are an individual tragedy, they are also a significant social problem (Jaffe, Scott and Straatman, 2020), and so their prevention has become a practice and policy concern (Truong *et al.*, 2022). There are many stakeholders with an interest in such deaths, including family but also activists, policymakers, and politicians (Monckton-Smith, 2012). Consequently, those killed have a posthumous career because domestic homicides are scrutinised; they are a type of 'out

[4] I primarily refer to victims to reflect the fatal outcomes experienced. I refer to victim/survivors when discussing DA more generally.
[5] A gendered perspective does not preclude considering the victimisation of men, given the significance of gender in shaping victim/survivor experiences (Huntley *et al.*, 2019).
[6] Given the gendered nature of domestic homicide, the killing of women and girls can be conceptualised as femicide, although the definition and adoption of this concept varies and there ongoing debates about it (Cook, Walklate and Fitz-Gibbon, 2022; D'Ignazio *et al.*, 2022). As appropriate, I draw on the femicide literature, although for the reasons outlined above, I refer to domestic homicide.

of order' death that needs to be explained given it was unexpected (Neuilly, 2013, p. 344). Notably, seeking explanation does not mean these killings are inexplicable: there is a patterning to domestic homicides (Websdale, 1999; Juodis *et al.*, 2014; Monckton Smith, 2020); they are often conceptualised as being 'the ultimate act of control' within a broader continuum of (usually male) violence (Sheehy, 2017, p. 374); and efforts continue to identify precursors and so prevent them (Graham *et al.*, 2021; Messing *et al.*, 2022).

The nature of this scrutiny has developed significantly in the last fifty years (Dobash and Dobash, 2015) as DA has moved from being a private matter to a public concern (Bjørnholt, 2021). However, different actors scrutinise these killings for different purposes. Thus, the aforementioned legal regime sees the state's ownership of death, wherein a concern with the management of domestic homicide can be conceptualised as a means to manage risk as part of a wider agenda of crime control (Walklate and Hopkins, 2019; Websdale, 2020). Meanwhile, while domestic homicide commands significant attention from the criminal justice system (CJS) and media, accounts of these deaths are often victim-blaming (Monckton-Smith, 2012; Lloyd and Ramon, 2017; Buxton-Namisnyk and Butler, 2019). Conversely, feminist activists and scholars have sought to better attend to who is killed by whom (including the significance of gender) but also to inform preventative responses (Walklate *et al.*, 2020; Dawson, 2021). Importantly, feminist approaches ask questions about whose voice is heard and how (Sheehy, 2017).

Fourth, the victims of these killings cannot directly share their experiences (Weil, 2016; McPhedran *et al.*, 2018). Moreover, while a victim is silenced by their killer, sometimes they are also silenced by others if their death and/or the perpetrator's

actions are minimised or somehow justified. This too is structured by gender (Dobash and Dobash, 2015).

1.1 An Overview of Domestic Homicide Review

Given the import of these sociological questions to domestic homicides, it is pertinent to examine how we make sense of this phenomenon. Consequently, this thesis is concerned with Domestic Homicide Review (DHR), a form of scrutiny in England and Wales that encapsulates many of these questions, including how the dead may have a posthumous career and how knowledge about their life and death is generated.[7] DHRs are state mandated in s.9 of the *Domestic Violence, Crimes and Victims Act (2004*) [DVCVA], wherein they and domestic homicide are defined as:

> A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he [sic] was related or with whom he [sic] was or had been in an intimate personal relationship, or (b) a member of the same household as himself [sic].[8]

The stated purposes of DHRs are learning from, acting on, and applying lessons about domestic homicide; preventing DA by improving service responses through earlier intervention; better understanding DA; and highlighting good practice (Home Office, 2016b, p. 6). Notably, although there is a call for DHRs to 'articulate the life through the eyes of the victim' to 'understand the victim's reality' (Home Office, 2016b, p. 7) – which I refer to hereafter as 'seeing through the victim's eyes' – this is not specifically foregrounded as a stated purpose.[9]

---

[7] My focus is England and Wales. DHRs commenced in Northern Ireland from December 2020 (Department of Justice, 2020). In Scotland, a review system has been proposed but not yet established and this has limited opportunities for identification, measurement and learning (McPherson, 2022). In November 2022 it was announced DHRs would be implemented (Scottish Government, 2022).

[8] There may be an overlap between DHRs and reviews into the death of children over the age of 16. In these cases, one or other review may be commissioned, or a joint review may be undertaken (Boughton, 2022).

[9] The statutory guidance also refers to seeing through the eyes of any children, as well as the perpetrator (Home Office, 2016b, p. 7,17). Here, I focus on the victim although, as appropriate, I will refer to these other subjects.

The emergence of DHRs has been described as 'slow-paced, [and] evolving' (Boughton, 2022, p. 51). Notably, DHRs emerged after the development of other types of statutory review into deaths or serious incidents in the United Kingdom (U.K.) (Stanley and Manthorpe, 2004). These other review systems examine the serious harm or death of children or vulnerable adults, homicides by patients being treated for mental illness, and deaths in custody.[10] Meanwhile, DHRs have similarities with peer systems internationally, with these collectively described as Domestic Violence Fatality Reviews (DVFRs) (Dawson, 2017a; Websdale, 2020). DVFR has emerged in several high-income, English-speaking countries (Bugeja *et al.*, 2017), being first conducted in the United States (U.S.) in the 1990s and then developing in Australia, Canada, Aotearoa New Zealand, and England and Wales (Dawson, 2017a).[11] Hereafter, I refer to 'review' as a collective noun and use DHR to refer to England and Wales and DVFR for international systems.

The expansive definition in the DVCVA means DHRs encompass IPH and AFH, but also where someone has been killed by a non-intimate/familial household member, i.e., a lodger or flatmate.[12] Furthermore, since 2016, DHRs can also be conducted when someone has died by suicide.[13] Consequently, I refer to 'DA-related deaths' to capture all these scenarios. When discussing the review system in England and Wales, while I generally refer to DHRs, to reflect their differences to the killings

[10] I do not examine these other review systems, but I draw on the relevant literature. For a discussion of the overlaps between DHRs and other review systems, see Robinson, Rees and Dehaghani (2019).
[11] This expansion continues: DVFR has also been introduced in Portugal (Castanho, 2017) and is being considered in the Republic of Ireland (Study on Familicide and Domestic Homicide Reviews, no date).
[12] Such killings are rare. Bates *et al*. (2021) reported that six of 151 DA-related deaths of adults identified by the police in the year to March 2021 involved a non-intimate/familial household relationship. In this study, two of 60 DHRs involved such relationships.
[13] The first two iterations of the statutory guidance did not include deaths by suicide in scope (Home Office, 2011, 2013d). However, the latest version states DHRs can be commissioned into these deaths where the 'circumstances give rise to concern' (Home Office, 2016b, p. 8). I explore the conceptual and operational challenges around these cases in *Chapter Six*.

that constitute the majority of DHRs, I use the term 'DA-Related Death Review' (DARDR) when referring specifically to the review of a suicide.

Notably, after being introduced in statute in 2004, the implementation of DHRs took a further seven years (Home Office, 2011). Thus, DHRs only became routine after 2011, albeit some were conducted informally before this (Payton, Robinson and Brookman, 2017).

As I will explore in *Chapter Two* – where I examine their conceptualisation and the extant literature – DHRs are both a process and a product. As a *process*, DHRs can be understood *individually* and *as a system*. In terms of *individual DA-related deaths*, each DHR is a stand-alone case examination. A DHR should be commissioned by the relevant local Community Safety Partnership (CSP) following a DA-related death,[14] usually based on a notification by the police (Home Office, 2016b, p. 9), if the DVCVA criteria are met. To deliver a DHR, an independent chair is appointed and is 'responsible for managing and coordinating the review process' (Home Office, 2016b, pp. 12–13). This includes leading a multi-agency review panel.

Referred to as the 'review team' in the international literature (Websdale, 2020), a review panel should be 'sufficiently configured to bring relevant expertise in relation to the particular circumstances of the case as they will see the dynamics of the relationship through a different lens' (Home Office, 2016b, p. 11). 'Relevant expertise' can be defined *by virtue of contact*, meaning representation from organisations that were involved with the victim, perpetrator and/or any children. This may include statutory organisations like the police, local authorities (departments like children or adult services, housing, and community safety, with the latter often represented by a

[14] CSPs – or 'Crime and Disorder Reduction Partnerships' – bring together different local organisations to reduce crime and disorder, substance misuse, and re-offending.

Domestic Abuse Coordinator (DAC)[15]); the national probation service; as well as health commissioning and provider bodies. Where appropriate, this may also include non-governmental organisations (NGOs). However, expertise may also be defined *by virtue of specialist knowledge*, regardless of contact. Here, expertise most commonly relates to specialist DA services, as well as other NGOs with issue or community-specific knowledge, including 'led-by-and-for' services. That is, 'services that are governed, managed and staffed by the same community they are providing services for' (Kumar, 2019, p. 180).[16] Testimonial networks – notably family members, but also friends, neighbours and colleagues (Rowlands and Cook, 2022) – may also be involved (Home Office, 2016b, pp. 17–19). This involvement is by of *virtue of connection*. That is, testimonial networks are involved as a source of information and may be able to help 'paint a picture' of someone's lived experiences (Gregory, Williamson and Feder, 2017; Eriksson, Mazerolle and McPhedran, 2022).

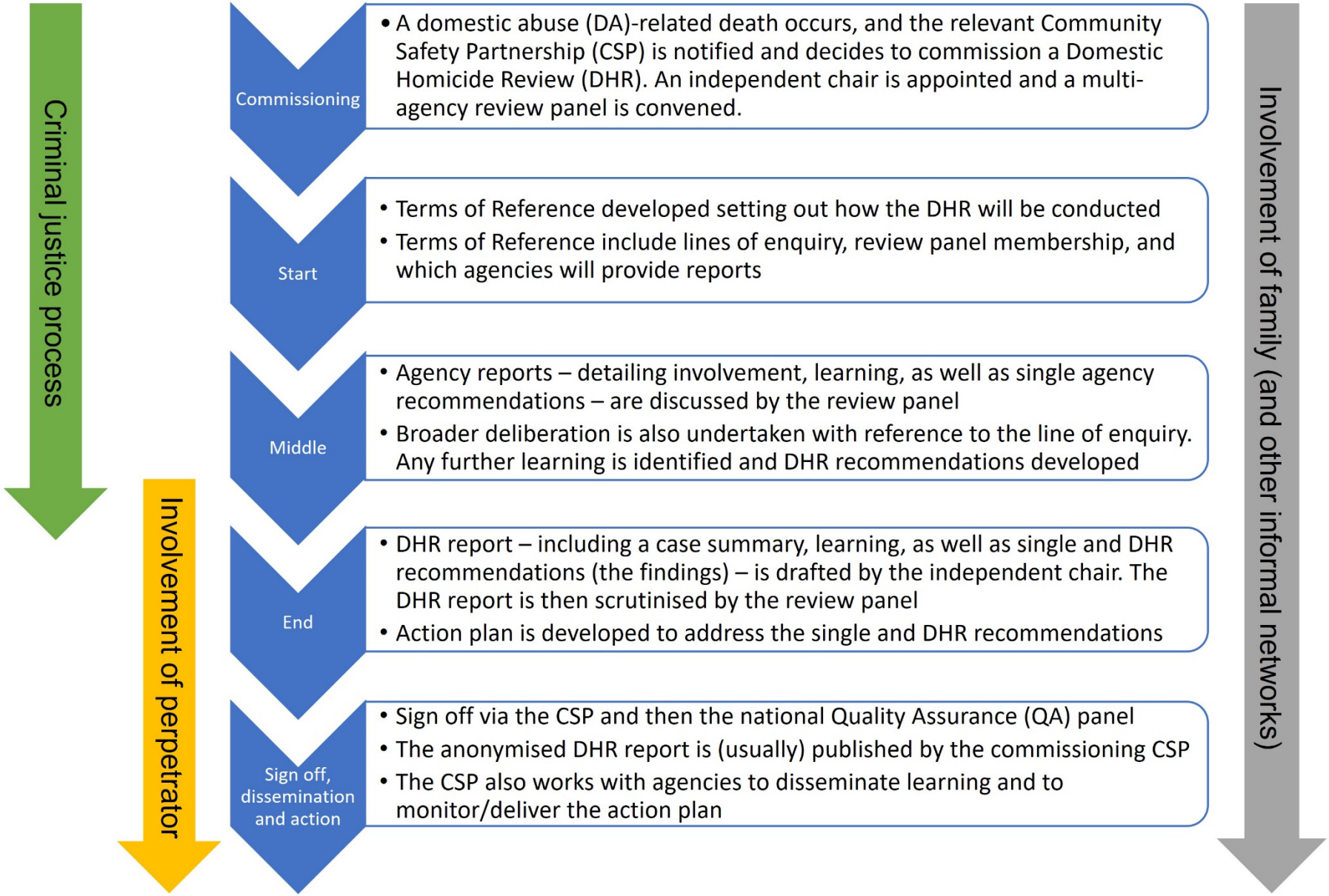
The intention is that these stakeholders work together to build a case history to try and understand what happened before a death, then identify any gaps in professional, organisational or system responses, and/or what might have helped or hindered access to, or the receipt of, support. Thereafter, recommendations should be agreed upon to address the learning identified. Together, this is the knowledge produced by DHRs, their 'findings', with the recommendations then addressed through the implementation of an action plan. See Figure 1 for an overview of the DHR process.

[15] A DAC is a postholder who coordinates local responses to DA and sometimes other forms of Violence Against Women and Girls (VAWG). There is no standard definition, title, or job description for a DAC, and not all local areas have one. DACs are often, but not exclusively, employed by local authorities and can have operational, strategic and/or commissioning responsibilities. DACs often have a role in DHRs, including managing the appointment of an independent chair, supporting or participating in review panels, and/or facilitating the dissemination of findings and the delivery of recommendations.

[16] E.g., Black and minoritized, disabled, and lesbian, gay, bisexual and queer (LGBTQ) victim/survivors.

Figure 1

Overview of the DHR Process



A wider process perspective is to look at DHRs collectively as a *system* (Rowlands, 2020a). From this perspective, DHRs are a rare example of a national-level review system (Bugeja *et al.*, 2017). This is because DHRs were established by the DVCVA; there is single framework for their conduct that has developed through the thrice issued statutory guidance (Home Office, 2011, 2013d, 2016b);[17] and national oversight is provided by the Home Office (the sponsoring U.K. government department) and the national Quality Assurance (QA) panel.[18] However, the DHR systems status as a national-level review system is deceptive because it is in fact two-tier with dual loci of control. Thus, while there is legislative basis, a single framework, and national oversight, individual CSPs are responsible for commissioning and delivering each DHR. This two-tier system will also become more complicated given proposed reforms in the *Tackling DA Action Plan* (HM Government, 2022).[19] Amongst a range of commitments – to update the statutory guidance (including to better address DA-related deaths by suicide); introduce training for independent chairs; and bolster the role of the QA panel – these reforms propose an oversight role for the DA Commissioner for England and Wales,[20] and potentially a role for Police and Crime Commissioners (PCCs).[21]

Yet, DHRs are also a *product* because the knowledge they produce materialises as a documentary artefact (Riles, 2006), specifically as an overview report and

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[17] Hereafter, references to 'the statutory guidance' relate to the 2016 iteration, the latest at the time of writing.

[18] The QA panel is Home Office convened and includes representation from statutory organisations and NGOs with DA expertise (Home Office, 2013e). The QA panel's primary role is to quality assure DHR reports, although its functioning is opaque and has been critiqued (Rowlands, 2020a; Boughton, 2022). Upon receipt of a DHR report, the QA panel can approve it for publication or, alternatively, request amendments. If the QA panel requests amendments, it can also ask to see the report again.

[19] Additional changes are being taken forward in Wales, as part of the introduction of the Single Unified Safeguarding Review (SUSR) process. See: https://safercommunities.wales/safeguarding-early-intervention/safeguarding-reviews-domestic-homicide-reviews/.

[20] The DA Commissioner is a statutory office holder and is charged with providing public leadership on DA. See: https://domesticabusecommissioner.uk.

[21] Introduced in 2011, PCCs are elected officials and oversee a local police force. See: https://www.gov.uk/police-and-crime-commissioners.

executive summary (hereafter: a 'DHR report'). A DHR report is usually anonymised and then published.[22] Tragically, DHRs are not singular events given the 'entrenched and enduring problem' of domestic homicide (Bates *et al.*, 2021, p. 8). Thus, DHR reports do not stand alone. They can also be analysed in aggregate to identify patterns and trends. The potential for aggregation is significant: since their introduction some 800 DHRs have been conducted (Monckton-Smith, 2021). However, there are challenges both with the publication of DHR reports and also in the extent to which aggregate analysis is undertaken, in a large part due to the absence, to date, of a national repository to enable storage, access, and analysis (Benbow, Bhattacharyya and Kingston, 2019).[23] It may be that this absence will soon be addressed: as part of the proposed reforms to the DHR system, the Home Office and the DA Commissioner are developing respectively a national repository (to share completed DHR reports) and an oversight mechanism (to track recommendations and change) (Wood, 2022).

To date, practice, policy, and scholarly interest have largely focused on the analysis of DHRs' findings (e.g., Home Office, 2016a; Sharp-Jeffs and Kelly, 2016; Chantler *et al.*, 2020; Chopra *et al.*, 2022). This reflects perhaps the ambition articulated by Mullane that DHRs should 'illuminate the past to make the future safer' (2017, p. 261)[24] and an understanding of review as being a preventative 'method of learning' which produces findings that can drive improvement in policy, practice, education and awareness (Dawson, 2021, p. 671).

In contrast, the operation of DHRs as a mechanism in and of itself has been little explored, meaning how DHRs operate has mostly been described instrumentally

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[22] Exceptions to publication can be made for welfare considerations (Home Office, 2016b).

[23] The absence of a national repository speaks to the neglect of the DHR system (Rowlands, 2022a). Indeed, in a damning indictment, the fact that I can refer to the number of DHRs report that have been completed is only because of a passing reference by Monckton-Smith.

[24] I chose this quote for my thesis title because it is a widely known articulation of the ambition for DHRs and in recognition of Mullane's contribution to their development (for a discussion, see page 43).

(Rowlands and Bracewell, 2022). Thus, an irony about the claim to learning at the heart of DHRs is that the conduct of individual case examinations, and wider system functioning, are something of which we are largely ignorant, albeit their complexity is increasingly recognised (Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022).

This thesis addresses this lacuna, and it is concerned with how DHRs produce knowledge, rather than being an examination of efficacy per se, although I also explore whether DHRs are a site for action. My starting position is that the knowledge produced by DHRs is not – to borrow Clark and Braun's formulation (2021) – waiting to emerge. Instead, I understand DHRs (including their findings) as being contingent, reflecting the structuring effect of the operational and discursive practices which shape their *doing*. This contingent doing is relevant with respect to DHRs systemically and individually, in other words, *with* DHRs as a system and *within* DHRs as an individual case examination. As a DHR could be understood as bringing together different stakeholders in telling a victim's story, which may lead to change (Cook, 2022), attention to these practices is important because it might tell us about how these stories are used.

Reflecting these considerations, my theoretical perspective (explored further in *Chapter Two* and my *Methodology* in *Chapter Three*) is Foucauldian. I conceptualise DHRs as a technology (Foucault, 1977), specifically a technology of power, which might be defined as a method to 'determine the conduct of individuals and submit them to certain ends or domination' (Foucault, 1988, p. 18). To frame my engagement with DHRs as a technology, I draw on Ahmed's analysis of use (2019). For Ahmed, herself drawing on Foucault, considering use allows an exploration of what things are understood as being useful for; how this understanding comes about; and how use is both structured and structuring because of assumptions of how something should be

used and by whom. Importantly, both Foucault and Ahmed remind us that the deployment of technology is neither neutral nor passive. Rather, it is active and purposeful, even if it might appear otherwise (e.g., when something is left unused). Meanwhile, an awareness of use lays the groundwork for resistance or change through (queer) use as an alternative, including what something is understood as for and who may use it. My examination of use reveals both the potential of, but also the peril with and within, DHR.

1.2 The Origins of my Research

This thesis is rooted in my practice. In 2013, as a DAC,[25] I took on responsibility for a DHR into the death of an older woman who had died in what her husband claimed was a suicide pact (which he had survived). During that DHR, my first, I witnessed different ways of engaging with and responding to the DHR process. I also came to understand the difficulty of keeping a victim central when producing findings. This difficulty arose because of the limited information available about the victim, as well as how the perpetrator's account framed her death, particularly as she could not respond. Over the following years, I had the sad responsibility of commissioning further DHRs and, in 2016, began leading them as an independent chair.[26]

In both roles, I was motivated by a belief that we had a responsibility to the dead to understand what happened. Yet, my optimism about DHRs' potential was and is tempered with a recognition that, while we must hold perpetrators accountable for their actions, a DA-related death is a collective failure: we could not keep someone safe (either directly, or by way of addressing a perpetrator's behaviour) and did not prevent

[25] Following footnote 15, I use 'DAC' generically. My job title was 'Strategic Commissioner – Domestic and Sexual Abuse, and VAWG' and I had operational, commissioning, and strategic responsibilities.
[26] Working with an NGO called Standing Together Against Domestic Abuse. See: https://www.standingtogether.org.uk.

their death. In response, honouring a victim, both by attention to their life but also by ensuring our acts after their death are purposeful and meaningful, has become increasingly important to me. So too has open and effective engagement with testimonial networks after a victim's death.

My professional role then brought me into encounters with domestic homicide, with these encounters extending and deepening during my research. I use the word encounter because, in both contexts, I feel that I come to know someone. That knowing is partial; it is akin to a glimpse in a crowd. It is also fragile; it can be dissipated as I and others are pulled into the DHR process, distracted by discussions of procedure and policy, and/or wrangling between organisations. The same partiality is also true of my research. Yet, as is often the case in this field (Cullen *et al.*, 2021), these encounters have become the engine of my research. In response, I have used two strategies as part of a developing feminist praxis, which I explore further in the *Methodology*, but in summary:

1. In investigating use, *I turn inward*, considering what it means to use myself as the researcher. Specifically, as explained above, I enter research with situated knowledge reflecting my experience and positionality. Insider status can be both beneficial and challenging (Westmarland and Bows, 2019). To manage this, I have drawn on Schön's (1983) conception of the 'reflective practitioner'. Additionally, taking an intersectional perspective (Crenshaw, 1991), I have sought to *hold myself, not the victim, as the Other*. This means considering if and how I – as a Welsh, White British, gay man, whose gender aligns with the sex I was assigned at birth, who comes from a middle-class family, has dyslexia but has also benefited from an extensive education, and as someone who has not experienced the loss of a loved one to domestic homicide – can research and write about these

deaths. That question is particularly apt given my relative privilege and because many of those killed or who died led lives different from my own, shaped by structural inequalities and discrimination.

2. In using DHRs, I have learnt to think of the victim as *being next to me*, an imaginative act that, in writing about research practice, has been described as 'offering a corrective to the liberties we… are prone to take with their [research participants'] lives' (Back, 2007, p. 151). Thus, I have learnt to *start with, return to, and then part from*, the subject of a DHR. In taking this approach, I am indebted to Websdale (2005), who imagined a dialogue about DVFR between a researcher and, in his terms, a 'battered woman'. In this dialogue, the two interlocutors debate the purpose, conduct and outcome of DVFR. I draw on this dialogue in later chapters but note it here as it inspired me to consider the possibility of an external perspective as a means by which to critique review.

   I also draw attention to the *Dedication*, which is a product of that imaginative act and a way to acknowledge and centre, however limitedly or fleetingly, those I study.

1.3 Research Rationale and Aims

To summarise the preceding discussion, my practice has shaped my research while, at the same time, my research has led me to interrogate my practice assumptions. Consequently, I seek to answer the overarching research question, how do DHRs operate as a technology to produce knowledge? To answer this question, I consider five specific research questions:

1. What assumptions underpin DHRs?
2. What norms are employed in the conduct of DHRs?
3. How does decision-making and meaning-making manifest in DHRs?
4. How is individual, institutional, or social change understood?

5. How are learnings and recommendations produced?

1.4 Thesis Structure

In each chapter, I reflect on my practice experience. I do so to familiarise the reader to the issue at hand and, as noted above, to make explicit and engage with my insider status.

Following this introduction, *Chapter Two* examines the literature relating to DVFR/DHR. I introduce review as a technology and map out the analytical opportunity of exploring DHR – as a system, process, and product – through the prism of use. This conceptual framing allows me to examine what DHR is for, what is used by and in DHRs to generate knowledge and, finally, how DHRs themselves are used.

In *Chapter Three*, I discuss my method(ology), set out my theoretical perspective and positionality, and explicate how these shaped my mixed methods research design. I also address ethical issues and present my thematic framework.

In *Chapters Four* and *Five*, I present findings concerning how DHRs became *available for use* and then understandings of *what they are for*. I show how the foundations and framework for DHRs are neither stable nor robust. Compounding this, I also show how there are multiple ways of understanding what DHRs are for. Yet, while these ways of understanding are interconnected and reinforcing, if one or more of these purposes is not achieved, then this also means others can be adversely affected. Taken together, I argue that there is complexity and tension *with* the DHR system, which then affects their doing as individual case examinations.

In Chapters *Six*, *Seven* and *Eight*, I focus inward and consider use *within* DHRs. I explicate the practices in undertaking individual case examinations (i.e., what is *used by and in* DHR), as well as the relationships between stakeholders (i.e., how DHRs are *useful* as a site for dialogue). Finally, I address how DHRs can lead to action (i.e., how

they are themselves *used*). In each of these chapters I show how the complexity and tension noted above can affect the doing of DHRs, including potentially rendering them less useful.

Across my findings, I draw out the potential but also the peril of DHRs because of their functioning as a technology. Expressed as the latter, DHRs may individualise our understanding of domestic homicide, thus directing attention away from the broader context including the responsibility of the state. Such misdirection is to the detriment of learning, stakeholder experience, and the story told about a victim's death. Yet, as the former, DHRs may enable an attention to DA-related deaths, including accounting for a victim's experiences and being the basis for meaningful practice, policy, and systems change.

In *Chapter Nine*, I bring together my analysis, reflecting on the implications of my findings for scholarship, policy, and practice. Given my focus on use, I consider what I hope my research will be used for, both by myself but also for the development of DHRs. I conclude by thinking from use to make a call to broaden approaches to DHRs by seeking both procedural and outcome justice.

Chapter 2: Reviewing Domestic Abuse-Related Deaths

2.1 Approaching Review as a Technology

In the previous chapter, I introduced the complex, generative and yet perilous potentialities of DHRs. I address these perilous potentialities by exploring the doing of DHRs, including by focusing on knowledge generation. Before introducing my methodology and presenting my findings, here I examine the conceptualisation of review and the extant literature. To begin, I explicate my decision, introduced in the last chapter, to approach DHRs as a technology through the prism of use.

Technologies shape everyday practices and are also implicated in power relations (Sturken, 1997). Foucault identified technologies of power, production, signs, and self (1988). These different technologies do not stand alone and in fact intermingle (Tamboukou, 2003). My focus is on review as a technology of power. As an example of a technology of power, in *Discipline and Punish* Foucault explicated how the examination is a technology that 'constitute[s] the individual as effect and object of power' (1977, pp.187-192). In Foucault's account, power is first rendered invisible while the individual subject is foregrounded and treated as an object. Second, the individual is documented (i.e., they are described as an object). Third, the individual becomes a case that is an object of knowledge/power.

Importantly, any technology is Janus-faced. Thus, a technology can be disciplinary and, at the same time, facilitate opportunities for resistance (Sawicki, 1991). This duality is illustrated by prisons. Prisoners are, as Foucault has explored in *Discipline and Punish,* subject to discipline, with this being achieved through practices of observation and arrangement for the purpose of control. Yet, conversely, as Foucault's role in the French prisoner rights campaign, the *Groupe d'Information sur les Prisons* shows, this process of objectification can also facilitate resistance. Thus,

suspicious of state statistics, the group collected data (including prisoner testimonies) to raise public awareness of the dire state of prisons and to call for an end to oppressive penal practices (Welch, 2010).

In review as a technology, in the same way as in an examination, the dead subject is foregrounded, treated as an object to be documented, and becomes a case that is an object of knowledge/power. Thus, as a technology, reviews produce ways of knowing about the very problem with which they are concerned (Foucault and Rabinow, 1984). To demonstrate this, I have previously applied this conceptual framework to undertake a discourse analysis of policy documents about DHRs' emergence (Rowlands, 2022a). I highlighted how DHRs were framed in policy in terms of the potential for the state and organisations to be seen to be responding to, and learning from, domestic homicide. Yet, simultaneously, the policy framing rendered victims as objects to be examined rather than attending to their agency and subjectivity. Consequently, because this operated to appropriate someone's story (Opie, 1992), I described this as 'learning from, rather than about' victims of homicide (Rowlands, 2022a, p. 3671). In this way, reviews could be viewed as a technology to manage risk (Walklate and Hopkins, 2019; Websdale, 2020), doing so by producing a particular subject and integrating them into a prevailing regime of truth (Behrent, 2013). Such management might individualise a victim's experience and possibly blame them and/or contain or neutralise any critique of state responses. Consequently, review systems may be constrained or co-opted by the state, something Sheehy has argued affects their conduct and ambition (2017).

Conversely, reviews could be an opportunity for other forms of knowledge and thus resistance. This possibility is implicit within DHRs, given the emphasis in the statutory guidance on seeing through a victim's eyes (Home Office, 2016b, p. 7),

although as noted in the *Introduction*, this is not foregrounded specifically as a stated purpose. Nonetheless, in this way, Monckton-Smith understands DHRs as being a 'forum where victim voice can be considered' (2012, p. 146). This speaks to the possibility of DHRs narrating what Foucault called 'subjugated knowledges', that is, 'naïve knowledges', which are often excluded because they are seen as 'beneath the required level of cognition and scientificity' (1980, p. 82). Thus, DHRs may be one way of challenging power by better describing deaths and then demanding action (D'Ignazio and Klein, 2020).

Critically, and responding to my overarching research question, this interplay between discipline and resistance has a range of implications because, as described in the last chapter, DHRs are a process (of individual case examination and as a system) and a product (as DHR reports, individually and in aggregate). Thus, conceptualised as a technology, it is possible to consider both the discursive and operational practices at play with and within DHRs. Such consideration include how knowledge production is structured by the space created for, and relationships between, the stakeholders involved. This conceptualisation brings into focus that which is sometimes little considered, specifically the 'background practices' that produce scientific representations (Sawicki, 1987, p. 162). This is an important contribution given the literature about review has, to date, been 'limited, fragmented, and primarily descriptive' (Dawson, 2017b, p. vii).

2.2 Thinking from Use

Conceptualising reviews as a technology allows for an engagement with their doing including the data and epistemological gaps within them and the influence of gendered social structures. Although I conceptualise review as a technology, as already noted, I explore this by drawing on Ahmed's analysis of use, specifically by 'think[ing]

from use' (2019: 65). Ahmed approaches use by exploring what things are understood as being useful *for*. In approaching use, one metaphor that Ahmed deploys is that of a path. Using this metaphor, Ahmed explores how and by whom a path can be used, who is prevented from using it, as well as what happens through repeated use, and the opportunities for resistance through (mis)use. The metaphor of the path also captures how choices are made about when and how a path became available for use in the first instance. Use then is structured and structuring.

Understanding reviews as a technology is thus apt because – like other fact-finding processes about the dead – they function as an 'observatory mechanism' (Prior, 1985, p. 167). Thus, in effect, review is a mechanism through which an examination is delivered. Such examination is dependent on the body of a victim whose death is the trigger for, and anchoring moment of, a review. Yet, DHRs are not simply a factual representation of a killing or death and any findings about it. First, as noted in the last chapter, domestic homicide is a socially constructed phenomenon. Consequently, as with any homicide, there can be different ways of understanding a 'successful' response. In a criminal justice (CJ) context success can encompass securing a prosecution, the quality of investigation, addressing community concerns, or preventing future deaths (Brookman and Innes, 2013). Similarly, what is understood as a 'successful' DHR is contingent. This contingency arises because the knowledge generated is dependent on the operational practices employed and the impact of potentially competing explanatory discourses (Rowlands, 2020b), as well as stakeholder interactions (Haines-Delmont, Bracewell and Chantler, 2022).

Second, there are different ways of observing these deaths. Thus, reviews are a type of mechanism that examine DA- (and more broadly gender-based violence-) related deaths. Illustratively, with reference to femicide, Walklate *et al.* (2020) have

described such mechanisms as 'counts', identifying examples run by international bodies (like the UNODC, 2019); those undertaken at a national level, including in the U.K., notably femicide observatories (i.e., the Femicide Census. See: Long *et al.*, 2020[27]); administrative data (i.e., the Home Office uses police data to maintain a Homicide Index, with this then being used in official statistics. See: ONS, 2021); and DVFR/DHR.

However, these counting mechanisms face data and epistemological gaps (Walklate and Fitz-Gibbon, 2022). A *data gap* arises because data quality can vary, often linked to the source and method of data collected. Thus, in measuring violence, there is a predominance of more traditional forms of administrative data, particularly CJ statistics (Schröttle and Meshkova, 2018). Yet, while administrative data can identify broad trends it is limited when analysing the specific dynamics of deaths (Dobash and Dobash, 2015). Associated with this, an *epistemological gap* may also arise, reflecting the extent to which deaths can be explained, e.g., with reference to the effect of gendered social relations (Walklate and Fitz-Gibbon, 2022). This limitation, partly due to the data gap, also derives from the differing purposes of counts, which can be framed

[27] The Femicide Census is an important example of an activist driven count of men's violence towards women. Yet, I struggle in citing it because, while first including trans women (Brennan, 2016, p. 25), the most recent report included a section on those killed by 'perpetrators… known to be "transgender" or transvestites' [sic], while excluding trans women as victims (Long *et al.*, 2020, p. 86). Thus, by the manner of their inclusion and exclusion, trans people are framed as illegitimate data subjects (Guyan, 2022). This is despite, for example, the possibility of accounting for trans women's experiences using the concept of transfemicide (ILGA World, 2021). Consequently, the position adopted by the Femicide Census is trans-exclusionary and practices such as this illustrate the challenge in being trans inclusive while working on domestic homicide (Whynacht, 2022). My concern is that, as Ahmed has argued, citation has a political currency (2017, p. 15-17). Because citation is a way of reproducing ways of understanding the world, Ahmed has made the decision not to cite trans exclusionary radical feminists (2017, p. 269-270). For me, if I cite the Femicide Census, I risk re-producing trans exclusion. However, I do not feel I can adopt Ahmed's position for two reasons. First, because of the significance of initiatives like the Femicide Census. Second, because I believe it is possible to promote a dialogue, even where there are (potentially radically) different views (e.g., see how I and colleagues addressed this in Cullen *et al.*, 2021). To manage this, I acknowledge my concerns here and only cite the Femicide Census (and other similar work) where relevant and if there is no other alternative.

across the domains of justice, (public) health, and civil society (Cook, Walklate and Fitz-Gibbon, 2022).

Illustratively, consider the Homicide Index, which is derived from data collected in the domain of justice and is a product of the state. Given this focus, counts like the Homicide Index do not capture data on sex/gender related motivation because these are not relevant to prosecution (Dawson and Carrigan, 2021). Conversely, in the civil society domain, femicide observatories are NGO led and capture data on the broader context of these deaths, often using sources of information like media reports to 'fill the gaps' (Walklate *et al.*, 2020, p. 25). Femicide observatories are thus an example of a 'counter data' effort, whereby activists and researchers seek to address otherwise inadequate state efforts (D'Ignazio and Klein, 2020).

Importantly, Dawson and Carrigan (2021) have suggested that these data and epistemological gaps (and so the need to fill them) arise because the killing of women has not been a priority for decision makers and is therefore demonstrative of Walby's concept of public patriarchy (1990). As a result, a fuller picture of these deaths is required to enable preventative efforts (Cullen *et al.*, 2021). Extending this point, Walklate *et al*. have described how the differences between these counts could be understood in terms of whether they are 'thick' or 'thin'. A *thick* count seeks to contextualise a victim's experience and situate it within 'structure, culture, time, and space'. Alternatively, a *thin* count is more limited – often because it is based on administrative data – with this being to the detriment of understanding, not least in terms of gender and other inequalities (2020, pp. 98–101). At the heart of this distinction is that thickness is *more than simply counting* (i.e., tabulation), because it seeks instead to *account* for and understand the lives of those killed.

This conceptualisation can be applied to reviews. Like the Homicide Index, reviews are usually state mandated. Yet, like femicide observatories, reviews operate beyond the limits of CJS rules and data (Buxton-Namisnyk and Butler, 2019; Websdale, Ferraro and Barger, 2019). This potential is articulated by Websdale's call for reviews to adopt a 'wide-angled lens', thereby bringing the 'complexities of [IPH] and other [DA]-related deaths into sharp focus' (2010, p. 5). Consequently, reviews are perhaps the 'most systematic and coordinated' of counting mechanisms (Walklate *et al.*, 2020, p. 23), although their focus presents some challenges, given they are necessarily based on a subset of DA cases (Messing *et al.*, 2022).

However, despite being systematic and coordinated, I argue knowledge generation in review is contingent, and that questions of use enable an interrogation of DHRs as a technology. Such an interrogation is important because, reflecting the Janus-face of technology, innovation – of which the introduction of review is an example – can have uneven social impacts, including in terms of its effect on gender relations (Dahlin *et al.*, 2022).

Illustrating this contingency, some years ago, I was commissioned to complete a DHR, succeeding another independent chair. It is not necessary to recount the circumstances here. The key point is that I discovered that my predecessor and I had very different perspectives. Writing in my practice journal I reflected: 'it was as if we were writing about different cases. Our approach, analysis and conclusions barely overlapped. We had produced completely different accounts of the same homicide'. Extending Ahmed's metaphor of the path, I and my predecessor had begun our journey using the same mode of travel (the DHR system) and with the same provisions (the information gathered during the DHR). Yet, the paths we had then taken (the practices we used) were evidently different given we produced divergent findings. One way to

account for this divergence might be that we had different understandings of use relating to DHRs; that is, what they are for, what we could use when conducting them, and how we imagined the findings would be used. Thus, while my findings located the victim's death in a wider social context, I felt my predecessor had individualised the learning.

This experience piqued my interest in, and has gone on to shape my thinking about, use. Moreover, this example shows how the path taken in a DHR can structure an inquiry, something described elsewhere as the 'decision-making moments' in review (Albright *et al.*, 2013, p. 437). Finally, the consequences of these decisions speak to Sheehy's claim that – from the perspective of feminist analysis and participation – the knowledge generated by review systems can be problematised (2017).

Having set out my account of DHRs as a technology, and use as my way to approach them, I now turn to the literature. Inspired by Ahmed, I consider three aspects of use: purpose (*what is review for?*); process (*what is used by and in reviews?*); and product(s) (*how are reviews themselves used?*). For each aspect, I first discuss review generally, then address implications for DHRs.

2.3 The Purpose of Review

In asking *what review is for*, it is necessary to understand how review emerged. As already noted, DVFR first emerged in the U.S. before being adopted elsewhere, including England and Wales (Dawson, 2017a). Websdale (2012) has argued that review arose due to increased attention to DA, concern about crime/victims, and feminist driven policy/social change. These factors are present in the countries where review has been introduced, including public outcries following high-profile domestic homicide(s) (Dawson, 2017a), changed responses to DA (Devaney *et al.*, 2021), and the influence of feminist activism (Htun and Weldon, 2018).

Explaining their emergence, Websdale has emphasised that DVFRs are found in functioning democracies and are an attempt by the state to address domestic homicide (2020). However, while convincing, Websdale does not explore what the state's role may mean. Yet, the state's role raises challenges. Indeed, how these systems come into being is demonstrative of the potential tensions that review may present as a technology. As Dawson has observed, 'the impetus for [DVFR] has largely been driven by feminist and [VAW] activists/advocates' (2021, p. 672). At the same time, Dawson – and others like Websdale (2020) and Bugeja *et al*. (2017) – have highlighted that, whatever critical contributions activists/advocates may make, most review systems are dependent on the state for their establishment. The means that, as with DA more generally, there is a risk that the aims of activists/advocates may be compromised as responses to DA move from being about social change to becoming state action (Bender, 2017).

This tension can take the form of disagreement between stakeholders as to what review is for, thereby affecting both operation and knowledge generation. For example, Websdale, Celaya and Mayer have recognised that how review is established – including the extent to which its operation is 'prescribed' (2017, p. 40) – will affect its doing, although they did not explore this further. Yet, while it is sometimes helpful to refer to 'the state', it is not a singular entity; the state is not an "it" but rather a terrain of powers and techniques (Brown, 1995, p. 174). This means we might also consider *the role of the different parts of the state*. This is relevant in review, given both the multiplicity of state organisations that might be involved but also because, however disparate, collectively state organisations are usually in the majority, with less representation from activists/advocates (Sheehy, 2017; Dawson, 2021). Meanwhile, more broadly, the state's record towards DA is, at best, mixed and it can be

conceptualised as 'enabling and constraining, as a potential ally and as an oppressive force' (Charles, 2000, p. 5). Taken together, this means review systems may themselves be at risk of being constrained or co-opted by the state, as I have described above.

One way to illustrate this possibility is to consider the *primary conceptualisation of the use of review*, which is that it is preventative. That is, by examining DA-related deaths it is possible to learn from them, identify gaps and issues in practice, policy, and system responses, and then address these. The intention is that this will improve responses to DA and, perhaps, prevent future deaths (Dawson, 2021). In this respect, review has been influenced by ideas around cultures of safety, e.g., in the aviation industry, which emphasise a no-blame learning culture and instead a focus on individual and collective accountability (Websdale, Town and Johnson, 1999; Watt, 2010; Websdale, 2012; Boughton, 2022).

In this conceptualisation of use, reviews contribute to prevention by enabling an understanding of patterns in domestic homicide, including risk factors (Messing *et al.*, 2022). This reflects a broader interest in risk assessment to identify, intervene, and prevent homicide. The preventative agenda can also be understood as encapsulating associated changes, e.g., in professional practice or training, policy or legislation, and identifying ways to increase community awareness.[28]

This emphasis on prevention through understanding and responding to risk has implications for what review is understood as for, particularly as this conceptualisation might be situated within the framework of 'crime control' (Garland, 2002). Crime control provides a broader context that often frames both DA and homicide. A central

[28] The extent to which risk factors can be identified, assessed, and managed is the subject of much debate. This includes whether review can identify those risk factors that might be predictive of homicide (Belknap *et al.*, 2012; Dobash and Dobash, 2015). More broadly, this relates to the reasons for the adoption, as well as impact and efficacy of, risk assessment tools. For a critique see Walklate and Hopkins (2019) and Barlow, Walklate and Johnson (2021). For an overview of the evidence base, see Graham *et al*. (2021).

feature of crime control has been approaches that classify and manage risk (Feeley and Simon, 1992; Robinson, 2016) and a focus on the auditing of the performance of CJ organisations (Goodey, 2005). While this perspective has driven a panoply of practice, policy and system responses – often to the benefit of victim/survivors (e.g., see Robinson, 2006) – a risk paradigm has been criticised for focusing on those at the highest risk to the detriment of early intervention and/or longer-term recovery (Stark and Hester, 2019). As suggested above, that may mean review contains or neutralises critique of the (inadequacy of) state responses. One way to do this it to exceptionalise DA-related death by treating them as 'anomalies' (Whynacht, 2022, p. 7).

However, while a discourse of prevention dominates, other uses of review have been identified, including as a means to: offer (partial) redress to family and other testimonial networks (Mullane, 2017; Roguski *et al.*, 2022; Rowlands and Cook, 2022); challenge forensic narratives that tend to favour perpetrators at the expense of victims, both in the media and CJS (Monckton-Smith, 2012; Buxton-Namisnyk and Butler, 2019); memorialise victims (Walklate *et al.*, 2020); and act as a form of civic engagement (Websdale, 2012). What is less clear is the extent to which these broader understandings of purpose inform the doing of review, particularly if there is tension within review teams about purpose (Watt, 2010; Boughton, 2022).

A further consideration is *who is counted* and a first critical question facing any review system is what deaths are in scope (Websdale, 2020; Dawson, 2021). While usually including IPH, review systems are more or less inclusive of other victim-offender relationships or types of death events (Fairbairn, Jaffe and Dawson, 2017). One key difference is the priority given to 'relational distance' (Dobash and Dobash, 2012, p. 664) and, in review, there is often a focus on IPH/AFH to the exclusion of unrelated, corollary victims (e.g., bystanders, see: Smith, Fowler and Niolon, 2014). Other

differences are whether deaths by suicide are included (Bugeja *et al.*, 2017). Importantly, scope is not simply practical: it is normative because decisions about scope determine the inclusion or exclusion of specific communities (Jaffe, Scott and Straatman, 2020).[29]

Having decided on what types of deaths are in scope, the second critical question is *what proportion of cases are reviewed* (Bugeja *et al.*, 2017). This may range from a close scrutiny of some/all cases to a lighter touch examination of a larger number (Websdale, Town and Johnson, 1999). Watt (2010, p. 63) has described this as the difference between 'biographical' and 'epidemiological' approaches: the former enables in-depth understanding, and the latter identifies aggregate trends. This may seem like a practical decision, perhaps reflective of the resources available (Websdale, 2020). However, intentionally or not, it means some deaths are prioritised over others (Dawson, 2021).

Approached as a technology, these decisions about who is counted mean that there is a risk that the subjects of review are treated as objects, particularly if case type/selection is based on a nominally objective assessment of presumed importance. Such importance may be assessed based on case profile and thus the potential for a particular type of learning, perhaps about risk or contact with statutory organisations.[30]

In this discussion of what review is for, I have demonstrated how review operates as a technology. Thus, it is usually dependent on the state for its establishment, and while understandings of what it is for vary, they largely focus on risk. Moreover, reviews literally produce ways of knowing about the very problem with which they are

[29] For example, the killings of LGBTQ people may not be captured because of how scope is defined and/or if relationships are obscured (if one or both was not out, the nature of a romantic/sexual relationship was unclear, or administrative data is unable to capture identity) (Rossiter, Reif and Fischer, 2020).

[30] An example of this is the death of Ruth Williams, where the responsible CSP decided not to commission a DHR because there had been limited organisational contact (*BBC News*, 2021).

concerned (Foucault and Rabinow, 1984), with this happening as decisions are made about *what* (and so *who*) counts.

Implications for DHRs

A concern as to what review is for is also relevant to DHRs. Relatively little has been written about the emergence of DHRs, although Payton, Robinson and Brookman (2017) – like Websdale – locate their origins within the broader response to DA and identify antecedents like the development of different statutory review systems and the impact of high-profile killings. However, as previously noted, while DHRs were established by the DVCVA they were only implemented in 2011. This seven-year delay, which is largely unexplained, means there was a 'curious trajectory' to implementation (Rowlands, 2022a, p. 3660). Importantly, this delay provides a literal example of how the state can be both 'enabling and constraining' (Charles, 2000, p. 5) and thus the possible hazards of dependency. [31]

Given the sluggish progress of implementation, it is notable that a key driver in this being achieved was a campaign by Frank Mullane to secure a DHR into the killing of his sister Julia Pemberton, as well as his nephew Will, by their ex-husband/father in 2003. This campaign was successful, with the 'Pemberton Review' being undertaken before the implementation of DHRs (Walker, McGlade and Gamble, 2008).[32] Subsequently, the Pemberton Review has had a formative impact on the DHR system (Websdale, 2010; Monckton-Smith, 2012), not least for the role of testimonial networks

[31] A further example of this temporal peril is, as reported in footnote 7, the long timeframe to implementation in Northern Ireland and Scotland.

[32] Mullane has written an account of his experience (2012). Mullane's impact on the development of DHRs has parallels to the impact of others bereaved by domestic homicide who have then influenced policy formation, often because of their outsider status and the power of their personal experience (Wheildon *et al.*, 2021).

and the development of advocacy services.[33] This can be understood as an example of how 'personal troubles' can be mobilised as 'public issues' in the pursuit of justice, by family but also in service to the state (Cook, 2022, p. 4). This is particularly notable given DHRs place a distinct emphasis on family involvement in contrast to other review systems, although whether this is achieved is unclear (Mullane, 2017; Rowlands and Cook, 2022).

As with DVFR generally, DHRs are primarily conceptualised as preventative. Thus, in terms of their findings, an early focus of research using domestic homicide cases was on the identification of risk factors to inform safety planning (Richards, 2003, 2006; Robinson, 2006). Examining domestic homicides was also seen as a tool to measure performance when the police failed to manage risk (Stanko, 2008). Finally, DHRs' focus on prevention can be understood in the context of their functioning as a counting mechanism, given this is premised on them being 'an opportunity for information gathering' (McPherson, 2022, p. 3).

Meanwhile, as I have already highlighted, the policy discourse surrounding DHRs emphasised the state's role in introducing them, identifying them as primarily an opportunity to learn about risk at the expense of understanding victim experience (Rowlands, 2022a). More broadly, questions about purpose pervade DHRs, including whether they are – as outlined above – conducted as, or perceived as being, a way of containing or managing blame (Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022).

[33] Mullane subsequently founded an NGO called Advocacy After Fatal Domestic Abuse (AAFDA), which provides specialist and expert advocacy to families around DHRs. See: https://aafda.org.uk.The other main NGO providing support to families is the Victim Support Homicide Service (VSHS). See: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service/.

Finally, while DHRs are 'biographical', given that each death which meets the criteria should be reviewed, it is unclear whether this is always the case.[34] Thus, as with review generally, DHR as a technology has perilous potentialities, underscoring the need to consider how it came into use.

2.4 The Process of Review

After purpose, the question then becomes how to do review, including what is *used by and in this process*. While differences arise based on the manner of establishment (Bugeja *et al.*, 2017), review systems have commonalities. First, they are multi-agency, with this underpinned by the aforementioned no-blame philosophy. Second, reviews draw on a range of information from statutory organisations, NGOs, and perhaps testimonial networks. Third, this information is analysed to identify gaps in practice, policy, and system responses. Fourth, and to address these gaps, learning and recommendations (i.e., findings) are generated, disseminated and – in some systems at least – there are mechanisms to monitor the resulting changes (Websdale, Town and Johnson, 1999; Websdale, 2020; Dawson, 2021).

Yet, there is a lacuna at the heart of our understanding of what is used in review. Consider Albright *et al*. (2013)'s summary of the underlying assumptions of review, based on their reading of a key text (Wilson and Websdale, 2006). Paraphrased here, Albright *et al.* identified that: (a) no single professional or organisation can end DA alone; (b) DA-related deaths may be preventable; (c) the perpetrator is responsible for the homicide; but (d) those involved in review are accountable for their response, and so can recommend improvements that will lead to improved safety. While these assumptions are important, Albright *et al*. (2013) do not thereafter fully articulate the

[34] CSPs are not required to report on the 'conversion rate' from deaths to DHRs being commissioned. A study examining DA-related deaths during the Covid-19 pandemic indicated a high acceptance rate for police referrals. However, study limitations included a large amount of missing data (Bates *et al.*, 2021).

components required to do review. This oversight is ironic because, in an otherwise important contribution, they use an evaluation framework to identify a range of ethical issues affecting the doing of review. This silence is representative of the broader literature, wherein the doing of review has mostly been unexamined. Thus, when Bugeja *et al*. (2017) appraised review systems they focused on four elements including governance and structure; cases considered; outputs; and impact. Yet, Bugeja *et al*. did not examine the doing of review per se, albeit they did note the complexity of these systems as a study limitation, including that review is 'often iterative and evolves over time' (p. 7).

Instead, I would suggest that review seeks to (1) be collaborative, insofar as it brings stakeholders together; (2) achieve sense-making through dialogue; and (3) produce knowledge about DA-related deaths to facilitate change to practice, policy and systems. To highlight the value of considering what is used in and by review, I now address these components.

Stakeholder Collaboration

In approaching collaboration, we might recognise that review is useful because it brings together multiple stakeholders, usually organisational representatives, to form a review team. In essence, a review creates a community of practice, which can be defined as comprising a joint enterprise, mutuality, and a shared repertoire of communal resources (Wenger, 2000). Writ large, this model of multi-agency and partnership working, premised on bringing organisations together and mobilising them individually and collectively to respond to DA, is known as the 'Coordinated Community Response' (CCR) (Shepard and Pence, 1999). In addition to being an intervention, the CCR can also be understood as a theoretical model and is underpinned by assumptions about the best way to achieve justice for victims (Mulvihill *et al.*, 2018).

Not unsurprising, stakeholder identification has been described as critical in establishing a review (Dawson, 2021). A diverse review team is not only about knowledge and perspectives, but also about representation (Dale, Celaya and Mayer, 2017), including the involvement of the feminist movement and/or the representation of community expertise (Bent-Goodley, 2013; Sheehy, 2017). In other words, to effectively examine DA-related deaths it is necessary to 'tap the talents' of a team of reviewers (Websdale, 2020, p. 18).

However, *how a review team is used* remains under-examined. Reflecting this, a recent account detailing the development of a standardised DVFR dataset in the U.S. offered a normative account of review team functioning (Websdale, Ferraro and Barger, 2019). That review teams would function well is an understandable hope. Indeed, positively, some research has reported evidence of high levels of engagement, including improved partnership working and practice, policy or legislative outcomes (Jaffe and Juodis, 2006).

Nonetheless, there may be challenges in achieving collaboration because of the breadth of a review term and/or potential membership changes over time (Marsh Pow *et al.*, 2015). As a demonstration of this, in an otherwise descriptive account of a review team in Denver (U.S.), it was noted that there had been a fair amount of membership 'turn over' (Belknap *et al.*, 2012, p. 363). Such turnover may affect team culture, e.g., in managing the balance between a culture of no-blame and accountability (Watt, 2010). Changes in membership may also affect decision-making because conflict may arise from different organisational or professional backgrounds (Albright *et al.*, 2013).

More specifically, one reason for having a diverse review team is that, for the most part, it is from these organisational representatives that the information used by review is obtained. Hence, reviews usually gather information from a wide range of

sources, especially information from the CJS, other organisations, and sometimes information from testimonial networks (Marsh Pow *et al.*, 2015; Websdale, Ferraro and Barger, 2019). Yet, to date, there has been no study to examine the gathering and use of such information, although it has been reported that there may be challenges with completeness and quality (Jaffe *et al.*, 2014). What is left unanswered is how these review teams are formed and work together. That is, how is a multi-agency team used to do review?

Finally, it is important to note that testimonial networks are also stakeholders. While this is a developing area of practice (Dawson, 2021), it is nonetheless significant because family involvement can vary, from families being a source of information with relatively little direct influence to being active stakeholders (Rowlands and Cook, 2022). Similar questions about how family are used therefore arise.

Dialogic Sense-Making and Knowledge Production

The process of making decisions – what I term 'dialogic sense-making' – has been little considered. Yet, along with knowledge production, this – including how decisions are made about findings, which then materialise in any product – is a critical part of review. One author who has sought to address dialogue and knowledge production is Websdale (2012). Building on the idea that review enables multi-agency collaboration, Websdale describes review as a space for enacting dialogic democracy, drawing on Gidden's notion that controversial issues can be addressed in this way (1998, p. 16). In framing review, Websdale draws on the three elements, describing review as a mechanism that:

(1) Brings together different interests, given it involves multiple stakeholders.

(2) Provides an opportunity to discuss a complex issue, specifically, the circumstances leading to a DA-related death. This opportunity is particularly apt as DA can be

considered a ‘wicked problem’ given the complexities of cause, consequences, and any solutions (Stanley and Humphreys, 2014).

(3) Operates outside of pre-established mechanisms of power, in contrast to, e.g., the CJS.

Several broad observations can be made about what may affect both dialogic sense-making and knowledge production. Notably, there may be conflicts and/or power differentials within review teams (Websdale, 2012). There are also issues around who speaks for the dead, how decisions are made, the construction of the events being considered, and the information used to do so (Dawson, 2021). Review team functioning may also affect sense making and knowledge production (Sheehy, 2017).

Take, as an example, accounts of a state-wide review team in Ontario, Canada. This team produces regular annual reports (Office of the Chief Coroner Province of Ontario, 2019), and collaborates with academic partners (e.g., see Musielak, Jaffe and Lapshina, 2020; Dawson and Piscitelli, 2021). However, accounts of dialogic sense-making and knowledge production are normative. Thus, to reach decisions, it is reported simply that those involved ‘collectively discuss… [findings] and come… to agreement’ (Dawson *et al.*, 2017, p. 69). Furthermore, consider how possible risk factors are identified. The identification of depression is based on either a diagnosis by a mental health professional or the opinion of testimonial networks, while decisions about the presence of one or more defined risk factors require team consensus (Dawson and Piscitelli, 2021). Clearly, although it is little explicated, through dialogic sense-making, information is first collected from individual organisations and then interpreted (Rowlands and Bracewell, 2022).

This is illustrative of Albright *et al's* point about our understanding of review; they are a site of dialogic meaning-making, implied in their recognition of ‘decision-

making moments', but simultaneously there is limited research into review as a method of enquiry (2013, p. 437). Thus, it is unclear what conditions are necessary and what practices are used to have a dialogue, let alone reach a consensus. This is not unique to the review team in Ontario. There is considerable variation in the practice of review and few review teams provide information about the practices they use (Marsh Pow *et al.*, 2015). As a result, while review systems rely on dialogic sense-making for knowledge production, we know little about it. This applies too to discursive practices. Consider the otherwise excellent examination of judicial discourse by Buxton-Namisnyk and Butler (2019), who explored sentencing remarks in femicide cases in New South Wales, Australia, to show how victim experiences can be marginalised and perpetrator responsibility minimised. Having traced discursive practices and their effect in sentencing remarks, Buxton-Namisnyk and Butler contrast this to the state review system, suggesting this can offer alterative, victim-focused, feminist-informed, accounts. Yet, in doing so, beyond a largely descriptive account, Buxton-Namisnyk and Butler do not look inward to consider how review systems themselves produce knowledge.

Implications for DHRs in England and Wales

Like other review systems, DHRs are a process of collaborative, multi-agency enquiry. As it is a national-level review system, the statutory guidance sets out expectations that encapsulate both what DHR is for, and how to do it (i.e., what should be used in and by DHRs). These expectations include the notification process; commissioning and establishment if the criteria are met; the constitution of a review panel; the gathering of information; the involvement of testimonial networks; expectations around the DHR report (e.g., contents and publication); governance arrangements (e.g., the role of commissioning CSP and the QA panel); and guidance on

data protection (Home Office, 2016b). Therefore, one might expect the doing of DHRs to be more consistent. Yet, despite this jurisdiction wide framework, DHRs are also localised. This is because individual CSPs may make different decisions about their conduct (Payton, Robinson and Brookman, 2017). In effect, there are centripetal and centrifugal forces at play i.e., centralised control pulls the DHR system inward while localised control may appear to pull away in the doing of individual DHRs.

Furthermore, as with review more generally, stakeholder collaboration has been little considered in DHRs, although stakeholder experience has been examined more generally (Neville and Sanders-McDonagh, 2014; Sharp-Jeffs and Kelly, 2016). The emphasis on collaboration reflects wider developments whereby the CCR has become the dominant model for multi-agency and partnership responses to DA in England and Wales (Westmarland, 2012; Welsh, 2022), with this most recently expressed in the current U.K. Government's *Tackling Domestic Abuse Action Plan* (HM Government, 2022). As a result, the multi-agency nature of a DHR means it is reflective of the CCR model (Payton, Robinson and Brookman, 2017; Jones *et al.*, 2022).

However, despite positive accounts of the impact of the CCR (Robinson, 2006; Hague and Bridge, 2008), multi-agency and partnership working is challenging. Thus, there are both enablers (Hague, 2000) and potential barriers (Cleaver *et al.*, 2019). Moreover, although the CCR can have a positive impact, there is an enduring concern that it – as with DHRs – might 'act as a smokescreen', appearing to drive change but delivering little (Hague, 2021, p. 176). Additionally, given a review panel is an 'artificial and temporary micro-environment' for the enactment of the CCR (Boughton, 2022, p. 71), it is notable that there is emerging evidence of the potential for tension (Haines-Delmont, Bracewell and Chantler, 2022). Finally, the nature of DHRs as a bespoke embodiment of the CCR also raises questions as to dialogic sense-making and

knowledge production, yet this too has been little considered. Indeed, the extant scholarship has – as already noted, and discussed further in the concluding part of this chapter – focused on the aggregation of data and secondary analysis.

In summary, as with DVFR, in DHR there is the potential for multi-agency collaboration, dialogic sense-making, and knowledge production to be contested (Boughton, 2022). Yet, there is limited evidence for how DHRs operate 'in-room' (see Table 1). As a result, as a technology, DHRs' operation – including what is used and how – is a 'black box' (Rowlands and Bracewell, 2022). Investigating this use means examining the 'facts' of a DHR by attending to their generative circumstances (Code, 1993). Such attention may help us recognise how stakeholders engage with DHRs, including managing conflicting perspectives, agendas and solutions, as well as the extent to which the operational and discursive practices of DHRs as a technology facilitate or impeded this engagement.

Table 1

Evidence Summary – Establishment and Operation of DHRs

Key Areas	Establishment and Operation (Home Office, 2012, 2013e, 2016b, 2021a)	Challenges/Issues Identified
Establishment and Governance	• Legislative framework provided by DVCVA. • Operationalised through statutory guidance with defined purpose(s). Localised implementation with responsibility held by commissioning CSP. • National oversight via the Home Office QA Panel.	• Local implementation means there may be variation in practice between CSPs (Payton, Robinson and Brookman, 2017; Montique, 2019; Haines-Delmont, Bracewell and Chantler, 2022). • Challenges with timeframes (Benbow, Bhattacharyya and Kingston, 2019; Potter, 2022). • Limited evidence of the effectiveness of national oversight (Rowlands, 2020a; Haines-Delmont, Bracewell and Chantler, 2022).
Team Composition	• Led by an independent chair who works with a multi-agency review panel. • Review panel must include some or all statutory organisations specified in the legislation and should also include DA specialists. May also include other NGOs. • Usually, organisations involved if they had contact with the victim, perpetrator, and any children, but may also be included without having had contact if they bring specific expertise (e.g., relating to particular communities or expertise around a particular issue).	• Variation in practice within individual DHRs, including independent chair (Stanley, Chantler and Robbins, 2019). • Absence of robust training or competencies framework (Montique, 2019; Haines-Delmont, Bracewell and Chantler, 2022). • Variations in practices of engagement of family and concerns of lesser status (Sharp-Jeffs and Kelly, 2016; Mullane, 2017; Rowlands and Cook, 2022), including children (Stanley, Chantler and Robbins, 2019). Inconsistency of inclusion of knowledge and expertise relating to a victim's specific experiences and needs (Montique, 2019; Chantler *et al.*, 2022; Jones *et al.*, 2022).
Scope	• DA-related deaths involving a former or current partner, family member, or member of the same household. Also, deaths by suicide.	• Limited picture of commissioning decisions (Bates *et al.*, 2021). Potentially issues with commissioning DHRs in some cases, e.g., older people (Benbow, Bhattacharyya and Kingston, 2019), the

		killing of parents (parricide) (Condry and Miles, 2022), and deaths by suicide.[35]
What is Reviewed and Whose Voices are Represented	• Biographical case review. • Use of a wide range of information, most commonly provided to the review panel in the form of an Individual Management Review (IMR) or similar and/or Chronology. • Review Panel process is deliberative. • Involvement of testimonial networks, with a specific role for victim's family and access to specialist and expert advocacy. • The perpetrator may also be invited to participate.	• Little evidence for how DHRs operate 'in-room', including quality of information sharing and analysis, although suggestion that this does not always capture context and nuance of deaths (Condry and Miles, 2022), including information lacking on victim (Bracewell *et al.*, 2021). • Evidence of potential for tension and disagreement 'in-room' (Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022). Findings may reflect understanding and identification of specific issues (Ward *et al.*, 2016; Todd, Bryce and Franqueira, 2021). • Individualised focus, lack of consideration of intersectionality (Sharp-Jeffs and Kelly, 2016; Chantler *et al.*, 2022). • May not always identify case specific learning (Vulnerability Knowledge and Practice Programme, 2020). • Risk that perpetrators may use a DHR to abuse (Rowlands and Cook, 2022).

Note. Framework adapted from Dawson (2021).

[35] See *Chapter Six* for a further discussion.

2.5 The Product of Reviews

In this final section, I turn to the *use of the product of review*. I argue that, as with their purpose and doing, as a technology review has perilous potentialities. What does such perilous potentiality mean for how review is used? Reporting is a key output of review systems and is tool for driving improved outcomes with respect to practice, policy, and system change. DVFR systems generally have a process for the routine aggregation of data (Dawson, 2017a), with many review systems going to considerable efforts to enable this (e.g., for the U.S., see Websdale, Ferraro and Barger, 2019).

Regarding aggregation, it has been suggested that reviews have largely been treated as 'data-gathering instruments' (Websdale, 2010, p. 6) and indeed, with this in mind, the approach of researchers has some commonalities. First, while advancing our knowledge of domestic homicide, researchers often uncritically extract and use data from reviews. That is, while different forms of analysis (usually some type of content and/or thematic analysis) are undertaken, there is little engagement with review as a process and then a documentary product. Where these issues are discussed, the focus is on issues for researchers. Thus, Jaffe et al. (2014), like Chantler *et al.* (2020), note that DVFR/DHRs are not produced for research purposes with implications for data quality. Others have recognised the interpretative nature of this work, given researchers are undertaking secondary analysis (Musielak, Jaffe and Lapshina, 2020) (this is something I explore in terms of my research in the *Methodology*).

Yet overall, there has been limited consideration of epistemology. That is, while review processes may be described, there is rarely reflection on what the doing of review means for research. Even when there is more than a process description, this tends to be reflections on the review system rather than a consideration of the contingency of the process and any documentary product. Yet, DHRs – as for

documents generally (Bowen, 2009) – are not a product that is inert, and so cannot simply be used uncritically as data. Demonstrating this potential in research practice, some scholars have highlighted the 'confidence the researcher can have in [DHR reports'] content' (Todd, Bryce and Franqueira, 2021, p. 86), only to become more circumspect about DHR reports as a data source in reporting findings.

Moreover, there is a further issue, which is how we approach a review's subjects. Without engaging with epistemology, we risk simply using data and thus occluding victim subjectivity. Websdale's imagined dialogue between a researcher and a victim/survivor of DA demonstrates this point. Here, talking about researchers and their use of homicide data, the interlocutor declares:

> In doing that research, they feed off of women's blood and the homicide files put together by those professionals who turn up to deal with the mess and process it… (2005, p. 1198).

I explore this further in the next chapter.

Regardless of these questions about how the findings of review are used, and what this means for its subjects, it is also of note that we know little about the practice, policy, and system change brought about. Notably, the majority of DVFRs cannot measure impact (Bugeja *et al.*, 2017). Indeed, although recommendations may influence priorities there is less evidence of what specifically changes (Storer, Lindhorst and Starr, 2013). Meanwhile, there is also sparse evidence of the impact of these systems (Jones *et al.*, 2022), with any evidence often being anecdotal (Websdale, 2020).

Importantly, and with relevance to an understanding of review as a technology that could be used by the state, Sheehy (2017) has argued that, even if there is evidence of change following review, this must be contextualised. Sheehy asks two important questions. First, are putative changes implemented or are they the equivalent of policy window dressing? Second, and regardless of any changes, how are these contextualised?

As an example, Sheehy asks whether, if a review recommendation leads to increased refuge funding, to what extent is this a success if the context is sustained cuts to funding in the preceding years? In other words, how are reviews being used, and might this be for the management of DA rather than an improved response per se.

Implications for DHRs in England and Wales

Like DVFR internationally, DHRs aim to learn from deaths (Home Office, 2016b). In contrast though, there has only been limited aggregation of DHRs' findings with, as noted earlier, no extant national repository. Thus, to date, the Home Office has only released three reports (Home Office, 2013c, 2016a; Potter, 2022). While the 2016 report was reasonably robust, observers rightly suggested that the 2013 report was of limited value (HM Inspectorate of Constabulary, 2014; Neville and Sanders-McDonagh, 2014). Meanwhile, while the latest report added to the picture by considering the QA panel (Potter, 2022), it is largely descriptive. The absence of any systematic reporting is arguably illustrative of the relative neglect of the DHR system, which has limited its potential (Rowlands, 2022a).

As a result, the importance of research is heightened. Here, as internationally, there have been notable contributions, including summaries of learning (e.g., Sharp-Jeffs and Kelly, 2016; Montique, 2019; Chantler *et al.*, 2020). DHR findings have also been used to explore the experience of specific cohorts, including children (Stanley, Chantler and Robbins, 2019), older people (Benbow, Bhattacharyya and Kingston, 2019), Black and minoritized victims (Chantler *et al.*, 2022), or types of killings, including IPH (Chopra *et al.*, 2022) and AFH (Bracewell *et al.*, 2021).

However, while there has been important learning (see Table 2), there has been limited reflection on how the findings used are generated (Rowlands and Bracewell, 2022). Thus, while some studies have engaged with the complexity of DHR and the

implications for researchers (e.g., Chantler *et al.*, 2020; Bracewell *et al.*, 2021), this is often not the case. Furthermore, many studies acknowledge some of the issues with DHRs as a system, but in practice treat DHRs as documentary products from which data can be extracted with little or no account or reflection on this process (e.g., Bridger *et al.*, 2017). Others, like Chopra *et al.* (2022) may reflect on analytical challenges but treat these as practical (not epistemological) concerns.

Yet, DHR reports are a product. The findings they capture, based on the knowledge generated within the DHR process, are the consequence of overlapping 'interpretative layers' (Rowlands and Bracewell, 2022, p. 5). In summary, these layers begin with a victim's experience and then organisational information about and analysis of any contact (which is captured in the information provided to a DHR). Subsequent layers include interpretation within the DHR following scrutiny (along with testimonial network information), including any decisions made about findings, and then the production of a DHR report. A final interpretative layer is that provided by researchers. Yet, to refer to Ahmed (2019), while each interpretative layer is a self-contained path in its own right, we often treat these collective layers as a single path.

In addition to the fact that this is often overlooked, as detailed above, it is also evident that DHR reports can be misused. Thus, Hope *et al*. (2021) analysed 22 DHRs into the DA-related deaths of men, producing some potentially valuable learning about the experiences of, and responses to, this understudied cohort. However, undermining the trustworthiness of their research, Hope et al. chose to elide complexity in case histories, including evidence that many of the men killed had been abusive (Rowlands, 2022b).

As with review more generally, there has also been little consideration about how we approach the knowledge generated. Indeed, no research has specifically

considered the constitution of the subjects of DHRs and/or the analysis of organisational interventions and how this is then used to identify practice, policy or system changes. As explored earlier, the risk then is that victims may be objectified in pursuit of other interests, either because the generation of knowledge uses their lives with limited reflection, or to manage criticism of the state, with limited evidence of the change that this brings about. This speaks to the greater risk that review may represent, which is that it may be a source of epistemic injustice (Fricker, 2007) or symbolic violence (Bourdieu, 2009). Taken together, this means that while DHRs (and DVFRs) are being used, the nature of this use – both in terms of achieving change, but also in research – has been little considered.

Table 2

Evidence Summary – Dissemination and Implementation of Findings

Key Areas	Establishment and Operation (Home Office, 2012, 2013e, 2016b, 2021a)	Challenges/Issues
What and How is Information Disseminated	• DHR report produced including background information, chronology, analysis, and lessons learned. Also, records recommendations, made either for single organisations (identified as part of their submission to the DHR) or made by the Review Panel (may be directed toward one or more organisations or partnerships, locally, regionally, or nationally). • CSP reporting form completed and submitted to the Home Office. • DHR report anonymised and usually published (sometimes, the executive summary only and sometimes neither if there are welfare concerns around publication).	• Variation in format and quality of DHR reports (Home Office, 2016a; Chantler *et al.*, 2020; Bracewell *et al.*, 2021). Issues include missing data (Potter, 2022), and summary of agency contact can include limited or only partial explication of practice issues (Vulnerability Knowledge and Practice Programme, 2020). • Able to de-anonymise published DHR reports (Websdale, 2020; Jones *et al.*, 2022). • Inconsistent publication practices, meaning it is difficult or not possible to access published DHR reports (Bridger *et al.*, 2017). • Absence, to date, of a national repository (Benbow, Bhattacharyya and Kingston, 2019). Additionally, inadequate data collection framework and, to date, absence of routine aggregation (Rowlands and Bracewell, 2022).
Tracking and Monitoring Recommendations for Update and Implementation	• Commissioning CSP is responsible for monitoring the development and implementation of an action plan based on any recommendations made.	• Numerous similar recommendations being generated (Benbow, Bhattacharyya and Kingston, 2019). • Challenge of evidence of impact (Payton, Robinson and Brookman, 2017; Jones *et al.*, 2022).

Note. Framework adapted from Dawson (2021).

2.6 Chapter Summary

In this chapter, by asking how, when and where things are used, I have explored review as a counting mechanism. I have demonstrated why, with respect to use – in terms of what review is for; what is used by and in reviews to generate knowledge; and how reviews are themselves used – our understanding of DVFR generally and DHR specifically is limited. This means there are gaps in the conceptualisation of review and, critically, in its doing. Thus, in the same way that there are questions about the practice of (femicide) counts that have implications that encompass policy and theory (Cook, Walklate and Fitz-Gibbon, 2022), so too review is contested. Therefore, approaching review as a technology through the prism of use offers an analytical opportunity – including considering the extent to which review might have perilous potentialities – and thus may be of considerable benefit to practice, policy and researchers.

Chapter 3: Methodology

3.1 Introduction

My interest in use has shaped my research as much as it has shaped my concern with DHRs because I understand doing and knowing as intertwined (Letherby, 2003). In this chapter, I set out my theoretical framework and describe my mixed-methods design, which drew on data from published DHR reports, a web-based survey, and interviews. I also consider how my experience as an insider and as a researcher, and the research lacuna regarding the doing of DHRs, have shaped my research design.

3.2 Overarching Approach

Theoretical Framework

My research practice is feminist and is underpinned by a recognition of the gendered nature of DA-related deaths. Specifically, I understand DA as being both 'caused by and constitutive of gendered patterns of power and privilege' (Bjørnholt, 2021, p. 11). There are multiple feminisms and no single feminist research method (Ackerly and True, 2020). Nonetheless, a concern with gender structures feminist approaches (Acker, Barry and Esseveld, 1983), as does an emphasis on producing knowledge for social and individual change (Letherby, 2003). In defining my feminist research practice, I follow Westmarland and Bows (2019) who describe key feminist principles as including: a critical engagement with knowledge production; self-reflection; and a commitment to action; as well as the identification and challenge to power imbalances; a widened frame of reference; centring the voices of women and the marginalised; and a commitment to intersectional perspectives.

A social constructionist paradigm underpins my feminist research practice, meaning I take a critical stance toward understanding the world, ourselves, and knowledge claims (Burr, 2015). My perspective is that knowledge is socially

constructed and socially and historically contingent (Ryan, 2001). This perspective is apt, given – as previously noted – domestic homicide is a socially constructed phenomenon. Meanwhile, changing responses to DA can also be situated within a social constructionist paradigm (Muehlenhard and Kimes, 1999).

As outlined in the previous chapters, I conceptualise DHRs as a technology and draw on Ahmed (2019) to approach them through the prism of use. Thus, I am interested in what review is for, what is used by and in review, and how reviews are themselves used. In essence, I am seeking to understand how knowledge is generated in and by DHRs as a mechanism to understand DA-related deaths, including the place of victim(s). Seeking to answer such questions is consistent with feminist research practice, wherein a commitment to voice is central (Hesse-Biber, 2012). Moreover, if 'feminist work is justice work' (Olufemi, 2020, p. 12), if DHRs as a technology do an injustice to victims, research offers the possibility of reimagining their doing.

Conceptualising DHRs as a technology means I take a Foucauldian perspective (Foucault, 1977, 1980). Foucault allows for the exploration of knowledge/power and the tracing of discursive practices. As many feminist scholars have demonstrated, this includes the ability to isolate the operation of different technologies (Sawicki, 1991; Bordo, 1995). However, Foucault can present challenges for feminist scholarship (Diamond and Quinby, 1988; McNay, 2013). In particular, I share a concern about Foucault's lack of attention to gender (Ryan, 2001; Tamboukou, 2003) and recognise the challenges his thinking can pose for conceptions of agency and the possibility of resistance (Burr, 2015). Nonetheless, I follow Tamboukou's (2003) approach in contextualising Foucault's ideas e.g., by specifically attending to gender. Having summarised my theoretical framework, I now address my role in knowledge production.

Reflexivity and Positionality: From Where do I Speak?

Being a Reflexive Practitioner. Schön's account of the 'permeable boundaries' that might exist for a reflective researcher (1983, p. 325) frames my approach. When first researching DHRs, Boughton recognised that her limited prior experience meant she initially had a largely positive view of them (2022). In contrast, my research began with a concern about DHRs derived from my practice as an independent chair. Importantly, I have found there is no fixed boundary between my research and practice. My research has challenged and expanded my practice. Meanwhile, my practice has rooted my research in the everyday. This duality has been productive, including leading me to develop an activist-researcher identity (Hale, 2008), but it has also, as I address below, had an emotional impact. Naming this duality – and drawing on my practice experience throughout my thesis – makes explicit my 'intellectual biography' (Letherby, 2003, p. 9). This explicitness is also a way of enabling others to judge my research's trustworthiness, which I address shortly.

Researching DA as a Man. I recognise my voice is 'indelibly inscribed' within my research (Roulston, 2001, p. 281). Consequently, I seek to acknowledge the situatedness of my knowledge claims (Haraway, 1988). An intersectional perspective helps reflection on my own identity and the implications for my research praxis (Hill Collins and Bilge, 2020). This consideration can also aid interpretation by drawing on my likeness *and* difference to those I research (Back, 2007). As I research in a field where gender is both a concept and a driver (Devaney *et al.*, 2021), that is my focus here, given its relevance to the research process itself (Fontes, 2004).

First, I am a cisgender man. This is significant because women account for most homicide victims and are usually killed by men (ONS, 2021). Meanwhile, most of those

working on gender-based violence are women (Macomber, 2018).[36] Consequently, I occupy an uneven position; one of sameness (my gender compatriots are commonly responsible for DA) and difference (to most victims, and those working in the field).

This uneven position, which has been described as the paradox of the '(in)visible status' of men (Alilunas, 2011, p. 211), is pertinent to my practice and research: I have held leadership roles, including as an independent chair, and now I research a phenomenon largely affecting women. Yet, my perspective is shaped by my gender. Illustratively, for Campbell (2002), part of the emotional impact of researching rape was being reminded about what some men do to women and, by proxy, her own risk. For Campbell: 'men live very different lives with freedoms women don't know' (2002, p. 85). In addition to the possibility of my having a different perspective, this paradox also prompts questions about my voice. I need to consider when and how I speak, particularly as men have 'been far from quiet, historically, politically and culturally' (Hearn, 2014, p. 415).[37] Indeed, I face a particular risk, given I could claim both professional and research expertise concerning DHRs. This is part of the reason I seek to centre victims of homicide wherever possible.

But I am also a gay man, and so have an experience of marginalised identity (Peretz, 2017): I have often felt myself to be an outsider and, at times, paid a price for difference. Nonetheless, I accrue a patriarchal dividend (Connell, 2005), regardless of the unjustness of this, or whether I seek it. Here then is another paradox. As a cis gay man, I am aware of the constrictiveness and sometimes pain of my gender, yet still

[36] This is not to impose a reductive heteronormativity, and thereby exclude the experiences of LGBTQ people (a concern that has been a thread running through my career). Yet, here too, gender structures victim/survivor experiences (Donovan and Barnes, 2020).

[37] I return to this point in the findings, given that the majority of those leading DHRs are men, reflecting their broader dominance in the CJS itself (Hearn, 2021). See *Chapter Six*.

benefit from it. Recognising this, I seek to address my complicity in the gender order (Boone, 2013), and so provide the basis for action (Guyan, 2022).

Recognising my perspective as a cis gay man is important because, like Hearn (2021), I believe engaging with feminism requires criticality towards gender and issues of violence/abuse. This also leads to the second way in which my gender is relevant. Specifically, I do not identify as a victim/survivor of DA, although one prior relationship was marked by the beginning of a slow infiltration of coercive control. Maybe I do not identify as a victim/survivor because my then partner's abusive potential was never fully actualised. Or perhaps this is an example of the difficulty of recognising abuse, including for men (Huntley *et al.*, 2019). More broadly, I have never lost a loved one to domestic homicide, although this is tempered by the universality of mortality which provides a baseline resonance with loss (Borgstrom and Ellis, 2017).

My Journey to a Feminist Perspective. These reflections are important because, from a feminist standpoint epistemology, my access to the lived experience of DA victim/survivors is circumscribed (and even more for those who are killed or die by suicide). However, this does not prevent me from 'starting off' research from the lives of women and the marginalised despite my having a (largely) 'centre identity' (Harding, 1993, pp. 445, 447). Yet, given my (in)visible status as a man, I have struggled with whether men (I?) can be subjects of feminist thought. In answering this question, Harding focused on the possibilities of men's contributions when underpinned by respect and dialogue (1993, p. 192). Consequently, it is pertinent to ask how my feminist alignment came to be, including how I make sense of anti-violence work (Westmarland *et al.*, 2021).

Growing up, I do not recall discussions of feminism, yet my experience encapsulated several tensions. My grandmother was an extraordinary woman, very

much a partner to my grandfather, yet upon marriage she had to leave her career and return to the home. In contrast, her daughter, my mother, had a career and a family. Yet, while staking a claim to equal status with my father, who himself played an active role in our upbringing, my mother was largely responsible for the care of family life. In hindsight, I was aware of gender inequality but was not much concerned with it.

That transformed when I began working in the DA sector in 2004 as part of a wider 'professional' cohort of men who entered the sector from the mid-1990s, reflecting changes to its profile, funding, and organisation (Messner, Greenberg and Peretz, 2015). With some circularity, given the academic endeavour this thesis represents, my interest in DA was originally theoretical: during my social work training, I wrote an essay about the concept of 'good enough' parenting.[38] That essay served as a gateway, leading first to a professional and then an activist identity. On my journey, almost all of those who inspired or mentored me were women. Mostly too, they were feminists, albeit of different kinds, reflective of the movement's diversity (Walby, 2011; Mackay, 2015). This then is my journey to a feminist perspective, with this emerging over time.

Being a Pro-Feminist Researcher. Despite adopting a feminist perspective, I do not describe myself as a feminist. For bell hooks, men can participate equally in feminism as part of a movement to end sexist oppression (2000). Yet, tensions arise because, alongside a recognition of the value of men's involvement in anti-violence work (Jewkes, Flood and Lang, 2015), there are dilemmas (Crowe, 2013; Burrell and Flood, 2019). These dilemmas include whether men can claim to be feminists, and the risks of 'co-optation, paternalism, appropriation, infiltration' (Harding, 1998, p. 192).

[38] In making this assessment, and reflecting gendered patterns of both care and DA, the parent most commonly bearing statutory intervention is the non-abusive parent, usually a mother (Wild, 2022).

There is limited literature that specifically addresses men as gender-based violence researchers.[39] One exception is Websdale (2001), who emphasises being aware of gendered dynamics. Yet, for me, Websdale's account is unable to answer the question of whether I can be a feminist when many of the women who inspired or mentored me take the perspective that 'feminism is a movement of women's emancipation. Only women can be feminists and men can only be allies' (Todd, 2021). Reflecting radical feminism's legacy, this perspective is particularly influential in the DA sector (Mackay, 2015; Westmarland *et al.*, 2021).[40]

For me, to ignore this perspective is problematic: it would mean prioritising my own definitional needs over the views of those I respect, all for a label that is ultimately less important than the work I seek to do (Boone, 2013; Crowe, 2013). The result is that I, like Chiweshe (2018) who described a similar struggle, define as a pro-feminist and as a researcher who uses feminist methods.

Implications for my Research. Reflecting on my earlier discussion of Schön, like others, I understand reflexivity as vital (Burrell and Flood, 2019). Moreover, this is an ongoing process where, perhaps, it is the struggle that is important (Westmarland *et al.*, 2021). I have drawn on Phipps' (2021, pp. 168–170) suggestions to reflect on what I know, who I am speaking for, benefit, motivations, allyship, and aim. These reflections have led me to prioritise four concerns:

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[39] This is perhaps because most research in this area has been undertaken by women (Bender, 2017). Consequently, research guidance arguably assumes women are the researching subject (e.g., Ellsberg and Heise, 2005). This means male researcher experiences are not explicitly addressed. Meanwhile, although there is an increased interest in men's understanding of violence and abuse beyond perpetration, these do not tend to address men as researchers per se (e.g., see Peretz and Vidmar, 2021). Furthermore, while accounts by male researchers may address their relation to feminism, the focus tends to be on the issues of researching men and (anti) violence specifically (e.g., see Hearn, 2021). Finally, although the literature on DA/VAWG is developing, it is not always informed by a feminist perspective (Gottzén, Bjørnholt and Boonzaier, 2021). Arguably there is a need to address this limited engagement.

[40] That influence can be troubling in relation to the inclusion of trans victim/survivors (Whynacht, 2022), as I have already noted with respect to the Femicide Census.

1. *Insider status*: As discussed earlier, I am an insider. Being an insider can sharpen my gaze but may also blur it. One benefit is credibility, which can aid access (Barlow, 2016), and which is something I encountered. Additionally, as an insider, I am more likely to understand respondents' 'idiolect' (i.e., the specific ways they speak) (Wengraf, 2001, p. 64). Yet, an insider status can bring challenges. Thus, assuming my insider status is fixed is problematic because it may change depending on the circumstances (e.g., what I know of a specific DHR) or how respondents view me (e.g., in response to my role as an independent chair, or aspects of my identity as discussed above). Insider status may also mean I make assumptions, for myself or participants, so leaving areas unstated or unexplored (Mullings, 1999). Additionally, my perspective on DHRs is not neutral.

   Moreover, as a technology, DHRs were established by the state, so through my practice I am implicated in their doing (I explore this in the first findings chapter), and my research may also be affected. This risk arises for activists and researchers in any alignment where the power of the state is engaged in the response to DA (Bender, 2017). In this way, I occupy what has been described as a 'space in-between' (Gray, 2016), reflecting both my (practice) closeness to DHRs but also my attempt to introduce (a critical research) distance. To manage these challenges and benefits, in this chapter I identify my assumptions and unpick these. In the findings chapters, as explained previously, I also engage with my practice experience to make its influence explicit.
2. *Approach to knowledge*: As a researcher, I eschew claims to objective knowledge, being instead concerned with subjectivity. I wish to avoid speaking as (an expert) or for (as the voice of) others (Stanovsky, 1997). This also calls attention to the knowledge claims of DHRs, including what is used to generate these and how they

are used. This also links to my activist researcher identity, wherein I seek dialogue and collaboration with participants (Hale, 2008). In response, I seek to understand the experience of those engaged in DHRs.

3. *Speaking position*: As the preceding discussion demonstrates, I am aware of my gender, my position in a gendered order, and my (ongoing) potential for complicity in it. That leads me to pay attention to the operation of gender within DHRs.
4. *Accountability*: Accountability is key in men's work on violence (Macomber, 2018; Burrell and Flood, 2019). The question is, to whom am I accountable? In response, I acknowledge the influence of feminists in my life, as noted above, and adopt research practices that prioritise co-constructed knowledge. I also recognise an accountability to those affected by domestic homicide, and particularly to the dead subject. One can conceptualise this latter form of accountability as a methodological challenge, because as *objects* of study, 'dead people cannot be interviewed or observed' (Weil, 2016, p. 1130). While this is indeed a challenge, I nonetheless see myself as having accountability to the dead who, as I suggested in the *Introduction*, and as I will explore below, retain an agency of sorts, and to whom it is still possible to direct our action (Whynacht, 2022).

Recognising Emotion. A final consideration is a 'grey area' of research, specifically the experience, effect and management of emotion (McGowan, 2020, p. 1). I approach this through Hochschild's (1983) concept of emotional labour, which encapsulates the occupational management of emotions for self and others, as well as enforced expectations about feelings. My focus is on expectations of emotional

performance.[41] For me, there are two axes upon which my emotional experiences were oriented.

First, the transition into academia was affecting because, while the duality of my research and practice was productive, it was also difficult as previously taken for granted and experiential ways of knowing met more intellectual ones (Heron and Reason, 2008). Second, I have often engaged with distressing material (Williamson *et al.*, 2020), experienced 'pain-by-proxy' (Moran-Ellis, 1996), and faced mortality (Borgstrom and Ellis, 2017). Illustratively, and of relevance to my mixed-methods design (particularly the analysis of DHR reports and when undertaking interviews), Websdale has noted his 'emotionally charged contact' with family members (2010, p. 12), while Barlow (2016) has reflected on documentary research's effect. Consequently, I had to perform emotionally by managing my feelings, e.g., while leading DHRs, and during interviews.

Covid-19 also shaped my emotional experience. As restrictions began, I retrieved the published DHR reports (Phase 1) which I had worked with on campus. However, my initial relief gave way to ambivalence and then resistance. Upon reflection, while my practice experience had prepared me to read detailed, distressing accounts of death, Covid-19 left me 'acutely dislocated' (Oliffe *et al.*, 2021, p. 2). Struggling with anxiety, living alone, and with restricted social contact, I felt unable to process these accounts. Indeed, the presence of the DHR reports in my home weighed on me, engendering what Fincham, Scourfield and Langer described as an 'oppressive

[41] Hochschild's original research was conducted into private sector (service) industries. This led to a narrow definition of the enforcement of feeling through training and supervision. Increasingly, the confines of this definition have been challenged with an emphasis less on the specifics of enforcement and a focus instead on expectations of emotional performance (Phillips *et al.*, 2020). Consequently, researchers' experience of emotional labour has been recognised (Dickson-Swift *et al.*, 2009), in both sensitive, gender-based research (Williamson *et al.*, 2020) and for doctoral researchers (Waters *et al.*, 2020).

reverent atmosphere' in their encounter with coronial files (2008, p. 855). In consultation with my supervisors, I decided not to analyse the DHR reports until I could do so on campus. This was a privilege unavailable to frontline workers or indeed victim/survivors of DA (Dawsey-Hewitt *et al.*, 2021). I also benefited because I was able to undertake more interviews and wrote several of the articles that I cite here.

To manage my emotional labour, I engaged in self-care practices (Reed and Towers, 2021). I also used my supervisors and clinical supervision as a space to practice 'offloading talk' (Fincham, Scourfield and Langer, 2008, p. 859).[42] Like Rager (2005), I journaled about my research experience. I also journal about my practice, and, during my PhD, I found myself drawing on, or engaging with, my research and practice concurrently. Notably, these self-care practices increased my appreciation of the emotional labour in DHRs, and I explore this in the findings.[43]

As this discussion has demonstrated, an awareness of my positionality and reflexivity has been central to my research practice, including with respect to emotional labour. Such an awareness is important in feminist approaches and contributes to my research's trustworthiness.

3.3 Trustworthiness

An increasing amount of feminist research uses mixed methods (as I have done), combining both quantitative and qualitative methods to enable a macro and micro perspective (Westmarland and Bows, 2019). Despite the risk of overemphasising the differences between methodological paradigms (Oakley, 1999), there is nonetheless an ongoing debate about how to assess scientific rigour. Thus, while criteria such as

[42] I had access to clinical supervision not through my research but because the NGO with whom I work offered it. This illustrates how wellbeing is not routinely built into research practice (Cullen *et al.*, 2021) and, consequently, is often individualised (Schulz *et al.*, 2022).

[43] I conceptualise professional and testimonial network stakeholder participation in this way because it has been recognised that public sector professionals perform emotional labour (Phillips *et al.*, 2020), with this also required by service users during co-production (Faulkner and Thompson, 2021).

reliability, validity and objectivity are used in quantitative research, their applicability to qualitative (including feminist) research is contested (Bryman, 2016). Instead, following Lincoln and Guba (1986), and consistent with my critical perspective towards knowledge generation, I seek instead to demonstrate my research is trustworthy, particularly that it is credible (confidence in what is being reported); transferable (the findings could be applied elsewhere); dependable (the process used to generate data is clearly described); and confirmable (the findings are grounded in the data not, e.g., researcher bias). To allow others to make a judgement as to trustworthiness, in this chapter I set out the challenges I encountered and the decisions I made.

3.4 Research Design

My mixed-methods design encompassed three phases: published DHR reports, a web-based survey, and interviews. Mixed methods were appropriate because I was interested in a multi-faceted phenomenon and, as I have highlighted in the preceding chapter, I wanted to attend to the question of how DHRs operate as a technology, both as a product (as documents) and as a system and a process (and so, experientially). Table 3 summarises the data used and the analytic approach.

Table 3

Data and Analytic Approach

Phase	Data	Document Analysis	Descriptive Statistics	Reflexive Thematic Analysis
1	DHR reports	√	√	X
2	Web-based survey	X	√	√
3	Interviews	X	√	√

Table 4 illustrates how, to answer my overarching research question about how DHRs operate as a technology to produce knowledge, the specific research questions are addressed by each phase.

Table 4

Answering the Specific Research Questions

Specific Research Question	Data
What assumptions underpin DHRs?	Interviews.
What norms are employed in the conduct of DHRs?	Published DHR reports and interviews.
How does decision-making and meaning-making manifest in DHRs?	Web-based survey and interviews.
How is individual, institutional, or social change understood?	Published DHR reports, web-based survey, and interviews.
How are learnings and recommendations produced?	Published DHRs, web-based survey, and interviews.

Phase 1 – DHR Reports

This first phase was a document analysis, a method often used to provide context as part of a wider study (Bowen, 2009). My intention was to produce a descriptive profile of DHR reports, for which I used content analysis (Bryman, 2016). Content analysis is often considered quantitative (e.g., relating to the frequency of the appearance of particular words or phrases in a text) and, thus, can be presented as objective and systematic (Neuendorf, 2002). Yet, challenging this positivism, others highlight how the frequency of textual appearance may not represent importance (George, 2009). Moreover, content analysis can be used qualitatively (Schreier, 2012), particularly where interpretation is necessary to make sense of data (Downe-Wamboldt, 1992). In this respect, Flick draws attention to the difference between explicit content and implicit meaning (2018).

Being cognisant of these differences is important because DHR reports are not produced for research purposes (Chantler *et al.*, 2020; Chopra *et al.*, 2022). It may be straightforward to identify explicit content, including case information about subjects (e.g., age), timeframes (e.g., date of death), and the CJ process (e.g., perpetrator sentence length). However, sometimes this data may not be explicitly recorded and – based on a researcher's reading of implicit meaning – may have to be extrapolated (this is something Potter (2022) has described when generating data from DHR reports). Consequently, using DHRs as a source of data requires explication around decision-making and, critically, interpretation (Rowlands and Bracewell, 2022). Given these tensions, like Bracewell *et al*. (2021), I sought a combination of quantitative and qualitative data. I describe this not as extraction, but rather generation.

Instrument. Like Stanley, Chantler and Robbins (2019), I developed a template to guide data generation. I developed a coding schedule and manual, including a code

name, description, examples and decision rules for application (Bryman, 2016). Informed by the literature and my practice experience, codes were developed deductively (Mayring, 2000). The coding manual set out decision-making rules and/or pre-defined codes (e.g., the manner and cause of death, as well as demographic information, were based on ONS classifications).[44]

I developed a preliminary schedule and manual and piloted it on a small number of DHR reports. Reflections were captured in notes. After refinement, the final coding schedule and manual included 88 variables in seven categories (see Appendix A), covering:

- Case details (e.g., relationship, primary victim, and perpetrator characteristics).
- Death event and CJ outcomes.
- Process (e.g., key dates, independent chair, review panel membership).
- Testimonial network and perpetrator involvement.
- Recommendations.
- Sign off, handover and publication.

The entire sample was then coded (examples of application are discussed below).

Data Collection. Given the absence of a national repository, to source DHR reports, researchers have searched CSP websites (Chantler *et al.*, 2020; Chopra *et al.*, 2022) or used Freedom of Information (FOI) requests (Benbow, Bhattacharyya and Kingston, 2019). As these approaches would have been onerous, I mirrored the approach used elsewhere (Home Office, 2013c, 2016a; Potter, 2022) and constructed my sample from DHR reports considered by the QA panel. Using my insider status, I approached the Home Office, which provided information on the QA panel between

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44 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/appendixtableshomicideinenglandandwales.

2013 and 2019.[45] While published DHR reports were not available, this information – including the commissioning CSP and other details (e.g., the date of death, victim pseudonym, the name of the independent chair) – was sufficient to enable a targeted search. I focused on DHRs considered in 2018, given this was relatively recent but a reasonable time had elapsed to allow for publication. The total prospective sample was 102 cases.

The search was challenging. Some DHR reports were on CSP websites, while others were held elsewhere (e.g., local/regional safeguarding board websites). Regardless of location, ease of access varied depending on a website's architecture (e.g., sometimes webpages did not work but a google search yielded a DHR). Generally, there was limited or no contextual information about the DHR reports, including the date of publication or, indeed, if a DHR had been commissioned but was not yet available, or had been published but since removed. Thus, without the Home Office's information, it would have not been possible to isolate a sample of DHR reports considered by the QA panel in a specific period.

An initial search was completed between September and December 2019 and then repeated in December 2020. This meant that for each DHR report in the prospective sample, at least two years had passed since QA panel consideration.

Sample. The prospective (convenience) sample comprised 102 DHR reports considered by the QA panel in 2018. The initial search in 2019 yielded 67 DHR reports. Of these DHR reports, 58 were overview reports. Three were excluded, as I had either chaired or commissioned them, leaving 55 overview reports. In nine cases, only an executive summary could be located. Given the considerable variation between and limited information in executive summaries, these were excluded. See Figure 2.

[45] This information was provided in an excel spreadsheet and had missing data.

In 35 cases, no DHR report could be located. This may have been for several reasons. In some cases, the information from the Home Office indicated that a DHR had been submitted for QA but had not been approved for publication (i.e., the CSP had been asked to make changes). Other DHR reports may have been approved but then not published or they may have been published and then removed. Other causes may have been the accessibility of DHR reports as noted above.

When the search was repeated in December 2020, of the 35 DHR reports not previously located, six were found. Of these, four had been resubmitted to the QA panel and must thus have been given permission to publish since the original search. It is not clear why the other two DHRs had since been published. Of these six DHRs, one was an executive summary and was excluded, leaving five overview reports. See Figure 3.

Figure 2

DHR Reports – Initial Search

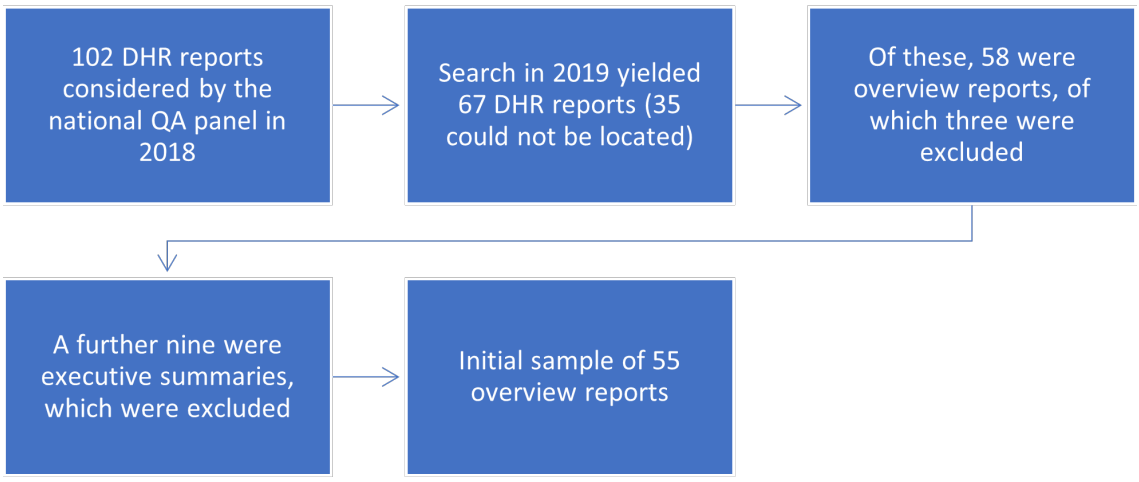
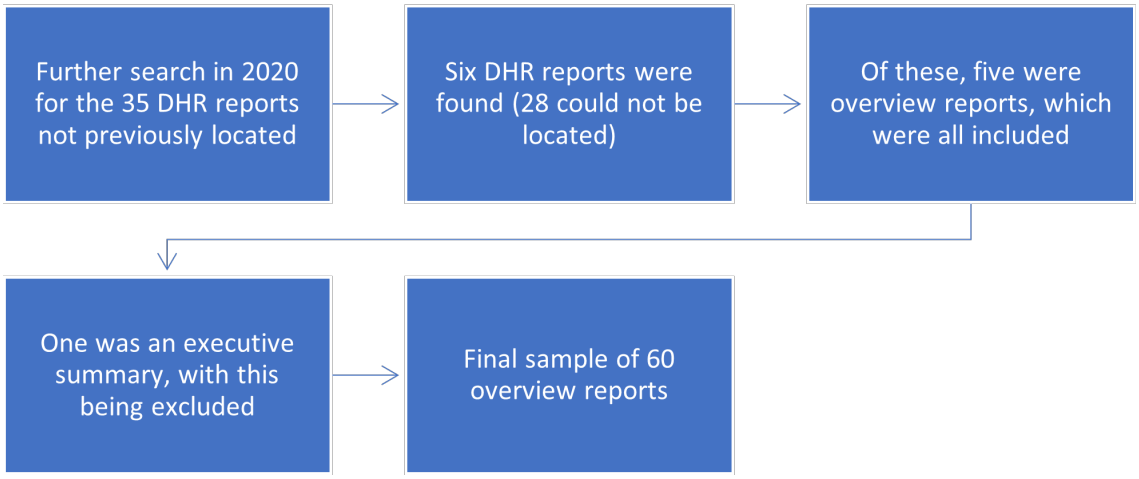


Figure 3

DHR Reports – Further Search



The final sample was made up of 60 overview reports, with three overview reports and 10 executive summaries excluded, and no report being located for 29 DHRs (see Table 5).

Table 5

DHR Reports – Sample

DHR Reports	*n*	%
Excluded – Chaired or Commissioned by Me	3	2.9
Excluded – Executive Summary Only	10	9.8
Included	60	58.8
Not Located	29	28.4
Total	102	100

That 28.4% (*n*=29) of DHR reports could not be located is striking. This finding is similar to (though less than) a study by Bridger *et al*. (2017), where 47.9% of a known sample of DHR reports were not available. The greater availability in my sample may be an artefact of the study design. Bridger *et al*. considered DHR reports between April 2011 and 2013 and used the Homicide Index as a reference. I used submission to

the QA panel and my study was conducted after the DHR system had been established for a longer period. Regardless, this stands in contrast to the reason given for publishing DHRs, which is to 'improve transparency' (Home Office, 2016b, p. 24).

Procedure. Aided by decision-making rules in the coding manual, I coded for explicit and implicit content. For some data, *explicit coding* was possible, particularly for variables relating to basic case information as noted above. Other variables were not numerical but could be identified if reported (e.g., relationship type, CJ charges). However, other data required *implicit coding*, including where:

- Data were reported inconsistently or not explicitly stated: reflecting the gendered nature of domestic homicide, most of the DHR reports concerned a male-female dyad. However, sexual orientation was often not stated. In these cases, inferring heterosexuality may seem self-evident. However, such an assumption is assumed heterosexuality (Donovan and Barnes, 2020), a limitation of much DA research. Consequently, I coded for sexual orientation based on the relationship between the victim and perpetrator, unless otherwise stated. In DHR 088, the victim was in a heterosexual relationship, but his sexual orientation was recoded as 'Bisexual' in the DHR report.
- More than one coding outcome was possible: in DHR 077, the cause of death was not recorded, and the method of killing was described as blunt force trauma and compression of the neck. The absence of a cause of death meant the method of killing was unclear. In this case, because the victim had 19 head injuries, the method of killing was coded as 'hitting, kicking, etc'.[46]

[46] This could also be described as overkill which is the excessive use of one or more forms of violence beyond what would be necessary to cause death (Family Violence Death Review Committee, 2017).

- Process descriptions were unclear: the number of organisations in a review panel was not always apparent. In DHR 008, there were two 'youth support' representatives, but it was unclear if they were from the same organisation. To manage this, data was collected on the number of review panel members (excluding the chair and, where appropriate the report writer, or any administrative support), as well as representation by organisation. I also used my professional experience to inform coding. Similarly, the recording of contact with family and friends varied considerably, with information often reported but little explicated. E.g., in DHR 036 the nature of family engagement was described differently across the report. This was coded as 'approached' but noted as having detail 'missing'.

Finally, in some cases, *data was not available*. A significant number of DHR reports included partial or no information about decision-making timeframes. Additionally, data was missing across several demographic measures (I discuss this further below). In such cases, this was coded as 'missing'.

Coding was consistently applied and was then re-checked in a second coding cycle. As a doctoral study, only I was involved. It was therefore not possible to ensure validity and reliability (e.g., interrater agreement). However, given these concepts are positivist, to reflect my theoretical framework I draw on the concepts of trustworthiness, and the qualitative parallels of credibility and dependability.

Analysis. In the coding schedule, data was recorded in Excel, before being transferred into SPSS for analysis. Descriptive analyses were performed to identify proportions, frequencies, and averages.

Consistent with other findings (Sharp-Jeffs and Kelly, 2016; Chantler *et al.*, 2020; Potter, 2022), the majority of DHRs had been commissioned into IPHs (71.7%, *n*=43), and thereafter AFHs (18.3%, *n*=11). Other typologies were less than 10% in

total, of which 5% (*n*=3) were deaths by suicide i.e., DARDRs. In a recent report – which is directly comparable because it was based on a sample of cases considered by the national QA panel in the 12 months from October 2019 – DARDRs accounted for 11.3% (*n*=14) of cases (Potter, 2022). This may be tentative evidence that the number of such reviews being commissioned is increasing. See Table 6.

Table 6

DHR Reports – Case Typologies

Typology		*n*	%
AFH		11	18.3
	Adult child	2	3.3
	Parent	7	11.7
	Sibling	2	3.3
IPH		43	71.7
	Opposite sex	42	70.0
	Same sex	1	1.7
Other		6	10.0
	Familicide[47]	1	1.7
	Homicide of person living with[48]	2	3.3
	Death by suicide	3	5.0
	Total	60	100

Case demographics can be found in Appendix B. In summary, in the 60 DHRs:

- The majority of victims and perpetrators were women and men respectively, with a mean age of late forties.
- Ethnicity data was missing in just under half of DHR reports. Where reported, almost half of victims were White, with a small number being Asian, Black, Mixed, or Other. This pattern was similar for perpetrators.
- Disability data was also missing in just under half of DHR reports for victims and for over half of perpetrators. Where reported, almost half of victims had a disability,

[47] The homicide of multiple family members (Liem and Koenraadt, 2018).
[48] I.e., a non-intimate/familial household member like a lodger or flatmate.

with this less for perpetrators. Where recorded, mental health issues were the single largest category for both victims and perpetrators.

Missing data was even more acute for other demographic characteristics, including Country of Origin and Citizenship/Migration Status, as well as Gender Reassignment and Faith/Religion.

These findings are comparable to those reported in other studies of DHRs, notably Chantler *et al*. (2020) and Potter (2022) who, despite different samples and methods, also report data for all domestic homicide types. The high levels of missing data echoes that found in these and other studies. As Chopra *et al.* (2022) have observed, the absence of data on different variables means findings must be interpreted with caution. It may also, as Chantler *et al*. (2020, 2022) have suggested with respect to ethnicity, reflect normative assumptions about protected characteristics. This, in turn, suggests a lack of clarity and understanding about what data should or could be reported (Rowlands and Bracewell, 2022).

The cause of death varied considerably, with missing data in 50% (*n*=30) of cases. However, it was possible to code for the method of killing, although this varied and was often presented in broad terms (i.e., the actual killing was not necessarily described). The most common methods of killing were a sharp instrument (33.3%, *n*=20) and either a blunt instrument or strangulation/asphyxiation (each being 15%, *n*=9). Hitting or kicking accounted for 10% (*n*=6) of deaths. All other methods of killing accounted for less than 10% of cases and data was missing in 8.3% (*n*=5). This is comparable to data reported by the ONS (2021). The high levels of missing data and/or how killings are described is potentially a barrier to the identification of the overkill.[49]

[49] For a definition, see footnote 46.

Ethical Issues and Dilemmas. Coding presented an ethical challenge given, as described above, the potential for missing data and/or misrepresentation. However, the key ethical dilemma arose from the process of quantification because, in generating data, I was effectively reducing someone's life and death to numbers. Such abstraction is an inevitable consequence of this kind of research and can be justified given the potential benefit that quantification can bring. It was, nonetheless, uncomfortable. As set out previously, I have sought to address the potential marginalisation of the dead both in terms of my theoretical and conceptual focus but also, as above, through ideas of accountability. I explore this further later in this chapter.

Phase 2 – Web-based Survey

To gather data about participant experience, a web-based survey was developed. A survey is a systematic way to gather data (Groves *et al.*, 2009). Online, self-administered questionnaires have several benefits, including flexibility and ease in design, administration and data collection (Bryman, 2016). Although surveys can be seen as positivistic, Miner *et al*. describe them as having potential as a feminist method (2012). Indeed, surveys have been an important way to gather data on DA, e.g., to measure preventative efforts (Walby *et al.*, 2017).

Instrument. As described in *Chapter Two*, while there has been little research into participant experience of review, these processes can be understood as part of the CCR. Thus, to develop the questionnaire, I drew on CCR research. For example, Javdani and Allen (2011) identified three proximal outcomes: promotion of relationships (i.e., collaboration between organisations); knowledge (i.e., information exchange between organisations); and institutionalised change (i.e., changes to policies and practices).

In developing questionnaires, Groves et al (2009, p. 158) emphasised the importance of clarity of researcher involvement; the level of interaction with participants; the level of privacy; the 'visual syntax' (that is, its layout); and the technology used. In my survey, participants – taking part anonymously unless indicating at the end they wanted to be involved in a follow-up interview – were invited to join by clicking on a URL. The questionnaire was delivered via an online survey tool (Qualtrics) and was designed to maximise user experience (e.g., by using skip logic to route participants based on their responses).

After completing initial questions to confirm respondent understanding and to gain consent, respondents were filtered by their experience of DHRs and an enforced

screening criterion (anyone who had not participated in some way was excluded). There were three respondent groups. The first of these included professionals involved directly in DHRs:

- Advocates for family or friends for whom a DHR was conducted.
- Independent chairs.
- Local authority officers who commission or support DHRs (usually DACs, but also council officers with other roles).
- Review panel members.

The second and third respondent groups were family/friends of someone who died and for whom a DHR was conducted (i.e., testimonial networks), and QA panel members.

A core set of nine questions about DHRs were asked of all respondents covering:

- Role (i.e., nature of involvement).
- Process (i.e., understanding, and how they became involved).
- Reflections (i.e., preparing and participation, including reflections about recommendations and impact).

Additional targeted questions were also asked. For professionals involved directly or via the QA panel, these targeted questions explored their training and support. For testimonial networks, the first targeted question acknowledged the tragedy that had led to the DHR and – recognising my ignorance of the circumstances – invited respondents to share anything they would like to say about their loved one. Further targeted questions explored notification and support.

Across the questions there was a mix of response options, including free text boxes to provide more detail to closed questions. A ‘prefer not to say’ response option

was included were necessary. There was a shared final set of demographic monitoring questions. See Appendix D for the survey template.

The questionnaire was shared with two expert informants (a review system researcher and an independent chair), with the final design incorporating their comments and feedback.

Recruitment. I sent an introductory email and flyer directly to professionals I knew, as well as opportunistically via mailing lists, networks, and to organisations working on DA/DHRs. To try and ensure a diverse sample, I sent information to umbrella specialist DA and led-by-and-for services. Recipients were invited to participate and/or forward the information (in some cases, the email was forwarded to specific contacts, or it was promoted e.g., in a newsletter). The survey was also disseminated via Twitter and LinkedIn. The survey was open from March to July 2020.

Sample. Reflecting the account of recruitment above, this was a non-probability sample, gathered through a combination of convenience, snowball, and purposive sampling. It was also self-selecting, as respondents had to opt in. In summary:

- 118 respondents took part, with one being screened out, yielding a sample of 117.
- There were responses from six family and eight QA panel members. Given the small numbers, bar some aggregated data in *Chapter Eight*, no data is reported because of the risk of identification.
- The largest cohort were those involved in a DHR directly (*n*=103), with most being review panellists (58.3%, *n*=60). See Table 7.

Table 7

Web-based Survey – Professionals Respondent Roles

Role	*n*	%
Family Advocate/Caseworker	7	6.8
Independent chair (of a DHR)	9	8.7
Local Authority officer (who commissioned a DHR)	13	12.6
Other[50]	6	5.8
Panel member (who represented an organisation on a DHR)	60	58.3
Report writer (who wrote a DHR)	8	7.8
Total	103	100.0

In terms of professional respondent backgrounds, respondents were diverse, although most commonly from CJS organisations, in particular the police (8.7%, *n*=9); health (notably Clinical Commissioning Groups (CCGs),[51] followed by mental health and hospital trusts) (22.3%, *n*=23); local authorities (usually community safety) (31.1%, *n*=32); and specialist DA services (16.5%, *n*=17). See Appendix E.

While these data are not generalisable, it is noticeable that state organisations predominated, along with specialist DA services. These organisations are core stakeholders (Home Office, 2016b, pp. 5–6 and 11) and it may also be that they are most likely to be involved based on case circumstances. This means one limitation is that other organisations were less well represented.

Demographic data for professional respondents can also be found in Appendix E. In summary, where data was available, professional respondents were predominantly aged between 35-64. Most were women and identified as the sex they were assigned at birth. Thereafter, most respondents were White, identified as heterosexual/straight, with the largest faith being Christian and the next largest category being Atheism. Most

[50] These participants appear to have chosen this as it best suited their role (e.g., one participant had been involved in DHRs in terms of recommendations, another was linked via another type of statutory review, and one was both a panel member and had also written the report).
[51] CCGs were established in 2012 to organise National Health Service (NHS) services in England. In 2022, Integrated Care Systems took over CCG responsibilities.

respondents did not have a disability. While the sample was reasonably diverse, the lack of racial/ethnic diversity was disappointing, although this is reflective of the wider challenges of ensuring research captures a diverse range of experiences (Westmarland and Bows, 2019).

Procedure. Respondents completed the questionnaire with no interaction with the researcher.

Analysis. Data was collected in Qualtrics before being transferred into Excel for analysis. At transfer, identifying data (i.e., contact details provided in Phase 2, if a respondent responded positively to an invitation to participate) were removed. Thereafter, descriptive analyses were performed to identify proportions, frequencies, and averages using SPSS. Some data were analysed thematically using the approach detailed below.

Ethical Issues and Dilemmas. Given there was no direct interaction between respondents and the researcher, ethical issues were limited, primarily around the steps taken around issues like informed consent, as well as confidentiality and anonymity. These are discussed below.

Phase 3 – Interviews

Semi-structured interviews were chosen to give voice to participants (Creswell, 2013) because, as noted above, there has been little research in this area. While the web-based survey (Phase 2) began to build a picture of respondent experience of DHRs, semi-structured interviews enabled a more in-depth exploration of participants' views, reflecting their capacity as 'commentators on their own experience' (Gubrium and Holstein, 2002, p. 5). As well as being descriptive about participants' experiences, semi-structured interviews were an opportunity to explore respondent understanding of DHRs and allowed for unanticipated contributions.

Instrument. An interview guide was developed, informed by the literature and the specific research questions (Rubin and Rubin, 2012; Bryman, 2016). The interview guide was tested with four expert informants, recruited via my professional network (a DAC, a family advocate, an independent chair, and a review panellist). Piloting allowed me to reflect on issues like ordering and comprehension.

In the interview guide, the first question asked participants to describe their involvement in DHRs. This allowed professionals to share information about their role and any other information they felt was relevant (e.g., their involvement in other statutory reviews). Thereafter, the interview guide elicited participants' experience and views of DHRs. For the rest of the questions, the structure from the web-based survey (Phase 2) was followed but with greater flexibility. As with the survey, demographic monitoring questions were also asked (including a 'prefer not to say' response option), with participants invited to complete and return the form.

For testimonial networks, the same questions were used but the interview guide was revised to reflect the different mode of family involvement (i.e., usually via the independent chair). As in the survey, I invited participants to say anything they wished

about their loved one. In this way, I was able to begin by acknowledging that testimonial network participants were involved in sensitive research (Cook, 2022).

Template interview guidance and demographic monitoring questions are included in Appendix F and G.

Recruitment. At the end of the web-based survey (Phase 2), respondents were asked if they would be willing to participate in a follow-up interview. Those who responded positively were invited to participate in an interview for this final phase, meaning I could be assured they had appropriate experience and knowledge (Rubin and Rubin, 2012). In effect, participants were expert informants – as detailed above, the different perspectives encompassed professionals involved directly in DHRs; family/friends of someone who had died; and members of the QA panel – who could provide rich accounts of their experiences and views. No inclusion criterion was required, as all the prospective participants had already been screened.

However, I employed exclusion criteria. If I had worked directly and extensively with prospective participants in my previous DAC role, or if their primary experience of a DHR was one I had chaired, they were excluded.[52] Excluded participants were contacted with an explanation. However, this did not mean I had not had contact with other participants, some of whom I knew professionally (e.g., one participant had participated in a DHR I had chaired but, as they had experience of more than one DHR and of other statutory reviews, I felt this was appropriate).

Prospective participants were sent a personalised email with an information sheet attached (Appendix H) and, if they indicated they wanted to take part in an interview, a consent form was sent (Appendix I). Both these documents addressed a range of areas (e.g., purpose; voluntariness; withdrawal; and how the data collected

[52] This did not apply to the pilot interviews, given I had to use existing professional contacts.

would be stored and used). Additionally, participants were informed that they could choose or agree on a pseudonym/role description. Participants were also informed that they could check and comment on a draft transcript if they wished. This practice is a form of respondent validation (Bryman, 2016) and is known as 'Interview Transcript Review' (ITR) (Hagens, Dobrow and Chafe, 2009). These offers are discussed below.

Prospective participants were asked to return a signed consent form. All but two participants did so (in these cases, verbal consent was provided instead at the start of the interview). Interviews were scheduled based on participant and researcher availability.

Sample. This was a convenience sample, given participants were recruited directly from the web-based survey (Phase 2). Of web-based survey respondents, 66 expressed an interest in being interviewed. Of these, eight were excluded. 58 prospective participants were then contacted, with 44 responding. Subsequently, 37 interviews were completed between March and August 2020, although one interview was lost as the recording failed. This means I had data from 40 interviews, based on four pilot and 36 main sample interviews.[53] All interviews were in English. See Table 8.

Table 8

Interviews – Participants Roles

Role	*n*	%
Family	5	12.5
Family Advocate/Caseworker (including 1 in the pilot)	4	10
Independent chair (including 1 in the pilot)	9	22.5
DAC (including 1 in the pilot)	6	15
Panel Member – other (including 1 in the pilot)	9	22.5
Panel Member – specialist DA service	7	17.5
Total	40	100

[53] I had intended to interview between 20 to 25 participants. However, considering the Covid-19 response – in particular, the decision to delay some of my research (discussed above) and the response rate from prospective participants – I offered to interview everyone who volunteered (subject to the exclusion criteria).

Demographic data for interviewees can be found in Appendix J. In summary, most of the interview participants were aged between 35-64. Most were women and identified as the sex they were assigned at birth. Most respondents were White, with the remainder being Asian. A majority identified as heterosexual/straight. Religion or Belief varied, with the largest faith being Christian and the same proportion stating they had no particular religion. A majority did not have a disability.

Given participants were drawn from the web-based survey, their diversity is largely reflective of the data reported in Phase 2. However, two trends could be observed. First, to some extent the sample was more diverse. Second, there was a consistently higher 'no response' rate. It is not clear why either may be although, for the latter, perhaps the direct nature of the relationship between myself and participants meant they did not feel they needed to provide (or did not feel comfortable providing, despite the monitoring form being separate) this data.

Procedure. Before each interview, I sent interview guidance. It has been suggested that this practice might re-assure participants or help alleviate stress (Rubin and Rubin, 2012; Roberts, 2020). To be consistent with my feminist approach (Brooks and Hesse-Biber, 2007), I shared the interview guide to avoid positioning myself as the all-knowing inquirer and contributing to an uneven power balance. This enabled me to approach participants as conversational partners (Rubin and Rubin, 2012).

While sharing the interview guide could have affected the interviews by organising them, I felt this was unlikely given the participants were expert informants and would have existing experience and views that had motivated their participation. However, to mitigate this risk, I sent the interview guide in a short form showing only interview topics (a similar approach was used by Haines-Delmont, Bracewell and Chantler (2022) when interviewing professionals in DHRs).

I used the interview guidance flexibly, exploring issues I was interested in, while also enabling opportunities for unexpected discussion on the part of both me and the participant (Hesse-Biber, 2007). While I did not collect data on the sharing of the interview guide, several participants spontaneously referenced using it to prepare.

At the start of the interview, I reminded participants about the information sheet, consent, and their rights. With consent, interviews were recorded using the voice memo function (phone) or inbuilt functionality (video conferencing software). As noted above, in all but one case this proved reliable.

Each interview was participant-led, although, as required, I used summaries or redirections to maintain a focus on the research topic. More generally, I acknowledged the contributions being made, offered contextual observations and/or probed further. Given my insider status, participants often alluded to what they felt was shared knowledge and, as appropriate, I asked follow-up questions. My insider status also meant that participants sought my views or asked me to share information. In these cases, reflecting my commitment to a feminist research ethic, as well as concern with reciprocity (Jackson, 2021), I responded in kind.

Interviews lasted between 60-90 minutes, with the shortest being under an hour and the longest extending to almost two hours. Where necessary, I checked to see if participants needed a break and/or felt able to continue.

After an interview, participants had the opportunity to debrief and/or say anything they felt had not been addressed and/or to ask me any questions they wished. Many took up this latter option, asking me about my motivations and/or hopes for the research. I also provided verbal confirmation of what would happen next, including that I would send an email to summarise what we had agreed regarding the participant's choice of pseudonym and/or their role description and their decision regarding ITR.

Emails were sent within 24 hours if a participant chose not to receive a draft transcript. For those who asked for a draft transcript, emails were sent as soon as the transcript was available (in most cases this was within 2 weeks). The demographic monitoring form (identified only by a Personal Identification Number (PIN)) was also sent with the email, to capture data on participants' characteristics. Of the 40 participants, 38 (95%) returned a completed form.

Interviews were then transcribed. While time-consuming, transcription increased my familiarity with the data, aiding subsequent analysis (Bird, 2005). Transcription was verbatim and, as my interest was in meaning rather than form, I used a denaturalised approach (Oliver, Serovich and Mason, 2005). Additionally, moments of irrelevant extemporaneous discussion were not transcribed.

Analysis. A reflexive thematic analysis was undertaken. After a process of familiarisation, this included coding; initial theme generation; theme development and review; and then theme refinement, definition, and naming (Braun and Clarke, 2021; Terry and Hayfield, 2021). This process was inductive and iterative. The analysis was conducted using qualitative data analysis software (NVivo), which facilitated the management of the data. However, I remained responsible for the analysis and interpretation (Zamawe, 2015).

Ethical Issues and Dilemmas. 'Ethically important moments' arose where I had to make decisions about specific issues (Guillemin and Gillam, 2004, p. 265). The first of these related to pseudonym use and the second to the offer of ITR. Both cases are examples of the practical steps I took, in line with a feminist research ethic, to try and equalise power relations (Buchbinder, 2011):

1. De-identifying data to ensure it is anonymous is one way of operationalising confidentiality, including using pseudonyms (Heaton, 2021). While this is often

treated as a technical procedure, it has epistemological, methodological and ethical complexities (Allen and Wiles, 2016), not least because anonymisation may silence participants (Berkhout, 2013).

Of the 40 participants, 33 (82.5%) chose to have a pseudonym selected by me, with 7 (17.5%) self-selecting. There was no pattern to this distribution, with self-selection by different professionals and family members. None of the participants for whom I had selected a pseudonym asked for it to be changed, although a number commented on my choice, reflecting on the name or asking about my selection. However, like Guillemin and Gilla (2004), one participant wanted to use their actual name. This request illustrates the tensions that can arise in anonymity, here because of competing claims (Berkhout, 2013). For me, pseudonymisation was part of my duty to offer anonymity. For the participant, pseudonymisation meant I (and my institution) was exercising power and preventing them from being associated with their ideas. Thus, the participant asked: 'Is it ethical for the ethics committee to override my personal choice on waiving anonymity?' After speaking to my supervisors, I explained to the participant that I would need to seek ethical approval for their name to be used. To manage their expectations, I addressed the possibility that the ethics committee might not agree but committed to keeping them informed and discussing further steps if needed (e.g., the participant writing directly to the ethics committee chair). Ultimately, after considering their options, the participant chose to select a pseudonym, explaining: 'this would put you to a lot of trouble which I don't want to do'. Ironically, then, the application of institutional norms around research participant protection ended with a participant protecting me as a researcher. While the outcome was perhaps unsatisfactory, I sought to navigate this

ethically important moment through reciprocity and transparency: I committed to reflecting on the experience and discussed this summary with the participant.

2. During the interviews, participants sometimes shared sensitive information that could identify them or the area where they worked or lived. Where this happened, I paused the interview to clarify how I could use this data (in most cases, participants were happy for me to use the information indirectly i.e., not to be quoted but described in generalised, aggregated findings). In addition to ensuring a shared understanding in the moment, this later acted as a prompt during transcription. Additionally, I offered participants the chance to receive and review a draft transcript i.e., ITR. Offering ITR aligned to my feminist approach because it is a means to try and ensure that a transcript is representative of a participant's experience as they understood it (Thomas, 2017), and helps reduce the risk of participants being identified (Wolgemuth *et al.*, 2015). Of the 40 participants, 32 (80%) requested their transcript. Thereafter, 19 (59.4%) subsequently requested changes. While many of these were grammar or typographical changes or addressed transcription errors, some confirmed or identified sensitive material. See Rowlands (2021).

3.5 Data Protection

Published DHR reports, anonymised survey data, and interview transcripts (identified only by a PIN and pseudonym) were stored using file-sharing software (OneDrive) provided by the university. Identifiable data – including participant information (e.g., their name, role, and contact details), as well as any associated correspondence – was stored separately and securely on my password-protected home computer. A removable hard drive was used as a backup; this too was password

protected and stored at my home. The specific data protection issues for each phase are noted in Table 9 below.

Table 9

Data Protection

Phase	Issue
1	DHR reports are anonymised and are then placed in the public domain, so no specific data protection issues arise. Ethical considerations nonetheless exist, which I address below.
2	No identifiable information was collected in the survey but if respondents expressed an interest in being interviewed, they provided contact details. On extraction from Qualtrics, identifiable data was removed and stored separately and securely.
3	Each participant was assigned a PIN, with this and the pseudonym being used to label interview transcripts. An Excel document served as an index, including participant information and associated correspondence. The index was also used to track participant involvement (e.g., choices relating to pseudonyms and ITR) and any requests (e.g., to be updated about publication). The index was stored separately and securely.

3.6 Limitations

An overarching limitation is that I focused on one type of statutory review (i.e., DHRs), which can reify the differences between statutory review systems despite their connections (Robinson, Rees and Dehaghani, 2019). Nonetheless, this focus was appropriate given it has generated rich data and illuminated a hitherto largely unconsidered aspect of DHRs' doing.

Each research phase had limitations, with key issues being addressed in turn in the preceding discussions. These are summarised in Table 10.

Table 10

Research Limitations

Phase	Limitation(s)
1	• Convenience sample, based on DHRs submitted to the QA panel in a year, meaning data is only representative of a specific period. • Not all DHR reports could be located, and some were excluded. • DHR reports are not written for research, with significant differences in if/how case information is recorded. Coding decisions required.
2	• Respondents were self-selecting, i.e., non-probability (convenience, purposive and snowball) sample. Potential for bias (e.g., if snowball sampling meant participants were recruited because they had shared roles or experiences). • Over and underrepresentation of roles and personal characteristics, with a small number of family participants. • Respondent accounts were 'stand-alone' i.e., they did not all relate to shared DHR experience. • Surveys do not allow for an in-depth exploration.
3	• Convenience sample derived from Phase 2. • Over and underrepresentation of roles and personal characteristics, with a small number of family participants. • Subjective accounts i.e., while interviews allow for in-depth exploration of experiences, they are shaped by the encounter between myself and participant, as well as my analytical approach.

These limitations are also illustrative of the issues that are the focus of this thesis. In particular, challenges in analysing DHRs reports have repeatedly been noted (Home Office, 2016a; Benbow, Bhattacharyya and Kingston, 2019; Chantler *et al.*, 2020; Chopra *et al.*, 2022), as well as for DVFR (Musielak, Jaffe and Lapshina, 2020). These challenges arise from practical reasons, including availability (Bridger *et al.*, 2017) and – although, as I argued in the last chapter, this has been less considered – how DHR reports are constructed and interpreted (Rowlands and Bracewell, 2022). While using similar methods as other studies (Neville and Sanders-McDonagh, 2014; Sharp-Jeffs and Kelly, 2016; Montique, 2019; Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022), my findings are not generalisable. Despite the above limitations, my thesis nonetheless responds to the call for qualitative research into

'individual, local, regional and national experience of DHRs' (Haines-Delmont, Bracewell and Chantler, 2022, p. 7).

A final issue is my insider status. As already discussed, this could be described as a limitation but by engaging with this – including reflecting on my situated knowledge derived and being explicit about influence of my practice – I have sought to demonstrate how I managed my insider status and its value.

3.7 Ethics

In approaching research ethics, while I have considered my university and funder's ethical governance, I have also sought a widened ethical lens given my concern with the centrality of the dead subject (in particular, concerning Phase 1's use of published DHR).

Ethical Governance

My research was guided by the ESRC's principles for ethical research, which emphasise a concern with research participant rights and the conduct of the research itself (2015). In the preceding accounts, I have described my methods and key ethical issues and dilemmas. However, given my mixed-methods design, I provide an overarching summary in Table 11.

Table 11

Ethics

Principle	Summary
Voluntary, free, autonomous	• In Phases 2 and 3, informed consent. • In Phase 2, able to decline to answer questions, and invited to re-confirm participation before submission as, once submitted, data could not be withdrawn. • In Phase 3, also able to decline to answer questions. Option for ITR and/or to withdraw data. Option to choose or approve pseudonym/role description.

Worthwhile, benefit outweighs harm	• In Phases 2 and 3, explanation of the purpose of research, and recognition of potential impact. Provision of information about sources of support. • In Phase 3, option to debrief, ask questions of me, and receive updates about the research.
Information about the purpose, methods and intended uses	• Provision of information forms (adapted for Phases 2 and 3 respectively).
Anonymous and confidential	• In Phases 2 and 3, the information provided to participants addressed anonymisation, as well as data management and confidentiality. • In Phase 3, ITR assisted in identifying sensitive data • Identifiable information was held separately and securely.
Research integrity	• Compliance with the research governance regime, including an ethics application. • Research diary and an audit trail, with input and advice from supervisors. • As a lone researcher, steps taken to address quality e.g., through (re)coding.
Research independence	• Information form (adapted for Phases 2 and 3 respectively) set out the research process, affiliation, and funding.

A Widened Ethical Lens

While these steps addressed university and funder requirements, ethical governance frameworks have been critiqued (Boden, Epstein and Latimer, 2009), particularly regarding their normative limits in research involving gender-based violence (Mortimer, Fileborn and Henry, 2021).

In my research, this is most evident in terms of how the ethical considerations set out above largely relate to Phases 2 and 3, which are the phases directly involving research subjects. In contrast, I used DHR reports in Phase 1 and, as documents, these have often been treated as being amenable to 'unobtrusive' research (Lee, 2000) by way of secondary data analysis (Hakim, 1982). Thus, different studies have either not explicated ethical issues (Sharp-Jeffs and Kelly, 2016; Chopra *et al.*, 2022), or noted that ethical approval was not required (Benbow, Bhattacharyya and Kingston, 2019;

Chantler *et al.*, 2020a; Bracewell *et al.*, 2021). In part this may be bound up in the broader conceptualisation of DHR reports, as discussed in *Chapter Two*, which includes the extent to which they are seen primarily as a product to the detriment of being seen as a process (Rowlands and Bracewell, 2022) along with, as noted at the start of this chapter, the absence of the dead subject. However, this may also reflect a prioritisation of the formal requirements of ethical governance to the occlusion of other considerations (Guillemin and Gillam, 2004; Pascoe Leahy, 2021). I am not satisfied with this position.[54] Consequently, I have adopted a 'widened ethical lens' (Clark and Walker, 2011).

This widened ethical lens was informed by my feminist research practice. Although I could not produce research that was useful to the (dead) subject, a goal that has often been identified as an important principle, I nonetheless did not want to treat them as 'research fodder' (Edwards, 1993, p. 183). Indeed, in that regard, Websdale's aforementioned imagined dialogue between a researcher and a DA victim/survivor graphically described how processes like review could be critiqued as vampiric (2005). To address these concerns, I have turned to other areas.

The first area concerns the use of online, open access data which, while produced differently from DHRs, has a shared feature insofar as it crosses the public/private divide and so raises questions of use. The dilemma, as framed by Hine (2011), is the balance between access and ethical use. Ethical considerations include whether anonymity can or should be preserved, and the risk of possible harms (Sugiura, Wiles and Pope, 2017). The parallel is only partial. First, DHRs carry the imprimatur of a statutory process. Second, the key dilemma arising in using online, open access data – whether data sourced online is 'public or private' and the producers' 'subjects or

[54] I am not suggesting that other researchers have been unethical. Rather, I seek to highlight an ethical issue that I believe needs further attention.

authors' (Snee, 2013, p.52) – does not apply to DHRs. Yet, while DHRs are anonymised, their subjects can be identified using media reporting (Websdale, 2020; Jones *et al.*, 2022), so questions of access and ethical use are pertinent.

The second area relates to the response to, and engagement with, 'crime archives', i.e., material generated during a CJ process, but which may later be used for various purposes including research (Biber, 2013). The issue here is that material generated in the CJS is governed by strict rules as to collection and use, but such strictures do not necessarily apply thereafter. Thus, Biber calls for sensitivity in using such materials, drawing attention to their potential effects and what we do with them. This sensitivity should include considering the implications of disseminating emotive findings (Reed and Towers, 2021).

Taken together, this draws attention to the question of to whom an ethical duty is owed. Participants in the web-based survey (Phase 3) and semi-structured interviews (Phase 2) are owed an ethical duty, as described above. However, as noted, my concern with both DHRs and the research into them is that, as a technology, they may objectify their subjects and may lead to testimonial injustice and/or symbolic violence. I wish to avoid doing this myself. Specifically, I do not want to render the research subject as an object of study (Fontes, 2004). Thus, I conceptualise the victim of the DHR as a subject to whom, while dead, I have an ethical obligation. Moreover, in engaging with the dead subject I also recognise what I referred to in the *Introduction* as their attenuated agency, given they are still part of the lives of their loved ones who may remain protective of them (Valentine, 2007).

I also understand my research as including an ethical obligation by proxy. That obligation is to those who knew a victim about whom I speak in relation to a DHR report, including if they participated in the review process (Jaffe, Scott and Straatman,

2020). Concerning my study, a further obligation arises to testimonial network respondents and participants. Thus, as an example, asking testimonial network members if they wanted to say anything about their loved ones was an opportunity to enact my ethical concern with the subjectivity of victims of homicide. For family, I hoped it was a way of ensuring testimonial networks felt my research would centre their loved one, whom I could come to know in terms they chose.

Yet, as Acker, Barry and Esseveld (1983) note, here I face a dilemma: my research translates subjective experience into more objective terms through abstraction. The goal then is, perhaps, to minimise such objectification. Reflecting on this, I have developed a context-specific ethical response (Vearey *et al.*, 2017), taking inspiration from Back's (2007) conceptualisation of the 'art of listening'. I sought to attend to those things that cannot be said and be critically reflective in my engagement with the data generated. I hope that my praxis can hear, and bear witness to, the complex stories of those who have been killed or died in the context of DA, as well as the experiences of those who subsequently engage in DHRs. This is an area I have explored previously concerning victim voice (Rowlands, 2020b). In doing this, I have sought to:

- Represent something of each DHR report I gathered in Phase 1. As a form of 'reconstructive activity' (Valentine, 2007, p. 167), I have done this in the dedication at the start of my thesis to underscore a focus on those who have died.
- Critically engage with the DHRs as a process and a product, with a particular focus on victim subjectivity. Like Barlow (2016), my focus – reflecting my feminist research practice – is on the experience of victims, meaning I paid particular attention to victims' voices and perspectives and, more broadly, the operational and discursive practices that shape knowledge generation about their experiences.

- Recognise the influence of the forensic narrative on accounts of domestic homicide (Monckton-Smith, 2012). I take a critical stance toward the process of knowledge generation about domestic homicide and recognise that this generation is also not fixed. Thus, I critically engage with DHRs as a process and a product.
- Reflect on my use of DHRs, including the risk of appropriation (Opie, 1992). This has included considering my use of data, in particular avoiding sensationalisation (Jaffe, Scott and Straatman, 2020).

3.8 Chapter Summary

This chapter has described the theoretical and methodological framework for my research as well as its undertaking. A concern with my positionality and reflexivity has structured my approach, with both being of importance when carrying out research into domestic homicide.

In the following chapters, I explore my findings. As previously discussed, the framing analytical concept was 'use', inspired by Ahmed (2019). Although my study uses mixed methods, I prioritise the data from interviews (Phase 3) for two reasons. First, it became apparent that it was the richest way to explore the concept of use. Second, this decision was pragmatic as I was a solo researcher. Thus, findings from the published DHR reports (Phase 1) and web-based survey (Phase 2) are used to illustrate and expand on the interviews. Table 12 shows the themes generated using reflective thematic analysis (Braun and Clarke, 2021; Terry and Hayfield, 2021), with each theme being explored in the following findings chapters.

Table 12

Thematic Framework

Theme 1: Establishing DHRs
Theme 2: Visions of DHRs
Theme 3: Practices of DHRs
Theme 4: DHRs as a Relational System
Theme 5: DHRs as a Site of (In)Action

Chapter 4: Establishing DHRs

4.1 Introduction

> … If you can't get your shit together when somebody's been murdered, when are you going to get your shit together?' (Peter, a review panel member).

Peter's quote is a reminder that a victim's death is the trigger for, and the anchoring moment of, a DHR. Additionally, Peter's sentiment illustrates why the public outcry that can follow high-profile domestic homicide(s) has been identified as driving the introduction of review systems (Dawson, 2017a). Peter asked this, rhetorically, while reflecting on the (adequacy) of DHRs' oversight, and implicit in this question is who is expected to act and how. Peter's quote grounds this chapter, which is organised around the theme of 'establishing DHRs'. As a theme, this captures what Ahmed called 'becom[ing] available to use', which can include when something is 'made in order to be used' and is thus 'designed' (2019, pp. 7, 23). I understand becoming available to use to encapsulate both the foundations and framework for DHRs. I explore the theme of establishing DHRs through three sub-themes: (a) the statutory basis (b) framework for delivery (c) perceptions of the process. See Figure 4.

Considering establishment led me to identify how, in my early encounters with DHRs, I was aware that they were a response to several high-profile killings. Yet, I was not much concerned with their coming into use per se. Thus, for me, the foundations and framework for DHRs were, as with a building, largely hidden from sight or taken for granted. That was perhaps because of where I was looking: like Monckton-Smith (2012) my gaze was outward, concerned with how DHRs could be *put* to use. Yet, asking how DHRs came into use demonstrates why considering establishment is important. As discussed in *Chapter Two*, the state usually establishes the foundations for review, and thus shapes the framework for its doing (Websdale, Celaya and Mayer,

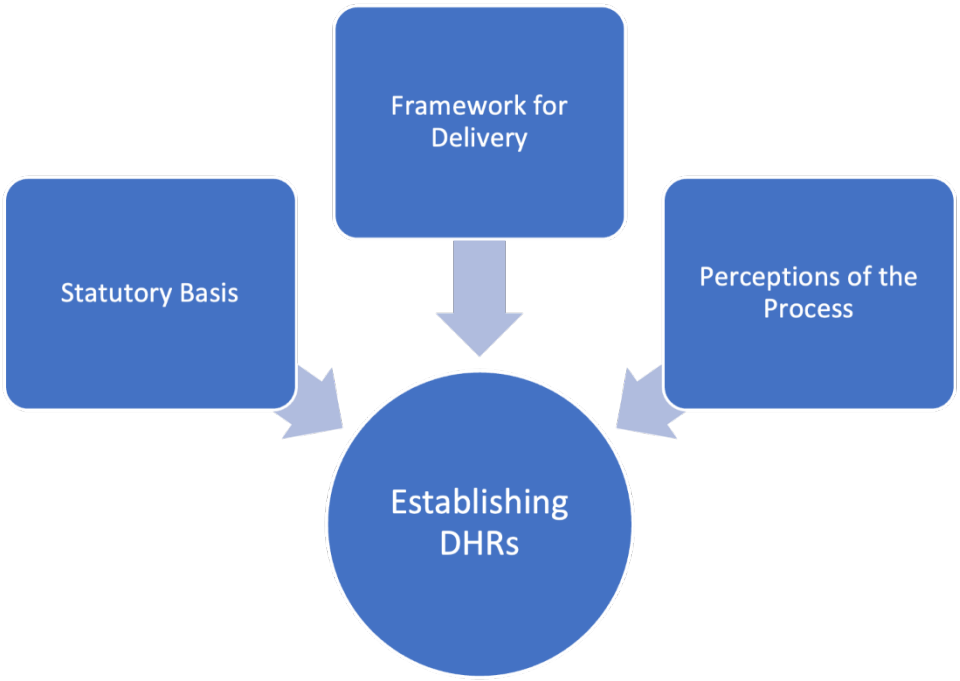
2017). However, although the state dug the foundations of DHRs in 2004, it waited until 2011 to fill them and build the framework. While the reasons for this delay are unclear (Rowlands, 2022a), it is indicative of the tension arising from the state's role in establishing DHRs.

As an independent chair, I have come to recognise that I am exercising power on behalf of the state. Thus, regardless of any critical assessment I might make of the state's role, as discussed previously, I am implicated in this power and so at risk of co-option. Yet, as also noted previously, the state is not a singular entity. That topography is evident in a DHR given that, as previously discussed, its multi-agency nature is reflective of the CCR model (Payton, Robinson and Brookman, 2017; Jones *et al.*, 2022). Within DHR, while statutory organisations predominate this does not mean they, or indeed NGOs, share the same agenda. So even while being enjoined by the state, those involved in DHRs may contest its power. This speaks to both the capillary nature of a technology like a DHR and the potential for resistance (Sawicki, 1991).

Taken together this appears paradoxical: the foundations and framework of DHRs structure their doing but they may not be as stable as they first appear. To explore this, by considering the establishment of review this chapter begins to address my first specific research question: what assumptions underpin DHRs? The next chapter explores assumptions about what DHRs are for, specifically. However, this chapter's focus is broader: it addresses the assumptions relating to the statutory basis and framework upon and through which DHRs were built and became available to use. In presenting findings – in this and in subsequent chapters – I primarily draw on interview data (Phase 3). To add breadth to the analysis, here, I also draw on data from the published DHR reports (Phase 1).

Figure 4

Establishing DHRs



4.2 Statutory Basis

A key finding is that participants understood a statutory basis as foundational to how DHRs became available for use. Professional participants did this by describing DHRs as a form of statutory review and/or referring to their 2011 implementation, the statutory guidance, or the role of the Home Office. Family participants were also aware of DHRs' statutory basis, albeit obliquely, and often as part of the formal response after a death. Ethan was told 'there'll be an investigation', while Isabella recalled receiving a letter from the Home Office.[55] However, while participants assumed a statutory basis was foundational, their views about it were mixed

The *benefit* of a statutory basis manifested in several ways. First, for Chloe (a DAC), DHRs brought 'visibility to victims of [DA]… For symbolism', with a statutory basis thus conferring legitimacy to DA generally, and domestic homicide specifically,

[55] This is likely the leaflet produced for families to explain DHRs (Home Office, 2017).

as an issue of concern. Such a rationale has been noted in the efforts to secure recognition of DA as a policy issue (Ishkanian, 2014), while the DHR system has been described as a way of raising status (Neville and Sanders-McDonagh, 2014; Mullane, 2017; Payton, Robinson and Brookman, 2017).

A second statutory benefit was convening power. Emma (an independent chair) described how some review panellists felt that she might be able to engage a local faith community because 'we had some sort of heavier weight' which might compel a response. Meanwhile, as a DA specialist, Jade pointed to the difference between securing representation in DHRs versus a non-statutory process like Multi-Agency Risk Assessment Conferences (MARACs).[56] Here, DHR had the advantage 'because it is a statutory [process]... You have that behind you, you know?'

Third, a statutory basis enabled shared understandings of purpose and/or expectations about practice. For Owen (a review panellist) DHRs were a 'common process that everybody understands', with other interviewees suggesting that organisations starting DHRs understood them (Hazel, a review panellist) or highlighting the importance of expectations around testimonial network involvement (Neil, a family advocate).

Finally, a statutory basis – bringing with it raised status, engagement, and shared understanding and/or expectations – was useful insofar as it could enable action. Thus, Victoria (a DAC) felt DHRs 'changed the landscape'. For Emma (an independent chair), this meant that:

> [Organisations] have to think of… [DA] not just as a Cinderella service or aspect of their service. They actually have to again, and in some areas again and again and again, justify what and how they do things.

[56] The absence of a statutory basis has been identified as a challenge for MARACs (Olumide, 2020).

DHR reports also attest to a statutory basis. An assertion of a statutory basis was found in all the published DHR reports analysed in Phase 1. Notably, this assertion is not a requirement in the statutory guidance and the template for DHR reports only suggests a description of purpose (Home Office, 2016b, p. 35). There has been no specific examination of the structure of DHR reports, but comparatively, one study in the U.S. noted that legislative requirements were reported in around a quarter of DVFR reports (Marsh Pow *et al.*, 2015).

Collectively, these findings point to the assumed importance of a statutory basis in enabling DHRs to become available for use, echoing, as described above, the emphasis in the literature. Yet, although there is a presumption toward a statutory basis, this is not always the case for review systems (Bugeja *et al.*, 2017). Moreover, and critically, there is no evidence in the literature of what benefit a statutory basis brings (Dawson, 2021), something these findings address.

However, the existence of a statutory basis was not *untroubled*. Thus, participants suggested that, rather than automatically imbuing authority, a statutory basis could be a contested and sometimes empty signifier, with the foundations of DHRs potentially being *unstable*. That is, whatever assumptions there might be about the value of a statutory basis, this basis did not automatically mean DHRs were useable.

The benefit of a statutory basis could be curtailed because, while DA has become a public concern, its nature and any response remain contested (Bjørnholt, 2021), with this also affecting DHRs. Thus, Victoria (a DAC) felt that DA was the ‘poor relation’ to child and adult safeguarding, which Hudson (an independent chair) explained meant DHRs came ‘third in that hierarchy’. This distinction is like Hester's three planet problem (2011), which describes how the DA, child protection, and child contact ‘planets’ are constituted by different and often conflicting professional habitus.

This conceptualisation has been used to illustrate how differences between DHRs and other statutory reviews can be reified (Robinson, Rees and Dehaghani, 2019). The findings here highlight the effect of power because these differences can create a hierarchy. Illustratively, Grace (an independent chair) compared DHRs to other statutory reviews and identified DHRs as having a lower 'kudos or gravity', suggesting that this was because they 'sit within' CSPs. This presents an issue for useability because, as explored in the *Introduction*, under the DHR system's dual loci of control, CSPs have responsibilities in relation to individual DHRs. I discuss this below.

For others, any statutory convening power was limited. Jade, a DA specialist who, as noted above felt DHRs benefited from their statutory basis, described this as 'great' but acknowledged: 'obviously, I know there's issues. I'm probably going to be more frustrated with them down the line.' In this way, Jade anticipated how, regardless of statute, organisational engagement might not always be achieved. Other participants also described the limits of a statutory basis vis-a-vis buy-in. As an independent chair, Hudson explained how he sometimes had to encourage (particularly health) organisations to take part and to 'convince them that… what you're doing is statutory'. While Hudson's experience demonstrates the usefulness of a statutory basis in terms of convening power, it is notable that ten years after implementation this was not a given. Notably, the sometimes difficultly of engaging health providers has been reported elsewhere (Sharp-Jeffs and Kelly, 2016). While Jade and Hudson's reflections are indicative of tension around DHRs' statutory basis, a need to secure buy in also relates to stakeholders' perceptions. These perceptions, which were often mixed, are explored in this chapter's final sub-theme.

A statutory basis was also potentially challenging for families. Despite assumptions around family having a central role as testimonial networks, a DHR could

be introduced with little or no explanation. Thus, as noted above, Ethan was told about a 'DHR'. Yet, what this meant was not set out until a family member asked for an explanation. Isabella, whose receipt of a leaflet was also noted above, recalled thinking 'now what?' Here, my building metaphor is again useful: families could be kept away from the building site. In contrast to professional participants, whose concerns about the foundations of DHR were that they were not necessarily stable, for families DHRs might appear solid. Solidity could be exclusionary: Luna described how she felt 'done to' at the start of the DHR into the death of her loved one. This was because, despite raising concerns, Luna felt the DHR's construction was 'not open to discussion' and so she was not an equal stakeholder.

To frame these different family experiences, one could understand each encounter in terms of use, with family becoming something to be used in the pursuit of a DHR (e.g., as a source of information), rather than having agency (Mullane, 2017). In this way, while the solidity of a DHR is problematic in itself, this is magnified because it may be just another example of the challenges families face in being subjected to multiple state-mandated responses after a death (Armour, 2002; Englebrecht, Mason and Adams, 2014). Notably, each family participant talked about the role of specialist advocacy support in navigating DHRs. The issue of family engagement and experience is examined further, along with other stakeholders, in subsequent chapters.

Thus far, the accounts offered by participants have troubled the assumption of the benefit of a statutory basis in terms of the stability of DHRs' foundations. However, for some, *being statutory could undermine DHRs' usefulness*. As a DA specialist, Jade felt some saw DHRs as 'just the statutory, tick box thing that you have to do to look at if you've messed up during a case'. Cora (a DA specialist and an independent chair) used this same language but pointed out this was not unique to DHRs, suggesting

instead that this was an example of the challenges of multi-agency and partnership working.

This speaks to the complexity of multi-agency and partnership working which, as discussed in *Chapter Two*, can be described as the CCR model and of which DHRs are part. Of relevance here is that, regardless of their statutory basis and the presumption of collaborative working, there may still be tension between stakeholders, particularly around the question of learning or blame (Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022). Moreover, multi-agency and partnership working is structured by power (Kelly, 1999). This includes power dynamics that often favour statutory organisations, potentially impacting which policy solutions are developed and/or compromising specialist DA services. This may mean organisations exert influence or control over specialist DA services e.g., by requiring them to operate within or alongside the confines of the CJS (Harvie and Manzi, 2011; Davies, 2020).

Additionally, being statutory did not guarantee DHRs' legitimacy. Thus, as a DAC, Victoria reported 'pushback' from some colleagues about the 'length and depth' of DHRs, which lead to the suggestion that 'oh, you know, this [process] is an industry'. This criticism may have reflected concerns about the burdens DHRs placed on stakeholders, particularly if the cost was seen as exceeding any benefit in terms of the changes achieved. The potential challenge in achieving a balance between the time taken to do DHRs and the impact of recommendations – which is a judgement on their usefulness – has been noted by Jones *et al.* (2022) and this is explored further in later chapters. More generally, this criticism can be placed against the backdrop of the proliferation of statutory reviews over the last thirty years (Stanley and Manthorpe, 2004). Thus, William (a review panellist), although largely positive about DHRs, suggested that 'there is some scepticism that there are reviews for everything now'.

Here then, there was a sense of both why something was brought into use through statute and then, perhaps, overuse. In response, we might first ask why DHRs were placed on a statutory footing at all? As already described, while participants perceived challenges with a statutory basis, many nonetheless assumed this was desirable or at least necessary. As discussed in *Chapter Two*, bringing DHRs into use can thus be understood as an attempt by the state to grapple with the issue of domestic homicide (Websdale, 2020). Yet, conversely, state-sponsored enquiry can be symbolic if it is used as a way of being *seen* to do something while simultaneously not necessarily bringing about change (Elliott and McGuinness, 2002). In this way, DHRs could be seen as useful to the state because, as a technology, they are a form of inquiry that contains or manages controversy (Sedley, 1989). This may be because the state comes to have a significant interest in DA only after someone has died (Whynacht, 2022). Illustratively, returning to the earlier contrast between the convening power of DHRs and MARACs, we might also ask why a process concerned with the dead (DHRs) is statutory when a process concerned with the living (MARACs) is not. One reason may be that, because of the harm to society (Jones, 2018), the state *needs to be seen* to take the issue of these deaths seriously.

Even allowing for either or both possible explanations, the decision to establish DHRs on a statutory basis could reproduce narrow conceptions of the state's interest (Whynacht, 2022), not least around a 'locked in' focus on risk and a CJ response (Walklate and Hopkins, 2019; Websdale, 2020). In this context, while Chloe (a DAC) was supportive about DHRs, she also expressed ambivalence, noting how DHRs took resources from 'doing the other bits'. For Chloe, these 'other bits' were interventions

with living victim/survivors because the cost of DHRs was often borne by DA or VAWG budgets.[57]

Second, being statutory means DHRs are, as already noted, in the gift of the state. Importantly, as discussed in *Chapter Two*, this is a difference between DHRs and other counting mechanisms like femicide observatories. Yet, a vulnerability flows from a statutory basis. Looking back, this vulnerability relates to *how things are used*. Simply put, just because a policy window opens – that is, a particular response to a problem gains traction due to the alignment between problem itself, the prospective solution, and the wider conditions conducive to its introduction – the desired outcome may still not be achieved (Mintrom and True, 2022). As noted at the start of this chapter, the curious trajectory between the introduction of DHRs in legislation in 2004 and their implementation in 2011 is evidence of such a possibility.

Looking forward, this vulnerability also relates to whether something remains *fit for use*. At the end of each interview, I asked participants about their hopes and concerns for the future. Many reflected on their frustrations with the doing of DHRs (explored across the remainder of this and in subsequent chapters), while others identified what was missing from existing arrangements, not least a desire to see a national repository, an issue repeatedly identified by researchers (Jones *et al.*, 2022). In summary, for participants, the curious trajectory to the implementation of DHRs has been superseded by a curious drift in use. To address these concerns, many hoped for changes at a national level. Yet, simultaneously, participants were also clear that this drift in use was largely a consequence of weaknesses in national oversight.

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[57] The average direct cost of a DHR is estimated at £8,688, with this principally reflecting the cost of an independent chair (Home Office, 2021b, p. 47). CSPs are de facto responsible for these costs with these most likely met from a community safety budget and within that, perhaps the budget for DA or VAWG, something suggested by Chloe and noted elsewhere (Neville and Sanders-McDonagh, 2014; Montique, 2019). In some areas, these costs may be shared. In my previous role, DHRs were funded from community safety budgets, sometimes with contributions from other statutory organisations.

A final dimension of this vulnerability is that – regardless of whether the statutory basis of DHRs means they are usable or useful – this foundation is not certain. Since I collected my data, as previously noted, the *Tackling DA Action Plan* (HM Government, 2022) has been published and includes proposals for DHR reform. While welcome, whether and how these reforms are actioned remains to be seen. Meanwhile, reform could pose a risk given that what has been made available for use can be taken away, or perhaps changed. Here, Margaret (an independent chair) summarised the potential and peril of a statutory basis:

> My fear would be that they will... you know, either the Home Office will decide, 'oh, we'll farm the whole process out', and they'll farm it out to someone or somebody that is not suitable… And I think then it would have to be very carefully done so that the statutory nature of them doesn't get watered down.

In summary, while a statutory basis might be assumed to be important for DHRs, it does not always bring certainty, nor is it unproblematic. Thus, a statutory basis can be of use symbolically and practically, bringing with it the power of the state. Yet, the manifestation of this same power is mixed. To return to my metaphor of the statutory basis as the foundations of DHRs, this suggests less stability than one might expect.

4.3 Framework for Delivery

While a statutory basis brought DHRs into use, it is a necessary but not sufficient because they still needed to be operationalised. This highlights the distinction between the making and implementing of policy and how the latter can be complicated or undermined (Barton and Johns, 2012). Thus, along with their foundations, many participants also talked about the framework structuring the doing of DHRs as a system, referring to both *local* and *national oversight*, as well as the *statutory guidance*. As with

a statutory basis, while participants assumed a framework was necessary – and indeed it could be useful – they reported it was not robust.

Statutory Guidance

Statutory guidance is not law but has a legal authority: when issued, it should normally be followed (Home Office, 2016b, p. 6). Returning to use, for DHRs, the statutory guidance can be understood as setting out their 'intended functionality' (Ahmed, 2019, p. 29). While the next chapter explores this further in terms of understandings of purpose, this is also relevant to establishment. To extend my earlier building metaphor, while statute provides the foundations for DHRs, the statutory guidance provides directions for the framework that structures them. While the statutory guidance is issued by the Home Office, and so could be consider part of national oversight, I discuss it separately because it is how most participants encountered the framework for delivery and, in use, it connected local and national oversight.

Many participants reflected on the positives of the statutory guidance. For example, Victoria (a DAC) explained that, on beginning a DHR, she and others would look to the statutory guidance to shape the process. This benefit also extended to testimonial network involvement, with family advocates like Marie and Neil highlighting the statutory guidance's expectations in this regard.

Yet, there were also concerns about the statutory guidance, relating to its content and/or because it was not followed. Unifying these concerns was the sense that the statutory guidance – as instructions about when, how and who can use DHRs – was inadequate. Illustrative examples, relating to the sections of the statutory guidance addressing delivery, are shown in Table 13.

Table 13

Issues with the Statutory Guidance

Section	Examples
Three – Establishing a DHR	Concern around completeness when deciding to commission a DHR, particularly that DHR is a 'one-size fits all' process regardless of case circumstances. Additional concerns for decision-making for deaths by suicide.[58]
Four – Conducting a DHR	Positive that specialist DA services involved but this has a significant unacknowledged impact. Concern about the absence of guidelines as to what constitutes specialism.
Five – Timescales conducting a DHR	Unrealistic as DHRs rarely if ever completed in the six-month timeframe in the statutory guidance.
Six – Involvement of Family, Friends and Other Support Networks	Lack of clarity about aspects of family involvement and/or inconsistent application. Specific examples where the views and wishes of a family were not proactively sought, listened to, or considered with respect to both the conduct of the DHR and its aftermath (e.g., publication).
Seven – Content of Individual Management Reviews (IMRs) and the Overview Report	Templates available but often not followed.
Eight – Publication of the Overview Report	Inconsistency with respect to if and how DHR reports were published, including liaison with family. Further inconsistency with dissemination of findings to both professionals and the wider public.[59] Conversely, a frustration that, once information was shared in the published DHR report, this could remain available indefinitely.
Nine – Disclosure and Criminal Proceedings	Concerns about understandings of disclosure and the potential impact on criminal or coronial proceedings.
Ten – Data Protection	Too much information being shared, with a potential impact on surviving family (including given potential duration of publication, see section Eight above).
Eleven – QA	N/A – discussed below.

[58] See *Chapter Six* for a further discussion.
[59] See *Chapter Eight* for a further discussion.

While the inadequacy of the statutory guidance was identified as having operational consequences, it is also another point of tension in the relationship to the state. Specifically, the U.K. Government's responsibility for the statutory guidance was described in different ways as problematic. The issue was – as with their statutory basis – the dependence on the Home Office to ensure the statutory guidance remained fit for use i.e., to maintain it as direction for the doing of DHRs. As illustrated here, and reflecting my own experience as an independent chair, this maintenance has been lacking and, arguably, is overdue: as I write in 2022, the latest statutory guidance is dated as it passes its eighth anniversary.[60]

Notably, these findings mirror research into statutory guidance generally as a tool for implementing government policy, where key concepts may be underdefined (Martin-Denham, 2021); there can be issues with operationalisation (Hodes and Creighton, 2017); variation between areas (Beenstock *et al.*, 2015); and any changes may be less scrutinised if made in statutory guidance rather than via revision to the underlying legislation (Ferguson, 2021).

The fact that the statutory guidance left many issues unaddressed, or was not followed, links to another aspect of the structuring framework, specifically the robustness of oversight arrangements. If the statutory guidance provides directions for the framework structuring DHRs, then local and national oversight is akin to the regulatory processes that ensure a building is up to specification. Local-national oversight is a feature of the DHR system given its dual loci of control. Yet, as Amelia (an independent chair) – who had expressed concerns about the 'current structure and format' of DHRs – observed:

[60] Although, as noted in the *Introduction*, the U.K. Government has committed to DHR reform, including updating the statutory guidance.

> One of the reasons that the effectiveness of the homicide reviews is not being realised to their full potential is that because, at the moment, it is a very local endeavour.

In other words, the quality and robustness of regulation left much to be desired and elsewhere this disconnect has been identified as compromising overall effectiveness (Rowlands, 2020a; Haines-Delmont, Bracewell and Chantler, 2022). It is to local and national oversight of the DHR system that I now turn.

Local Oversight

Views were mixed about the capability of CSPs to regulate DHRs. One way to approach efficacy is to consider whether DHRs are timely, given the statutory guidance requires completion within six months (Home Office, 2016b, p. 16). The following findings are significant because, to date, there has been limited reporting on timeframes.

Drawing on the analysis of published DHR reports (Phase 1), where data was available, the stages through to Home Office notification were relatively prompt. The mean for an organisation to make a CSP notification was 1.8 months, [61] with the commissioning decision being taken within a mean of 2.3 months, and Home Office notification occurring soon after. Notably, the mean was pushed higher by a small number of outlying cases (e.g., in DHR 006, 19 months elapsed between the date of death and Home Office notification because the victim's body was not discovered for 15 months). The median was in fact less than 1 month. See Table 14.

[61] Data was not collected on which agency made the referral, but this is usually the police.

Table 14

Timeframes – Stages to Home Office Notification

		To CSP Notification	To CSP Decision (Months)	To Home Office Notification
n	Valid	21	14	46
	Missing	39	46	14
Mean		1.8	2.3	3.0
Median		0	1.0	1.0
Mode		0	0	1

DHRs were also convened relatively quickly. Where data was available, the time between a death and the first review panel meeting was a mean of 9.2 months. However, as with the above data, this was affected by several outliers (perhaps reflecting delays as noted, but also potentially the deferral of the first meeting until after the criminal trial). Notably, the median was 6 months. While lengthy, this is perhaps not unexpected given it includes notification; the CSP's commissioning decision and then Home Office notification as reported above; as well as the appointment of an independent chair; and the convening of a first review panel meeting. See Table 15.

Table 15

Timeframe – to First Review Panel

		From Date of Death to First Review Panel (Months)
n	Valid	39
	Missing	21
Mean		9.2
Median		6.0
Mode		5

These findings suggest that, mostly, local oversight leads to the relatively timely commencement of DHRs. However, evidently the current statutory guidance timelines are misaligned to practice, and thus further consideration should be given to both the timeline required and/or if and how timeframes could be reduced.

Nonetheless, participants (particularly those who worked across multiple areas) identified difficulties with local oversight, with Louise (a DAC) speculating that 'every one will run slightly different'. For Margaret, an independent chair, variation could compromise DHRs' usefulness because:

> I think it depends on the area and how proactive they are and how organised they are. I think some are very good and … think strategically about things…. Other times I think… it's going to be put on a shelf.

Variation could also affect family experience. Marie, a family advocate, recalled one case where negotiations with the CSP were a 'battle'. Conversely, in another case, Marie reported that the CSP (and independent chair) listened closely to family concerns.

I explore the nature of this variation in subsequent chapters, but with respect to local oversight, its cause was explained in different ways. One explanation related to assumptions about what CSPs could provide in terms of regulation given their capabilities. Liam (a review panellist from a children's services background) highlighted that CSPs lacked the 'governance structure that's going to deliver [learning]'. He contrasted CSPs to Local Safeguarding Children Boards,[62] which have a more established structure and greater resources. As an independent chair, Joshua highlighted that, as important as DHRs were, for a CSP: 'it's a very, very small part of their role'. This speaks to what is known about CSPs: they have both a broad remit around crime and safety involving a range of multi-agency partners but tend to be centred on local authority community safety teams (Local Government Association, 2018).

Reflecting on my previous role as a DAC, I am conscious of DHRs' demand requirements: while I commissioned DHRs on behalf of the CSP, I was effectively

[62] Now Safeguarding Children Partnerships.

responsible for their oversight. Thus, the reflections of several DACs resonated with me. Many noted that, while a CSP may be the commissioning body, responsibility usually fell to them as the DAC.

Illustratively, all the DACs talked about their work to support DHRs. As an example, Victoria emphasised how she saw her role to make sure each DHR 'works smoothly'. Yet, this could be difficult, and Chloe talked about how she was reliant on the use of 'influence, support and negotiation' with other organisations but had 'no power to make them do… [the recommendations]'. She also observed: 'I think it is difficult that the actions aren't… statutory is not the right word… they are not mandatory, I guess'. For Harper, this was because 'you could put in a hundred actions at the end, and if you did none of them, nobody would ever come and check'.

This is not simply about the power of enforcement per se, it is also about geographical reach given that CSPs have a defined bailiwick (a local government boundary). Such limitations were noted by DACs (as well as other participants) with Charlotte providing an example of a DHR where the recommendations 'are all mental health and not even in our area'. To implement the recommendations, she had to negotiate with health organisations with which her CSP had neither an existing relationship nor any direct influence. Others, like Victoria, extended this question of reach nationally, noting the near impossibility of a CSP securing actions in response to a national recommendation. This also illustrates a final aspect of establishment, national oversight, to which I turn shortly (and any change achieved: see *Chapter Eight*).

Moreover, while recognising the important role that DACs played, and returning to the above points about the capability of CSPs, Emma (an independent chair) noted DACs did not always exist. This reflects evidence that one consequence of austerity (which I discuss below) has been that some DAC roles have been 'subsumed' into

generic community safety roles (Henderson, 2019, p. 107). This means DHRs may be facilitated by generic council officers, which Peter (a review panellist) highlighted too. This finding is important because, to date, the role of the DAC in helping facilitate the DHR process has not been explored specifically, although the significance of this role has been noted (Neville and Sanders-McDonagh, 2014). Yet, DACs have an important role as, reflecting DACs' accounts of their contributions, participants identified them as providing a key source of leadership (see *Chapter Five)*.

Perhaps as a symptom of a lack of DACs in some areas, Bobby (a family advocate) noted that in a previous role she was often 'explaining DHR processes… and what their expectations are and what their role should be'. Bobby also highlighted the frustrations that arose if DHRs were not well coordinated. Similarly, as a family advocate, Lily noted there was often a disconnect with CSPs. She said she sometimes struggled to 'find who is the CSP lead', while on occasion, she would contact a CSP, and they would say 'we weren't aware of this case'. This had implications for supporting a family because, in such situations, it meant a decision to commission a DHR had not been made.

This suggests assumptions about CSPs' capability to fulfil their regulatory function are fraught. Specifically, local oversight may be variable because it can be compromised by weaknesses in terms of CSP structure and/or personnel. This illustrates an important point about the conditions of the state's power regarding DHRs. As noted at the start of this chapter, the state's power is not singular. These findings evidence this because while the U.K. Government laid the foundation of DHRs through legislation, it did so without equipping CSPs with the ability to ensure they were useful. These findings echo an earlier study where stakeholders identified a disconnect between the

Home Office and its guidance and support for CSPs (Neville and Sanders-McDonagh, 2014).

One consequence of this lack of regulatory capability was a sense that CSPs, having convened a DHR and appointed an independent chair, might then 'move on' (Harper, a DAC). Joshua felt this was likely, with CSPs perhaps 'keeping an eye on' DHRs while relying on independent chairs like himself to take it forward. Supporting this possibility is the time that DHRs take, given they are often lengthy (I discuss the overall timeframe below). As an independent chair, Iris suggested that this could create a vacuum and so, having commissioned them and moved on, CSPs might not always take their share of responsibility for DHRs. Bobby (a family advocate) indirectly supported this too, explaining that sometimes CSPs 'don't have a clear updated view on what's happening' as they were reliant on independent chairs to manage the process. In the longer term, Bobby also felt that this might mean that some CSPs were 'not invested in action plans' because they did not feel ownership of them. This again returns us to consideration of the extent to which this aspect of the framework for DHRs is sufficient to ensure they are useful. The role of the independent chair and the recommendations made are, respectively, discussed further in later chapters.

Taken together, the issue was – as expressed by Lily (a family advocate) – that 'sometimes it feels a bit like the Wild West in terms of what the CSPs and the chairs decide to do'. In other words, despite an assumption – including in the statutory guidance – that they can, CSPs may not in fact be able to ensure that DHRs can be consistently useful. Such variability is precisely the opposite of the promise of a statutory basis, not least as this might be assumed to bring with it a provision for robust local oversight. Moreover, faced with such variability, one might expect the Home Office to step in, given it both issued the statutory guidance and placed expectations

onto CSPs about the conduct of DHRs (Haines-Delmont, Bracewell and Chantler, 2022). Yet, in line with participants' earlier concern about the Home Office's role with respect to a statutory basis, participants did not believe it had done so. It is to the Home Office's role I now turn.

National Oversight

In considering national oversight, many participants were critical of the Home Office's role, which Lily (a family advocate) described as a 'bit abstract'. Meanwhile, Harper (a DAC) expressed surprise at the absence of Home Office follow up around DHRs. In fact, Harper felt that inadequate national oversight called into question the benefit of a statutory basis, asking 'otherwise why would you make it statutory?' Notably, no participant talked specifically about the Home Office team supporting DHR. The team is relatively small,[63] particularly as some 800 DHRs have been completed since implementation (Monckton-Smith, 2021). Instead, in addition to the statutory guidance, participants talked about the national oversight function they encountered, with this being the QA panel.

Most participants who commented on the QA panel were DACs or independent chairs. This reflects other reports about a lack of awareness of the work of the QA panel (Boughton, 2022). Among these participants, there were some positive views about the QA panel, reflecting an assumption that its function was to ensure DHR reports were appropriate. Harper (a DAC) felt that, overall, the scrutiny the QA panel offered was 'quite robust'. Meanwhile, as a DA specialist, Alyssa felt the QA panel had challenged victim blaming in some DHR reports, which it had rightly sent back (I consider what makes a 'good' DHR report in *Chapter Eight*). These suggestions speak to the kind of

[63] In 2020, the team included four staff members, with just one team member working solely on DHRs. By early 2022, a further role had been added to the team, as well as a new workstream to improve the DHR process (Robinson, 2022).

feedback provided by the QA panel, including addressing practice (e.g., failure to follow the statutory guidance or templates) but also content (e.g., quality of analysis) (Potter, 2022).

However, most participants who commented on the QA panel had concerns about whether it was useful, questioning the scrutiny and challenge it provided. Building on concerns reported in earlier research (Montique, 2019), these questions focused on the time taken by the QA process versus its value. Commenting on the former, Grace, an independent chair, noted that DHR reports 'get absolutely bogged down there'. Meanwhile, two other chairs' perspectives encompassed a breadth of criticism of the QA panel. Hudson said, 'I find it is a bit of homework marking, to be honest', while Joshua thought the feedback was 'actually laughable sometimes'. In summary, the key issues were timeliness, quality, appropriateness, proportionality, transparency, and impact. See Table 16.

Table 16

Concerns about the QA Panel

Issue	Example
Timeliness	Long wait for feedback, with delays affecting the dissemination of findings and impacting family wellbeing.
Quality	Concern with feedback quality, with reports that this could be inconsistent or not to a good standard.
Appropriateness	Lack of understanding of key issues e.g., child safeguarding.
Proportionality	Feedback could be disproportionate.
Transparency	Lack of transparency around working and membership.
Impact	Unclear that there was a connection between feedback and any change (e.g., to DHR report content, but also associated practice issues).

The (in)adequacies of the QA process were also seen to impede the usefulness of DHRs. The issue of timeliness meant that, after a DHR report was submitted, it could take months to be considered. Looking at the data from published DHRs (Phase 1), the majority did not include the date of QA panel submission.[64] However, eight DHR reports did, and the length of time from submission to QA panel consideration was a mean of five months, with a slightly lower median of three months (see Table 17).

Table 17

Timeframes – Submission to QA Panel Discussion

		From Submission to QA Panel Discussion (Months)
n	Valid	8
	Missing	52
Mean		5.1
Median		3.0
Mode		3

While this finding is not generalisable, this is consistent with my experience, where I have often had to wait for up to 6 months to receive feedback, something noted elsewhere (Montique, 2019). Additionally, it is significant that DHRs are often not approved by the QA panel on first submission, with just over a third of DHR reports in the sample needing to be resubmitted (see Table 18).

This finding is consistent with a recent report – based on a sample of 124 DHR reports considered by the QA panel in the 12 months from September 2019 – where 36 DHR reports (or 29%) were resubmitted (Potter, 2022, p. 46). Such high levels of challenge might suggest the QA panel is fulfilling its function with respect to individual

[64] In contrast, the date when the DHR was heard at the national QA panel was included in the spreadsheet provided by the Home Office.

DHRs. However, looked at as a system, this suggests that DHRs are plagued by questions as to usability and usefulness.

Table 18

QA Panel Decisions

Decisions	*n*	%
Publish	26	43.3
Publish with amendments	12	20.0
Resubmit	22	36.7

The issue with timelines had broader consequences which called into question the QA panel's usefulness. Bobby, a family advocate, highlighted how delays could lead to resistance. She said, 'So, it's almost too little, too late' by the point of submission for QA, with there then being a reluctance by CSPs to make further changes, particularly if that – echoing an earlier point about the CSP's enforcement capability – meant agreement was required from other organisations. Joshua (an independent chair) echoed this when he reflected on how challenging it was to re-convene a review panel after months had passed waiting for feedback. Finally, others felt that a concern about the QA panel's potential feedback (and particularly a requirement to re-submit) affected independent chairs. Dylan (a review panellist) – commenting on the number of DHRs that were rejected by the QA panel or received substantive feedback (he had a county-wide view, as a children's services representative) – felt that this made the DHR process overly rigid, because independent chairs were 'sticking to the criteria and then that ends up taking over in some [way].'

Moreover, families were also not necessarily happy with the QA process. While some were often not aware of this process (perhaps because, of the family members interviewed, for most the DHRs were ongoing), some were. Claire was positive about her experience of the DHR overall but was waiting for the QA process to conclude. This

had been prolonged, and Claire was critical of the 'backlog', asking: 'when is it going to happen? When am I gonna hear results?' In contrast, for Isabella's loved one, the DHR had been completed. However, Isabella was angry about the QA 'verdict', which had described the report as 'adequate'.[65] Isabella felt that such language 'really adds insult to injury'. Isabella's hurt illustrates how testimonial network perception can be starkly different to policy makers for whom this verdict was a statement of a quality standard being met. This also speaks to purpose, including what such an assessment considers as important, to which I turn in the next chapter.

While there was criticism of the QA panel, there was also a recognition that its task was unenviable. Joshua, an independent chair, said, 'I think it's a system that doesn't have a chance of working', highlighting how its function was difficult, particularly as it involved second-guessing independent chairs and review panels. Echoing this point, others highlighted the challenges involved. Elizabeth, from the perspective of a DA specialist, suggested that the volume of work required of the QA panel might mean that there would not be enough attention given to each DHR. Finally, as a family advocate, Bobby pointed to the impact of under-resourcing of the QA panel itself because of the 'sheer volume' of work.[66]

Thus, QA – as an aspect of the regulatory framework – was affected by questions of usefulness. Moreover, as part of the DHR system, its under-resourcing mirrors that of the Home Office team and, referencing earlier discussion, CSPs. This under-resourcing does not only relate to the approval of DHRs. Nominally, as set out in its Terms of Reference (ToR), the QA panel's functions encompass a range of

[65] This terminology reflects the language used in the QA panel's ToR (Home Office, 2013e).
[66] The QA panel is made up of statutory organisations and NGOs who are not funded specifically to do this work. The NGOs are specialist DA services. It is of note, therefore, that they are being asked to provide this function for free. Such cost deferral has been a re-occurring dilemma for DA NGOs in terms of influence versus sustainability (Hague, 2021).

additional areas including identifying cross-cutting learning; oversight of national recommendations and liaison across government; identifying any national training needs; as well as communicating the impact of the DHR system (Home Office, 2013e). To date, no report, or any other data, has been published about the extent to which these functions of the QA panel are delivered.[67] With respect to the data collected in this study, there was no sense from participants that such activities were being undertaken.

With that in mind, it is worth making two observations. First, the QA panel's ToR were issued in 2013 and despite, it would seem, not being achievable, they have not been reviewed to date. Second, the QA panel is unique. While different DVFR systems operate at local, regional or national levels (Bugeja *et al.*, 2017), none have comparable QA arrangements. This raises the question of why QA is deemed important. Its existence may be an example of how the centralised nature of the U.K. state is manifest in the DHR system, meaning there is an assumption that there needs to be national oversight. Such centralisation is also posited as explaining other differences between DHR and international review systems, not least the former's permissive information sharing culture (Websdale, 2020). Another explanation may be that this is an example of an attempt to manage the challenges of the DHR system given the difficulties in oversight as detailed here (and other aspects of its doing, as explored in later chapters). Regardless of the reason for its existence, in the absence of any evidence that the QA panel is improving the overall DHR system (rather than simply addressing individual DHR reports case-by-case and leaving underlying weaknesses unresolved), it is possible that it is mis-directed effort to drive system improvement.

[67] The Home Office (2016a) summary of learning was based on reports approved by the QA panel but did not report on its functioning specifically. As cited above, while a more recent report has described common feedback from the QA panel (Potter, 2022), it does not address wider functioning.

Taken together, national oversight was – as with the other aspects of the establishment of DHRs discussed thus far – at best mixed. Indeed, based on the issues identified, it could be seen as a symbolic manifestation of the state's response to domestic homicide which, regardless of the intentions of those involved, has been compromised from the start.

4.4 Perceptions of DHRs

The complexity and tensions identified by participants – about the foundations of a statutory basis, as well as the framework for delivery through the statutory guidance and national and local oversight – highlight many of the perils with the state's role in making DHRs available to use. Indeed, these findings challenge the assumption that the state can or will provide a stable foundation and framework for DHRs. Critically for the doing of DHRs, the consequences were not solely experiential (i.e., relating to functionality); they also affected how DHRs were perceived in terms of usefulness (i.e., their reputation). This is the final sub-theme of this chapter.

As already discussed, although nearly ten years had elapsed since implementation, when participants were interviewed many were concerned that there remained significant weaknesses with the DHR system. As a result, according to Lily (a family advocate), the DHR process could be called into question because: 'so much effort, so much time, so much money… is put into these reviews. And then at the end, it's just sort of there'. Numerous other participants echoed this concern, focusing on what this meant for the understanding and doing of DHRs (explored in the following chapters). Here, the issue is such concerns affected perceptions of DHRs, including undermining assumptions that they were a useful exercise.

Most participants recognised DHRs as a resource-intensive process. The analysis of published DHR reports (Phase 1) supports this regarding the timeframes for

various stages but also in terms of other metrics (including the number of organisations involved, see *Chapter Six*). Illustratively, the time taken to complete a DHR, using the time between a death and consideration at the QA panel as a proxy, was a mean of 29.7 months. See Table 19.

Table 19

Timeframes – From Death to QA Panel

		From Date of Death to QA Panel (Months)[68]
n	Valid	60
	Missing	0
Mean		29.7
Median		26.5
Mode		21

Notably, Potter reported an average of two years between the date of death and submission (2022). This figure is comparable to the findings here which also show a mean of 24.6 months if the time taken from submission to being heard at the QA panel is considered (see Table 17). While there may be good reasons for the time taken, Bobby was concerned about what this meant in sustaining a sense of 'momentum' in a DHR. This concern is like the earlier discussion of the QA panel's functioning because it could affect perceptions about the usefulness of DHRs. Critically, for Mia, (a DA specialist) the length of DHRs risked a sense of fatigue:

> I think there's a bit of a communication issue between what the government or the Home Office are saying must happen, and the criticism that the panel that looks at the DHRs and signs them off or don't sign them off, and the realism about still trying to deliver proactive and reactive services in those districts.

[68] It was not possible to report on the time from the point of death to publication, as the latter data was rarely reported.

That DHRs took time was not necessarily a criticism per se. Many participants felt that DHRs were necessarily challenging. For Iris (an independent chair) DHRs could be ‘quite a bureaucratic process’ and, particularly at the start, quite ‘admin heavy’. Yet, while this could be a ‘slog’, Iris felt the ‘boxes do need to be ticked’ to deliver a good DHR. Yet, the time taken could affect perceptions of DHRs as both a process and a product.

In terms of participant experience, a key issue was the demand placed on stakeholders (both organisations and their representatives). Charlotte (a DAC) raised concerns about the demands of DHRs, noting that ‘if you’ve got a number of them running, it’s a piece of work that doesn’t really get built into your job’, so you just have to ‘tack it on’. This challenge could impact professionals and how they engaged. Emily, who had been a review panellist and an independent chair, suggested:

> If I am honest, I think some of it is people are very busy. It's capacity. And if somebody is told something, you know, there's a little of the "do I want to lift that stone, ‘cos I don't know what's going to come crawling out from under it. Do I need the work?”

This, then, is a further echo of the concern(s) about capability already noted, suggesting that, in their establishment, the focus was on making DHRs available to use rather than necessarily assuring that they could be done usefully (I also explore this more specifically in terms of capacity in later chapters).

Moreover, the weight of this process could distort the focus of DHRs. To manage these demands, Cora (a DA specialist) suggested that DHRs might need to be ‘very process driven’, though at the risk that this could 'take away a bit of humanity'. By this, Cora meant that process itself could come to dominate, rather than a concern with the victim. Illustratively, Owen (a review panellists) described how process requirements could sometimes be like ‘tablets in stone’, while Grace (an independent

chair) reported that some ‘areas are so intent on process, that they lose sight of what a review is really about’. I explore the practices of engagement in *Chapter Six*.

What these concerns mean in terms of establishment is that complexity and tensions around their foundations and framework could undermine the assumption that DHRs are a useful innovation. Ultimately, the concern was that DHRs might become ‘a drain on resources, something that everybody finds difficult to do’ (Cora, a DA specialist). Problematically, this could affect perceptions of usefulness because, as Charlotte (a DAC) noted, ‘there's a lot of goodwill involved in DHRs’ and so if people lost faith in the process, their delivery might come into question. This sense of DHRs as yet another process, and the resulting impact on their perceived usefulness, could also affect family. Amelia (an independent chair) described how, on first approaching a family after a homicide, ‘... it's just A.N. Other thing for the family to do, when actually their focus is elsewhere’. For Lily (a family advocate) her concern was that the notification of families could feel ‘quite…cold’. This meant family, rather than ‘feeling like it's a process that they were involved with’, instead experienced DHR as ‘…a process that they're being told about’.

Taken together, this sub-theme has demonstrated the length of time DHRs can take and the potential impact this has on the extent to which they were seen as useful. These findings speak to participant experience and doing of DHRs, which I explore in subsequent chapters, but here they also highlight that the statutory basis and framework for DHR are not unquestioned.

4.5 Conclusion

In summary, how DHRs became available for use was understood by participants as central yet problematic. This was because, while there was an assumption that the establishment by the state was a precondition for DHRs, the

foundations and *framework* it established were neither stable nor robust. Critically, as Ahmed highlights, coming into use has a temporal quality (2016, p. 24). In this case, while the establishment of review had to come first, this instability – which produces the complexity and tension explored in this chapter – has an ongoing resonance that affects the doing of DHRs. Indeed, a *statutory basis* presents a risk because it means the DHR system is dependent on the state for its maintenance. Since their implementation, the long periods of relative neglect and, more recently, promises for attention in policy pronouncements are emblematic of the potential and peril of this dependence. This duality is also evident in the framework that structures DHRs. In particular, the framework is demonstrative of many of the perils of a dependency, given the concerns identified by participants about the usefulness of the statutory guidance and local and national oversight. Notably, this could, at worst, reduce DHRs to a process that is not particularly concerned with the victim at its heart.

Despite these perils, in building the DHR system, participants recognised that DHRs had considerable potential. However, there was concern about the future shape of DHRs. Charlotte (a DAC) argued that, although they might 'need changing a bit, to make them more effective', they were a vital tool. Returning to the value of their establishment, she suggested: 'well, if we lose them, we have no accountability'.

At its core, the establishment of DHRs is about the role of the state in terms of the response to DA generally and domestic homicide specifically. In the literature, this same tension has been explicated. On one hand, as explored in *Chapter Two*, reviews are a post-hoc part of the CCR and an example of a type of counting mechanism that has been developed to respond to domestic homicide. Yet, there has also been a recognition that the state's response to DA can be problematic, including the extent to which review may be symbolic or co-opted. The findings here suggest that both these

perspectives can be observed in DHRs as a technology. Thus, it is positive that the state established DHRs and, in so doing, they became available for use. Yet, the complexity and tension reported in this chapter speak to how, thereafter, the state's commitment to this process can be described as, at best, inconsistent.

Attention to participant reflections on how DHRs became available to use is important because this points to the policy conditions around their introduction as a technology, including assumptions relating to the statute and framework upon and through which they were built and became available to use. As highlighted by Pillow, policies are 'value statements' which inform actions, and in doing so *construct* particular types of bodies (2003, p. 151). Given this, as has been evident throughout this chapter, the potential and peril in the establishment of DHRs affect their doing, both as individual case examinations and as a system. Before exploring the doing of DHRs, in the next chapter I focus on assumptions about what DHR is for.

Chapter 5: Visions of DHRs

5.1 Introduction

> I think they really are intended to be preventative. And that's a really difficult thing to do because you can never, ever know what you've prevented… So, there has to be… this leap of faith… (Henry, an independent chair).

In suggesting DHRs are a 'leap of faith', Henry speaks to a purpose of DHRs as being to prevent future deaths. Indeed, prevention is often taken as the raison d'être for review (Fairbairn, Jaffe and Dawson, 2017; Dawson, 2021; Montanez, Donley and Reckdenwald, 2022). Yet Henry identified other purposes too, saying:

> If we don't do this type of work to make a difference and to try and help us as a society and as a wider community really understand the effects of DA and the outcome of long-term DA, then who will?

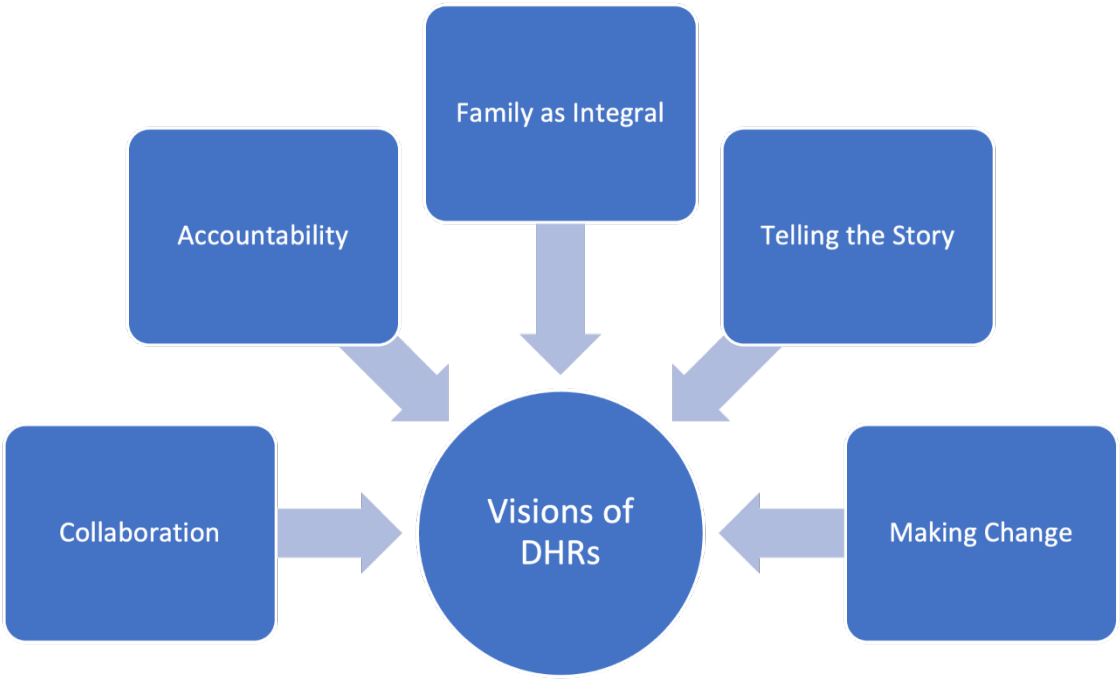
Here, the unnamed 'we' implies a collective purpose, while Henry also identifies a further purpose of improving understanding of DA. Together these purposes encapsulate the potential of DHRs (and DVFRs more generally) as a mechanism that brings together stakeholders to identify and address practice, policy, and systems issues about DA generally, including where it ends in homicide (Storer, Lindhorst and Starr, 2013). This plurality of purpose was also identified by Chloe, a DAC, who said: 'the core aim is, and should be, about improving practice to reduce future homicides. But I think *there's other aims and aims within that* [emphasis added]'.

To explore this plurality of purpose, this chapter is organised around the theme 'visions of DHRs'. I understand purpose in terms of what Ahmed called 'foreness'. In describing 'foreness', Ahmed offers not just an instrumentalised sense of what something is for, which might include its intended functionality (2019, p. 29), but also what its use might bring about, what she calls its 'positive value' (2019, p. 7).

Consequently, in terms of use, the theme visions of DHRs encapsulates ways of understanding what DHRs *are for*. I explore this through five sub-themes, each of which is described as an ideal type (Aspalter, 2021): (a) collaboration (b) accountability (c) family as integral (d) telling the story (e) making change. See Figure 5.

Figure 5

Visions of DHRs



An exploration of purpose builds on the last chapter because, implicit within an account of how DHRs became available for use, are assumptions about what they are for. Moreover, having established the DHR system – with the foundations having been laid, the framework built, and a regulatory process in place – the task of doing DHRs begins. To capture this idea, I return to my building metaphor: what something is understood as being for could be described as how the interior of a building is imagined. In this way, I imagine understanding(s) of purpose to be akin to the plan and layout of a

specific building, that is, how it should look, feel, and be used, both room by room and as a whole.

Suggesting DHRs have a plurality of purpose may seem self-evident. Thus, when Mullane described DHRs a mechanism to 'illuminate the past to make the future safer', he also described them as being to 'improve [DA] services for all victims' (2017, p. 261). Furthermore, the stated purposes of DHRs in the statutory guidance, as set out in the *Introduction*, illustrates the same point given that these encompass learning and applying lessons from domestic homicide specifically *and* DA more generally (Home Office, 2016b, p. 6). Yet, what is less well explored is if and how different understandings of purpose parallel, intersect, and/or overlap, i.e., how different aspects of what DHRs are for interconnect.

This interconnectivity is important, because if the purposes of DHRs parallel, intersect and/or overlap, failing to achieve any given purpose may affect the achievement of others, including leaving them at cross-purposes. This too can be observed in the statutory guidance itself which, having constructed purpose(s) as described in the *Introduction*, adds that DHRs are not solely about organisational perspectives and should also seek to see through the victim's eyes (Home Office, 2016b, p. 7). However, this call is not foregrounded as a stated purpose and, consequently and regardless of intent, a hierarchy is created.

These parallels, intersections and overlaps may affect the doing of DHRs. For example, Montique (2019) reported operational challenges with DHRs, although the underlying drivers were not explicated. Likewise, Haines-Delmont, Bracewell and Chantler (2022) identified challenges including the conduct of independent chairs, organisational contributions, or the engagement of testimonial networks. These challenges may be, at least in part, because of different understandings of purpose. This

possibility is supported by evidence from DHRs, and DVFRs in the U.S, where different understandings of review can lead to tensions (Watt, 2010; Boughton, 2022). As a result, at the end of this chapter, I consider whether the purposes of DHRs are always achieved and, if not, why failure to achieve one purpose may flow from the failure to achieve another.

More conceptually, the purpose(s) of DHRs can tell us about their use as a technology, given different understandings or emphases of purposes could illustrate whether DHR favours the state over the victim or, conversely, may have more expansive possibilities. Illustratively, I previously noted how the establishment of DHRs could give rise to peril if they functioned as a vehicle for state-focused conceptions of DA concerned with risk and a CJ response (Walklate and Hopkins, 2019; Websdale, 2020; Whynacht, 2022). Alternatively, and in contrast to such a *narrow or thin* perspective, DHRs could be understood to enable expansive potential, taking a *wider or thicker* perspective on the circumstances of DA-related deaths and therefore any possible learning (Websdale, 2010; Walklate *et al.*, 2020).

The idea of purpose as existing on a tapering continuum from wide/thick to narrow/thin is a powerful analytical tool to understand what DHRs are for and can help explicate the implications of difference in the width/thickness of the lens applied. My experience of chairing a DHR into the death of an LGBTQ victim provides an example of this. In the DHR, some review panellists took a narrow/thin perspective, asking whether there was evidence of direct discrimination, potentially individualising the analysis. In contrast, I and others sought a wider/thicker perspective that took an intersectional analysis (Hill Collins and Bilge, 2020), exploring how the hetero- and

cisnormativity of the public story of DA can exclude gay men as victim/survivors and/or affect their experience.[69]

These different approaches are an example of the continuum outlined above. Importantly, these approaches could have been driven by an understanding that the purpose of DHRs was to prevent future deaths. However, a concern with other purposes could play a part too, with these also being expressible on a wide/thick to narrow/thin continuum. These other purposes include whether one understands DHRs as being for collaboration; the shape of findings (e.g., in the balance struck between organisational learning or an account of a victim's experiences); the importance placed on the role of testimonial networks; and the kind of change imagined.

In exploring the understanding of purpose, this chapter continues the exploration of my first specific research question in the last chapter – what assumptions underpin DHRs? – but draws in from a broader focus about how DHRs came into use to consider specifically what DHRs are understood as being for. In addressing the plurality of purpose for DHR, and the resulting complexity and tension in their operation as a technology, in this chapter I lay the basis for subsequent chapters. This is because an understanding of what DHR is *imagined as for* is necessary *for its doing* (i.e., its operationalisation through practice[70]). That is, what and who is used in DHRs, and how (*Chapters Six* and *Seven*), and then what they are used for (*Chapter Eight*). In this chapter, I draw solely data from the interviews (Phase 3).

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[69] See Donovan and Barnes (2020) for an account of LGBTQ domestic abuse and practice, policy, and research.

[70] I use 'through' practice here because a reoccurring reflection from participants was that being part of a DHR was shaped by experience. Thus, participants talked about undertaking DHRs when they were first implemented (and so new) or in the present (where the statutory guidance was insufficient). Some talked about learning on the job (because of the limits or absence of training), while others simply encountered DHRs unexpectedly (particularly family, because of tragedy). Connecting these experiences was a sense that one could not be fully prepared for DHRs, either because the foundations for and framework around them was inadequate and/or because each DHR was necessarily unique because it was an examination of a specific DA-related death. This is an illustration of the contingency that is embedded throughout DHR, as individual case examinations and as a system.

5.2 Collaboration

A first finding is that collaboration is a central purpose of DHRs, with this being discussed by all participants in some way. That collaboration was understood as a central purpose is unsurprising, given – as discussed in the last chapter – one presumed benefit of a statutory basis is its convening power. However, participants often implied collaboration rather than directly stating it, usually when discussing what did or did not work in a DHR. Sometimes though, collaboration was referred to by way of a metaphor. For instance, Peter (a review panellist) referred to 'who is sitting around *the table'*, while Cora (a DA specialist) talked about being '*in the room* with the rest of the panel' [emphasis added].[71] Such obliqueness is reflective of the literature, where there have been calls for closer attention to how partnerships operate (Stewart, 2020).

However, close attention to participant descriptions generated a more nuanced understanding of collaboration, specifically that this was not something that simply manifested when a DHR was convened but is rather something that DHRs *are for*. Thus, one aspect of what DHR is for is to *engender collaborative potential* through the identification of stakeholders and the *maintenance* of existing, or the *creation* of new, relationships between them. This is something others have reported too (Boughton, 2022). In terms of the path described by Ahmed (2019), DHRs must ensure a previously walked path remains useable and/or create a new one.

Speaking to this potential, as independent chairs, both Grace and Henry described DHRs as 'a collaborative process' and a 'shared partnership approach'. Meanwhile, Elizabeth (a review panellist) placed DHRs in the context of 'multi-agency

[71] I also used this metaphor – e.g., by asking about practices 'in the room' – so participants may have been mirroring my language. However, some introduced this metaphor first and others, even if I had done so, went onto use it. This metaphor may be an example of an idiolect to which, as noted in the *Methodology*, I had access as an insider.

working'. These descriptions all refer to the CCR model which, as noted previously, underpins contemporary responses to DA.

Collaboration was understood to include, at least in theory, testimonial networks. Maria (a family advocate) recalled a DHR where she felt the family had been treated collaboratively, while Claire (a family member) described being 'kep[t]… in the loop'. In practice, family collaboration is important because they (and other testimonial networks) may bring information unknown to organisations (Gregory, Williamson and Feder, 2017). In policy terms, a concern with family collaboration also reflects the emphasis on the role of family involvement in DHRs (Mullane, 2017; Rowlands and Cook, 2022). While collaboration with family could be encompassed in this sub-theme, from participant accounts it was also clear that what DHRs were for in this respect could be understood as more than participation alone, so I explore this more fully as a sub-theme later in this chapter.

Conceptually, the idea that the review process enables the formation of a space for collaboration has been explicated by Websdale who, as discussed in *Chapter Two*, has described reviews as being for the enactment of dialogic democracy. Notably, Websdale does not romanticise collaboration and recognises the necessity to 'strive' to achieve it (2012, p. 32). Moreover, according to Giddens – on whom Websdale draws – achieving dialogic democracy is dependent on 'active trust' to 'open up' space for dialogue, with this space underpinned by transparency, reflexivity, and freedom to participate (1998, p. 17). Providing evidence for Websdale's account, the findings here demonstrate that a purpose of DHRs is to engender collaborative potential by *identifying stakeholders* and *enabling a shared ambition*, with each being underpinned by *leadership*.

Identified Stakeholders

To engender collaborative potential, participants understood DHRs as being for the identification of stakeholders who might, in some way, be useful. Identified stakeholders included family, although independent chairs Emily and Grace noted that family involvement was mostly facilitated through them, albeit sometimes a family might meet a review panel. However, reflecting the interview sample, most participants discussed stakeholder identification in terms of review panel membership.

In this respect, participants' accounts aligned with the requirements for review panels in the statutory guidance (Home Office, 2016). Moreover, that participants saw DHRs as being a mechanism for stakeholder identification is also reflective of review globally, where there is an emphasis on the importance of a broad membership (Wilson and Websdale, 2006; Dawson, 2021). According to participants, a DHR should include a range of statutory organisations and NGOs, including those that, because of their direct contact, could provide information about the victim or other individuals, such as the perpetrator and/or children. However, membership was not understood as being solely limited to organisations that had contact, so a review panel should also have specialist knowledge and expertise, particularly from NGOs. This meant:

> The key people will already be there around the table. But then if you've got specific issues – like mental ill health, drug and alcohol, if it's an older person, caring responsibilities – then I usually like to invite someone from a specific third sector organization covering those areas so they can act like a critical friend to the discussions (Margaret, an independent chair).

Participants particularly emphasised the role of specialist DA services, whose contribution was important because, for William (a review panellist), 'they come from a unique place'. Led-by-and-for services were similarly important because, as Caroline (a DA specialist) explained, 'they can speak… to the individual person and what impact that might have had on their experiences of [DA]'.

However, review panel functioning is not simply about identifying stakeholders who might be useful, it is also necessary to ensure they actively contribute. Thus, having been identified, stakeholders need to be willing to be useful as part of a DHR.

A Shared Ambition

Having identified stakeholders, DHRs are also for ensuring a shared ambition and a recognition of stakeholders' prospective role. Thus, to engender collaborative potential it was necessary to bring about a 'shared understanding of what we're trying to achieve' (Ella, a review panellist) because this afforded a 'bit of focus for everybody' (Emily, an independent chair).

This understanding of what DHRs were for could come about in different ways. According to William (a review panellist), a shared ambition might arise from having previously worked together to deliver DHRs, particularly if this was against the backdrop of a 'strong [wider] partnership that is open to improving and developing' (Mia, a DA specialist). In effect, doing DHR can include *maintaining* existing relationships (although, as I explore in *Chapter Seven*, in practice this familiarity could not be assumed to enable collaborations).

Yet not all stakeholder-relationships have a history, so sometimes a sense of what DHRs are for needed to be *created* (not least because, as I address in the next chapter, many stakeholders did not have access to training and support). For Bobby (a family advocate), a shared ambition meant 'setting the scene' at a DHR's start, with an independent chair articulating 'this is what we're here to do'. Family advocates like Lily and Marie emphasised the importance of developing a shared ambition with testimonial networks too, something family members also highlighted. Thus, Ethan described how the DHR process was explained to him by the independent chair, including what it was

for, while Isabella described how her family advocate helped her understand what was happening and why.

While the path to a shared ambition could vary, it allowed stakeholders to know 'why we're here, and what the steps are, and what their role is in it' (Sophia, a DA specialist). A shared ambition then engendered collaborative potential because it was underpinned by the recognition that 'it's not about blaming, it's about the identification of learning' (Amelia, independent chair).

Taken together, while a purpose of a DHR is collaboration, this is not a given and DHRs cannot not rely on collaboration occurring. Instead, what DHRs are for can be more fully described as being to engender collaboration by opening a space for dialogue by identifying stakeholders and ensuring a shared ambition. Drawing again on my building metaphor, this means ensuring that everyone has a shared sense of the plan and layout of the building being constructed. With respect to then doing DHRs, this means collaborative potential can thereafter be enacted because stakeholders are willing to be useful. That is, stakeholders are available to be engaged and so assist in the gathering of information from their organisation and/or about the victim (*Chapter Six*) and take part in a dialogue between those involved (*Chapter Seven*). However, while collaboration means that 'you are then relying on everyone on the review panel' (Chloe, a DAC), certain roles are critical in engendering a DHR's potential.

Leadership

Without leadership, participants identified how it was less likely or impossible to engender collaborative potential (and thereafter enact it) and explained how this could affect other purposes. As a demonstration, concerning the next sub-theme of accountability, Neil (a family advocate) argued that leadership was vital to 'free [review panels] up' if a DHR was to be a mechanism for scrutiny and learning. From participant

accounts, three 'focal roles' were generated. I have chosen this term to reflect Iris's description of her role as an independent chair as a 'conduit' and Peter's suggestion that DACs, including in a DHR, should be 'an intermediary, as a link, or as a fulcrum'. These focal roles included the independent chair, the DAC, and specialist DA and/or led-by-and-for services.[72] The importance of strong leadership has been noted in the context of DVFR in the U.S. where, interestingly, the description encapsulates the functions described here, with an emphasis on community connection, being able to get others to the table, and an understanding of team dynamics (McHardy and Hofford, 1999). To different extents, participants described how these leadership roles were useful in ensuring a DHR was delivered.

Independent Chair. Independent chairs are not merely useful to a DHR, they are central to it (Haines-Delmont, Bracewell and Chantler, 2022), reflecting their responsibilities as defined in the statutory guidance (Home Office, 2016b, pp. 12–13).[73] Participants understood independent chairs as having a role in *directing* collaboration. Thus, Owen (a review panellist) said independent chairs were essential for 'bringing everyone into the conversation' and Victoria (a DAC) felt that, while other elements were important too, a successful DHR 'depends on the skill of the chair'. Yet, being an independent chair was recognised as challenging, requiring a breadth of experience, skills, and knowledge, as summarised in Table 20. A further aspect of the role was independence. Participants addressed this specifically, referring to what this might mean for how independent chairs were recruited and appointed, conducted themselves, and what this meant when their role came to an end. In summary, independent chairs had a

[72] This does not mean that other stakeholders were not important, and participants described different review panellists as being vital. However, these other review panellists varied by DHR and/or area.
[73] The statutory guidance identifies eight prospective areas encompassing: knowledge of DA; an understanding of the individual and multi-agency working, as well as legislative, policy, research, and strategic context, and an individual's skills, experience, and training.

focal role in engendering collaboration (and thereafter enacting it by ensuring a robust process, as later chapters will explore). In terms of my building metaphor, independent chairs are architects. While an architect must work upon and within the foundations and framework already in place (i.e., the establishment of DHRs), they are responsible for designing the building itself.

Table 20

Independent Chair – Experience, Skills, and Knowledge

Experience, Skills, and Knowledge	Description
Process Management	Able to manage the process, including timescales, stakeholder liaison, and the production of DHR reports.
Relationship Management	Able to build and maintain relationships with and between stakeholders (CSP, review panellists and testimonial networks) during a lengthy, complex, and challenging process.
Meeting Management	Open and inclusive and able to promote a shared understanding. Able to facilitate engagement, recognising dynamics between stakeholders and encouraging or enabling participation as necessary. Committed to consensus whilst guiding, challenging, or containing where needed.
Knowledge	Understanding of the role. Knowledge of DA, other issues (reflecting professional background and experience), and wider partnership context. Recognition of limits of own knowledge, and ability to facilitate access to necessary expertise within or beyond the review panel (e.g., relating to case circumstances and victim/perpetrator characteristics).
Analysis	Able to analyse a large amount of information and facilitate robust scrutiny and the identification of learning. In doing so, able to ensure a balance between organisational and testimonial network accounts, avoid victim blame and consider individual, relationship, community, and societal factors.
Writing[74]	Able to write a good quality DHR report that accurately captures the information and perspectives shared during the review process, while keeping the victim central to the narrative.

[74] Some DHR reports are produced by a separate author, however the independent chair remains responsible for the process.

The DAC. Another focal role is that of the DAC, as a review panellist and as a link to the commissioning CSP. DACs use to DHRs was perceived as *supportive*. For Henry (an independent chair), DACs were 'a central point of contact'. This centrality was evident in Victoria's description of her role, which she described as being to ensure a DHR 'works smoothly' by making sure 'everything's happening'. However, a DAC might also enable a connection to the wider CCR which, for Victoria, meant she made sure 'everyone's there' *and* brought local knowledge. In effect, according to different independent chairs, DACs helped engender collaboration, including by supporting the identification of stakeholders; potentially securing expertise to address specific case circumstances, including facilitating representation by a led-by-and-for service; or as an avenue for escalation to resolve conflict.[75]

The participants who most stressed the importance of the DAC were independent chairs (who focused on how DACs assisted them), or DACs themselves (who described what they did). The limited comment by other participants might reflect two issues. First, as discussed in the preceding chapter, not all local areas have DACs, potentially removing this source of leadership. Second, a DAC's contribution was often unseen, something I am only too familiar with from my own experience of the role. Capturing this, Louise described 'the swan effect', by which she meant she had worked hard to navigate 'hurdles', yet she felt most participants would have felt everything was running 'smoothly'. Taken together, if an independent chair is an architect, a DAC is akin to a structural engineer who makes sure the building's design is sound and will work in practice.

Specialist DA and/or Led-By-and-For Services*:* The final focal role is provided by specialist DA/led-by-and-for services. Participants understood specialist

[75] DACs and/or the CSP could also be an avenue if an independent chair was ineffective, with several participants giving examples of where they had escalated issues for resolution.

DA services as distinctly useful because they could 'give expert advice' (Charlotte, a DAC). However, they also – as Alyssa (a DA specialist) suggested – had a role to be 'there for the victim… not there for process or whatever'. Thus, these organisations might also challenge assumptions.

> I think it enables people to think outside of the box in terms of learning, looking at how things can be done in a different way potentially. But also... yes, so looking at, are there much more creative ways of kind of accessing and making services accessible (Bobby, a family advocate).

Taken together, this meant specialist services could *be a critical friend*.[76] Additionally, the importance of an intersectional perspective was identified (Crenshaw, 1991). This was for two reasons. First, otherwise, the review panel might be 'all middle-class White people of a certain age and certain view' (Henry, an independent chair). Second, this expertise could help the review panel understand 'a victim's view on their everyday life' (Harper, a DAC) vis-à-vis aspects of their positionality like age, disability, ethnicity/race, faith, migration, sex/gender and gender identity, or sexual orientation. While specialist DA services might bring this in some respect, led-by-and-for services were useful too because:

> It would be important if someone was from a particular ethnic background to ensure that there was specialist [organisation] sat around the table that understands the dynamics of abuse and how that plays out, and how it draws on particular notions of stigma or shame, or what's talked about and what's not talked about (Elizabeth, DA specialist).

This mirrors the literature where there is an emphasis on a review panel including DA specialists (Sheehy, 2017; Dawson, 2021), and on being able to address a victim's lived experience and positionality (Bent-Goodley, 2013; Chantler *et al.*, 2022). In this way, specialist DA and led-by-and-for services are, in my building metaphor,

[76] As will be noted at the end of this chapter, and explored in later chapters, whether they could or did this is another question.

essential trade persons. They have an in-depth knowledge of DA and/or the needs of a victim that other stakeholders do not usually have.[77]

In summary, the focal roles of the independent chair, the DAC, and specialist DA services were understood to be essential in *directing*, *supporting,* or *being a critical friend* in engendering collaboration. Of course, these focal roles are at their most effective when there is a shared sense of understanding amongst identified stakeholders. Drawing once more on my building metaphor, these focal roles – together with other professional stakeholders who are all other trade specialists who can bring knowledge and skills for a particular task – can be understood as forming the team that goes on to deliver the construction project that produces a completed building.

Taken together, this means that while collaboration was understood as a purpose of DHRs, it was not a given because dialogic space must be engendered. Bobby (a family advocate) summarised this challenge, observing:

> And I think that's potentially dependent on your panel, your chair, the CSP: all the different people involved. If that structure and that kind of communication between all of those different people isn't going as smoothly as it should be, I think it just makes a DHR process much more challenging to see through, if you see what I mean?

Notably, these findings are like those reported for CCRs more broadly where, for example, Allen (2005) has suggested that effective CCRs are enabled by effective leadership, shared power, and a shared mission.

Moreover, while DHRs are a mechanism for engendering collaborative potential, this is not solely what they were for because, in turn, collaboration is a pre-

[77] Specialist DA services are often not funded to undertake this role. Sophia (a DA specialist) explained: 'we don't get paid to do that … in an already stretched service', something Caroline (also a DA specialist) echoed noting that many services struggled with funding and 'it's finding that time and resources to be able to contribute to a panel'. This was particularly relevant to the availability of led-by-and-for services with Charlotte (a DAC) noting that 'we don't have a specific [black and minority ethnic] organization in the borough'. In response to these concerns, Grace (an independent chair) emphasised the importance of being able to 'pay an expert' as a way of sustaining specialist DA and led-by-and-for service capacity.

condition for other purposes. Louise (a DAC) articulated this interconnectivity – foretelling several other purposes that I explore in this chapter – when she explained that the collaborative potential of DHRs made it possible 'to look at that case and work it out as a team…working out what went wrong, what can we improve'. Participants understood this 'looking' as requiring accountability, to which I now turn.

5.3 Accountability

A further purpose of DHRs is accountability. Within the broader literature, there is an emphasis on accountability as being something DVFR is for (Websdale, Town and Johnson, 1999; Neuilly, 2013), with this identified as a driver in DHRs too (Haines-Delmont, Bracewell and Chantler, 2022). Indeed, the importance of accountability is reflected in the statutory guidance which describes DHRs as a 'learning exercise and not as a way of apportioning blame' (Home Office, 2016b, p. 29). Accountability can be defined as giving a reason or an explanation. This definition was reflected in participant accounts where DHRs were understood as being for accountability, including *scrutiny and the identification of lessons*.[78] Demonstrating the connection between purposes, accountability was dependent on collaboration because the latter laid the ground for aspects of the operationalisation of DHRs upon which the former depended (like engaging participants, gathering information, and dialogue). As Leilani, a DAC, pointed out: 'it's very much about everybody having involvement and [then] being able to bring forward the information that they have'.

For participants, accountability was a large part of what DHRs were for. For Neil (a family advocate), accountability meant trying to 'find an intervention that would have kept [the victim] alive'. The result was that DHRs might reveal 'there was more to

[78] I describe this as 'identifying lessons' in recognition of the importance of distinguishing between learning and actual change (see Ryan, 2019). 'Making change' is a later sub-theme.

[the case circumstances] than meets the eye' (Marie, a family advocate), identifying 'stuff that was interest[ing], illuminating, worrying' (Emily, an independent chair). Indeed, an illustration of this potential is Monckton-Smith's 'homicide timeline' which is a way of tracking abusive relationship dynamics, including risk of lethality (2020).[79] However, domestic homicide is a complex phenomenon (Liem and Koenraadt, 2018; Messing *et al.*, 2022), something recognised by Luna (a family member) who identified that 'there was [sic] loads of different elements' in the death of her loved one. Reflecting this, while there was a shared understanding that DHRs were a mechanism for accountability, how scrutiny and the identification of lessons were undertaken could vary, including by focusing on *the agents involved*; *episodes of time*; or individual, relational, community, and social contexts (*an ecological approach*, which I define below). Notably, these different approaches affected the knowledge generated by, and so the findings of, a DHR, providing further evidence of contingency.

Agentic Focus

Many described approaching scrutiny and the identification of lessons agentically, with the scrutineers' gaze focused on individuals and the decisions they made or actions they took. Such agentic focus was often directed towards professionals (and by proxy, organisations), drawing on chronological accounts and analysis of victim contact (and that of other subjects). This could be useful because it shed light on professional/organisational practices. This meant 'utilising hindsight' to 'see what [the victim's] life was like, in terms of each contact [with organisations], the response, how that impacted on them or did not' (Owen, a review panellist). Leilani used similar terms, suggesting a DHR was about 'recognizing what worked well, what didn't work well, what could have been done differently'. In effect, an agentic focus on

[79] This study is a good example of the tendency of researchers to treat DHRs uncritically as a source of data. Monckton-Smith uses DHRs as one of her data sources but provides little methodological detail.

professional/organisational responses identified issues like the knowledge, skills and behaviour of professionals, the offer and/or efficacy of interventions, and/or placed these within an organisational context or indeed multi-agency working.

However, while considering professionals and/or organisations was important, this was only a partial perspective. At best, this partiality meant that scrutiny and the identification of lessons were incomplete. At worst, this could mean that DHRs, as discussed at the start of this chapter, adopted a narrow or thin perspective, which could lead to victim blame. As a counterpoint, most participants therefore identified that an agentic focus also had to be directed towards the victim and their decisions and actions. This meant, as articulated in the statutory guidance, attempting to see through the victim's eyes (Home Office, 2016b, p. 7). Such an agentic focus could also encompass the perpetrator, any children, and other individuals involved. While these other subjects were discussed, participants primarily referred to the victim. This emphasis reflects my research questions. As these research questions were explained to participants, this may have influenced their responses. In relation to practice around this, the sub-theme 'orientation to the victim' is explored in the next chapter.

Seeing through a victim's eyes was understood as something that a DHR was for because it de-centred professional/organisational narratives. As described by Grace (an independent chair), this was 'about [a] different perspective'. In effect, seeing through the eyes of a victim means attempting to understand someone's lived experience, including barriers to safety (Storer, Rodriguez and Franklin, 2021). To be achieved, this requires an act of imagination, like Back's idea of coming alongside someone (2007) and feminist standpoint perspectives (Haraway, 1988). Thus, numerous participants used the metaphor of standing in a victim's shoes, including Iris (an independent chair), Neil (a family advocate), and Chloe (a DAC). This metaphor is often used in campaigns

against VAWG, including the 'Red Shoe' protests in South America, an image of which adorns the cover of a recent history of the DA sector (Hague, 2021).

In practice, this information could sometimes be based on a victim's accounts (e.g., a diary) but, for the most part, required information from testimonial networks. Thus, Bobby (a family advocate) suggested that family information could lead to 'robust discussions… about how we interpret the [service derived] information that we've got'. Moreover, testimonial networks could themselves be a source of scrutiny, serving as a reminder that families were not solely there to be used. Another family advocate, Lily, highlighted that family might have 'their own questions'. While potential family roles could be found in this sub-theme, as for collaboration, I explore this more fully as a sub-theme later.

Agentic scrutiny and the identification of lessons then involved both a professional/organisational *and* victim focus, and I explore their operationalisation in later chapters. The key point here is that for most participants, for a DHR to best achieve its purpose, these should come together. Thus, Harper (a DAC) noted how 'from an [organisational] point of view, you would just see a snapshot of that person. But actually, what was it like? What was it like every day getting up in the morning?'

Episodic Focus

Such duality could also enable an episodic focus, with this being a further aspect of accountability. Episodic scrutiny meant a focus on 'significant events and incidents that happened and talking about what [organisations] did around it' (Hudson, an independent chair). These episodes could be single events, but they could also encompass longer periods. Thus, Lily, a family advocate, explained:

> You're not just looking at, sort of, what happened in that incident. It's everything around that and speaks to the complexity and complications in people's lives and

> that, you know, tragedies… like this don't happen for one reason and one reason only.

Episodic scrutiny could ensure a DHR was neither procedural nor, critically, victim-blaming. For Elizabeth (a DA specialist), an episodic focus meant taking a temporal perspective, scrutinising repeated system failures and therefore enabling the identification of lessons:

> You know, there are these, sort of, bizarre scenarios where, you know, someone's contacted sometimes three times and they don't respond. Then the case is closed. As opposed to saying, "well, there must be a reason why this person's not engaging and how do we do that in a different way?"

Ecological Focus

Finally, in seeking accountability, scrutiny and the identification of lessons could be *ecologically* focused. Ecological models have become influential as a way of understanding and preventing DA across four levels: the personal/individual, microsystem/relationship, exosystem/community, and macrosystem/societal (Heise, 1998, 2011; World Health Organization [WHO] and London School of Hygiene and Tropical Medicine, 2010). See Figure 6 for a summary.

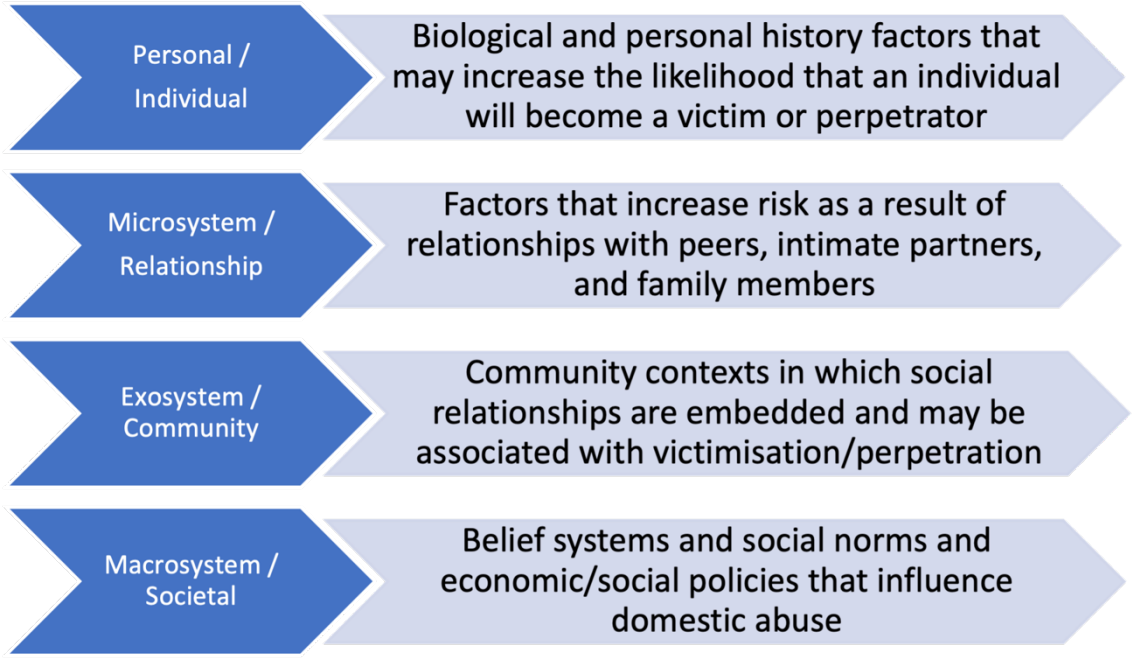
Ecological models have been described as being used in review (Bugeja *et al.*, 2015; Jeffrey, *et al.*, 2018), with DHRs described in this context as part of a 'public health approach' (Jones *et al.*, 2022, p. 2). However, while acknowledging the value of a public health and an ecological model, the latter have been critiqued for their limits, particularly in so far as they can treat each level as being equal, and both run the risk of failing to address wider variables like sexism and racism (Walklate and Fitz-Gibbon, 2022). Nonetheless, reflecting this emphasis, participants identified how an ecological perspective could enable a fuller scrutiny of the circumstances of a DA-related death. An ecological focus expanded agentic and episodic focus by taking account of the

context of a victim's lived experiences, through the individual, relational, community, and social levels. An ecological perspective involved asking:

> Did we do enough? Should we have done more? What could we have done more and were there individual, you know, [organisational], service, government, policy issues that got in the way of us doing that? (Emily, an independent chair).

Figure 6

Ecological Model



The utility of an ecological focus is reflected in a recent systematic review of the domestic homicide literature, although it is noteworthy that personal/individual and microsystem/relational levels were far more likely to be examined (Truong *et al.*, 2022). Notably, while many participants emphasised this approach in DHRs, it may be difficult to achieve. Thus, reflecting Truong *et al.*'s findings, often, when barriers to help-seeking for minoritised communities are recognised in DHRs, these may be

individualised, without any consideration of structural factors that shape these experiences and indeed organisational responses (Chantler *et al.*, 2022).

Taken together, DHRs were understood as being for accountability, with this potentially achieved through different ways of focusing scrutiny and the learning of lessons. Yet, as an aspect of what DHRs are for, accountability is dependent on the achievement of other purposes. In introducing this sub-theme, I have already noted that accountability is only possible because it is the product of the alchemy that collaboration, once enacted, enables. Further illustrating the interconnectivity of purpose, while DHRs are a mechanism for accountability this, in turn, leads to others, including producing findings which needed to be communicated by *telling the story* of what had happened. Moreover, if DHRs enable accountability, this itself is the raw material for *making change* because:

> … if it's a process issue, then we need to you know, we've got that responsibility to go, "ok, it didn't work. So, let's look at why it didn't work. What can we do to try and make sure that that's more robust moving forwards? (Ella, a review panellist).

Before turning to these as sub-themes, I turn first to how participants understood what DHRs might be for family. This is because, for many participants, ensuring family satisfaction with the process and outcome was essential. Chloe (a DAC) encapsulated this when she was reflecting on the end of a DHR, saying: ‘if that is useful to the family, then that is a positive’.

5.4 Family as Integral

In the sub-themes discussed thus far, DHRs have been understood as being a way for family to be brought into collaboration and then to play a part in achieving accountability. Additionally, as discussed in later sub-themes, participants also understood family in terms of their part in telling the story and/or making change. However, treating family as mere elements of other sub-themes risks their

instrumentalization, insofar as it means family might be seen solely in terms of their usefulness *for a DHR* e.g., as a source of information. Such an atomised approach would not be consistent with participant emphasis on family role which, for many, was totemic.[80] Thus, and in contrast to such instrumentalization, many participants understood DHRs as, at least in part, *for family*. This emphasis on family reflects their central role in the statutory guidance (Home Office, 2016b) and the literature (Mullane, 2017).[81] Echoing the language in the statutory guidance, and which is used to describe this sub-theme, Marie described family as 'being integral'. As a sub-theme, family as integral encompasses what DHRs might be for in terms of family *role* and perceived *benefits*.

Family Role

As a purpose of DHRs, being integral was, as put by Lily (a family advocate), about ensuring families, if they wished, felt 'it's a process that they were involved with, rather than a process that they're being told about, [which] I think is a big difference'. This purpose was founded on the recognition that a DHR was not an abstract process – which might treat a victim of domestic homicide as an object – but rather about, as Sophia (a DA specialist) described it, 'somebody's daughter and it's somebody's… mother' which meant 'seeing… she was real'.

Consequently, participants understood family as having a role and, reflecting the earlier sub-theme of collaboration, this included being identified as a stakeholder and ensuring a shared ambition. If done well, this meant a family might then exercise influence over the DHR, which family members Isabella and Luna said they had sought.

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[80] Yet, in practice, sometimes family might not participate in a DHR. This is discussed further in *Chapter Six.* Additionally, the interviews I undertook were with family and family advocates, so I have no data on the experience of other testimonial network stakeholders.

[81] The statutory guidance also indicates that DHRs should consider approaching a perpetrator's family (Home Office, 2016b, p. 19). For a discussion, see pages 212.

This finding is important because it highlights how, as stakeholders, families need not be passive and might be involved as part of a process of sense-making about their loved one's death (Armour, 2003). Indeed, such an active role means that, in this light, DHRs might *be for a family* because they can be a way to partly counter or even challenge the state's appropriation of loss (Christie, 1977), and with it the potential for it to inflict harm following a death (Armour, 2002; Englebrecht, Mason and Adams, 2014).

Moreover, in respect of the earlier sub-theme of accountability, this also means that families can have a role in identifying areas for scrutiny and the identification of lessons. It also, anticipating the sub-themes of telling the story and making change, might mean families have a role in these respects too. Thus, Elizabeth (a DA specialist) described how it was important that a family were able to 'indicate the particular areas that might need delving into'. Others, like Harper (a DAC) and Ella (a review panellist), described this as being a way of ensuring 'answers' to any questions the family had. Such questions were useful because they could help direct scrutiny within a DHR, with Emma describing how, as an independent chair, she would ask: 'so, what is your answer to the family about that one?' This also linked to how the story was told and change achieved, with Neil (a family advocate) suggesting that a purpose of DHRs was to challenge narratives produced through other state technologies (including the CJS, as noted previously). This underpinned a purpose of DHRs for family too, as they might be the voice for their loved ones through proxy. Isabella described this, saying: 'I had to be there for [my family member]. To be her voice'.

In summary, being integral means family have a role throughout a DHR. This means that what DHRs are for is to, potentially, reduce the risk of a family being

exploited *and* to ensure that someone's loved one is recognised as a subject and not objectified.[82]

Benefits to Family

The second aspect of this sub-theme is linked to what a DHR might be for in terms of benefits. It is important to note the limits of these benefits. As Amelia (an independent chair) observed:

> For families the worst has already happened. And anything you are offering about, you know, "this will be useful to learn lessons so that other people don't go through what you are". It's a bit trite really, in the terms of their grief.

Nonetheless, participants understood DHRs as having a purpose in helping families understand what happened and, through that and their participation, a possibility of catharsis and healing.

In terms of understanding, a purpose of DHRs is that they can potentially offer *knowledge and answers*, including by explaining the circumstances before and around the death of a loved one (of which a family may not be fully aware), or being open about what organisations did or did not do. Importantly, understanding as a purpose was not constructed with family as mere recipients. Thus, expanding on the preceding discussion of family role, DHRs' purpose can be seen as a corrective to state technologies, with some participants suggesting that these answers might be obtained even when the CJS had not provided them.[83]

Another purpose of DHRs is that they might help toward *catharsis and healing*. This was related to both the individual experience of families but also potentially their relationship with the state and its agents. In both cases, this purpose derived from

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[82] Albeit, as will be noted at the end of this chapter, and discussed in later chapters, this did not always happen.

[83] The reasons for this might be where there had been a murder-suicide and so no CJ outcome, or the perpetrator pleaded guilty and so there was not a full trial. Even if there was a trial, DHRs could have a role because it may not necessarily cover the 'whys and wherefores' (Lily, a family advocate).

families being supported to be part of, and then having a role in, DHR, but also its outcomes including the extent to which it brought about change (discussed below). If this could be achieved, Marie (a family advocate) described DHRs as being 'powerful and cathartic'. Thus, in the words of Hudson (an independent chair), a key purpose of DHRs was to ensure that families could see something 'come out of their tragedy'. Taken together, this speaks to what has been described as the possibility of both relational and systems repair, meaning DHRs can be a way for family concerns to be addressed *and* to drive improvements in service responses (Rowlands and Cook, 2022). Encapsulating this possibility, Neil (a family advocate) observed:

> I think that for some families there is distrust of [organisations]… if a review is done… there's at least the potential… [that] that broken relationship between [an] individual [and] society, which we all need in a successful democracy, in some way heals slightly.

In summary, a purpose of DHRs is to centre family as integral, encompassing their role and potential benefits. In some ways, DHRs are therefore *for family as much as they are for the state or any other stakeholder*. Another way of articulating this was described by Chloe, a DAC, as 'telling a story'. It is to this idea of telling a story I now turn.

5.5 Telling the Story

Reflecting the emphasis on prevention referenced at the start of this chapter, one oft stated purpose of review is that it will aid the understanding of the 'etiology and intricacies' of domestic homicides (Montanez, Donley and Reckdenwald, 2022, p. 4). As a result, there can be a focus on lessons learnt in terms of risk and need profiles (Chantler *et al.*, 2020; Chopra *et al.*, 2022). This, as I argued in *Chapter Two*, might be to the detriment of a concern with the victim, with this standing in contrast to what many participants emphasised, which was that DHRs should 'tell the victim's story'

(Emma, an independent chair). A desire to tell a victim's story is a call to prioritise lived experience, reflective of the emphasis on listening to the voices of women and other oppressed groups in feminist research (Westmarland and Bows, 2019).

Emma's desire that DHRs might be for telling a victim's story was echoed by other participants. This was articulated in different ways, from 'looking at … [the victim's] experiences' (Owen, a review panellist), to making sure the victim was 'at the forefront' (Harper, a DAC), or that a 'victim should be central to the review' (Lily, a family advocate). As a sub-theme, telling the story is linked to the statutory guidance which emphasises seeing through the eyes of a victim, with this being explained as making it possible to 'understand the victim's reality' by 'situating the review in the home, family and community of the victim' (Home Office, 2016b, p. 7). However, telling the story is more than simply describing a victim's experiences, albeit this is important in the pursuit of accountability, as discussed in the earlier sub-theme. Instead, telling the story as a purpose means DHRs are *for the victim*.

First, in the words of Emma (an independent chair), telling the story enabled a representation of the victim: 'so that [there] voice continues to be there'. Thus, in effect, DHRs were for visibility, with Chloe explaining this meant:

> … making victims visible, because they often aren't. Within the abuse, they often aren't. Within society, they often aren't. Within our services, they often aren't. And it is a document all about them and their story and their experience. Which is both visible... I can't think of the right word... which is quite elevated in terms of importance.

Demonstrating the interconnectivity of purposes, telling the story enabled other purposes too. It meant that family and other testimonial networks might feel that 'their loved one's voice has been heard' (Lily, a family advocate), so achieving the purpose of family being integral. It might also enable another purpose, that of accountability, by enhancing scrutiny by anchoring a DHR in a victim's experience, which in turn enables

a more complete understanding that complements and challenges organisational accounts. For Amelia (an independent chair) this included trying to understand ‘what decisions were [victims] making, not making? Why were they making them?’ Such questions are particularly relevant in a DHR, given the extensive evidence of barriers to help-seeking (Sharp-Jeffs and Kelly, 2016).

Second, a recognition of a victim’s experience might also help avoid objectification. The risk of objectification derives from the way that a DHR might work as technology, particularly if it reduces a victim to a case, a possibility I explored in *Chapter Two* by using Foucault’s discussion of the examination. The effect is to render the subject an object of knowledge/power while power itself is invisibilised. This is particular evident in the context of whose knowledge counts because, e.g., as has been suggested in the context of Aotearoa New Zealand, organisational ways of knowing may be privileged over family accounts, potentially reproducing power imbalances (Roguski *et al.*, 2022). To avoid this risk, ensuring that DHRs told a victim’s story was understood as purposeful. This means that, while there is always a risk of what Opie called ‘textual appropriation’ (1992), this can be mitigated through an orientation to the victim as the central focus of DHR (I explore this further in the next chapter). For Iris (an independent chair) this meant:

> Making sure there is a reason for telling their story. So, you are not exploiting them in retrospect. That just saying, "we are doing this in order to make things better for other people". So, there is some justice to what happened to them, and telling their story.

In one sense then, what DHRs is for as a counting mechanism is to enable testimonial justice (Walklate *et al.*, 2020). In contrast, testimonial injustice occurs when someone is afforded less credibility than someone else (Fricker, 2007). In the context of

domestic homicide, that might mean that a victim's experiences are less centred than professional/organisational accounts.

However, telling a victim's story is not only about what it must avoid, but also about what a DHR might be for in terms of a sense of hope, which both Victoria and Harper (DACs) described as the idea that something 'positive' came about because of, and following from, someone's death. This sense of what reviews might be for has been described in an article I co-authored – and where I explained why I worked in the DA sector and as an independent chair specifically – as their 'hope and ambition' (Cullen *et al.*, 2021, p. 625). This hopefulness has been given visual form on the cover of one of the few volumes concerning review, edited by Dawson (2017a). There, the cover shows a burnt-out log, from which new growth is seen emerging, a powerful visual illustration of hope (of prevention) emerging even after destruction (death). Websdale has described this as the 'startling juxtaposition of the daunting and the propitious' in review (2012, p. 29). It is to that propitiousness of DHRs that I now turn.

5.6 Making Change

Making change was generated as the final sub-theme and, for participants, the possibility that DHRs might bring about change was fundamentally what they were for. However, in the same way that collaboration could be described as a pre-condition for DHRs, so making change is a post-condition. Thus, making change is marked by interconnectivity with, and built upon, the other purposes of DHRs. As an example, while Marie (a family advocate) emphasised that a DHR was about collaboration and accountability, she also argued that it was then necessary to 'come up with a robust action plan to prevent another tragedy'. For others, this change was framed concerning family as being integral and telling the story. Thus, Luna hoped that the DHR into the

death of her loved one would make it possible ‘to be able to tell [the children] when they were older that… at least maybe some good came from the learning around it’.

In making change, for Emma (an independent chair), Owen (a review panellist), and Victoria (a DAC), the purpose of DHRs was to make things ‘better’. However, what this betterment might be demonstrates how, as with other sub-themes, the understanding of making change was multi-faceted.

For Owen, a review panellist, a purpose of DHRs was about ‘do[ing] it better next time’. By this, Owen felt that what DHRs were for was to prevent future deaths. This view was expressed by other review panellists too: Peter described DHRs as being to answer the question ‘how do we prevent individuals from getting into that position again?’, while Hazel said the goal was to ‘save the next person’. This concern with prevention as something that DHRs are for is found in policy, practice, and research, where there is a focus on improving understanding of pathways to domestic homicide to intervene sooner (Monckton Smith, 2020; Messing *et al.*, 2022).

The most frequent reference in terms of making change was to the findings of a DHR, either relating to the findings generally and/or specifically the development of recommendations and resulting action plans. This emphasis echoes the statutory guidance, which requires DHRs to ‘make recommendations for future action which the review panel should translate into a specific, measurable, achievable, [relevant], and timely (SMART) action plan’ (Home Office, 2016b, p. 22). Elizabeth (a DA specialist) emphasised that action plans had to be clear about the ‘actual difference that is made because of it’. Participants’ use of this language may reflect the interview sample, given it was primarily professional. Notably, however, while the small number of family members who were interviewed did not use this language, in their accounts they nonetheless pointed to concern with change, as Luna described above.

However, other potential purposes also came to the fore. This was not because participants did not want to see future deaths reduced. Rather, this was a question of whether it was possible to demonstrate prevention and whether other outcomes might also be valuable. In terms of prevention, some participants suggested that this was unrealistic, with Iris (an independent chair) describing this claim as 'shaky'. For other independent chairs (Grace, Henry, and Margaret), while preventing future deaths might be an aspiration, the difficulty was measuring this, meaning it was not possible to make this claim, or it could only be made tentatively. This attribution challenge has been noted by Payton, Robinson and Brook (2017), and bedevils review systems generally (Storer, Lindhorst and Starr, 2013; Bugeja *et al.*, 2017; Jones *et al.*, 2022). Others, like Bobby and Lily (family advocates), suggested that another reason why prevention was not appropriate as a goal was because of issues within the DHR system itself. For Lily:

> The purpose is supposed to be to improve things and prevent future deaths. And it doesn't feel to me - and this is just based on my feeling - that any real changes have been effectively made to do that.

In effect, even if a DHR was able to identify changes, it was not always able to make them. Participants identified this as occurring because of the operation of the DHR system, including both local and national oversight. Therefore, I have described this sub-theme as 'making change' to convey a sense of *possible but not certain change*. The tentative nature of change was captured by Margaret, an independent chair, who, reflecting on the challenge of the oversight of the action plans – particularly considering the challenges locally and nationally as identified in the last chapter – emphasised that the goal was to determine 'has there been any tangible change or visible change as a result…?' Notably, however, this means that if DHRs are for prevention (or indeed any other change), to achieve their 'foreness' there must be a sense of faith (like that

expressed in Henry's quote at the start of this chapter) and hope (as discussed in the previous sub-theme).

The question of whether and to what extent DHRs can be understood as being for the prevention of future homicides did not mean that participants were unambitious about the possibility of making change. The focus in this respect was that the purpose of DHRs might be better understood as improving the response to DA, as has been suggested elsewhere (Storer, Lindhorst and Starr, 2013). Indeed, William (a review panellist) explained how the latter might make one more confident of the possibility of the former, arguing:

> Those changes, we'll never be able to measure whether or not they have made a difference and kept people safe. But what we do know is, from the work we've done, by not doing them before we did fail those people previously.

Participants identified how DHRs could be a mechanism for changes across multiple domains, either reporting on specific DHRs or describing what they felt DHRs should seek to achieve. In making sense of these domains of change, I have drawn on the systematic review conducted by Jones *et al.* (2022), which looked at 11 studies into the impact of DVFR/DHRs. Jones *et al*. identified reports of recommendations across the domains of training and awareness; service provision; resources; prevention programmes; and community-wide changes. While a weakness of the Jones *et al*. study is that it does not explicitly define these domains, it nonetheless adds to the thinking about what reviews might be for beyond the direct prevention of death. Importantly, these domains could be found in participant accounts of the change they felt DHRs could be for. These included:

- *Training and awareness*, including improved understanding of DA within services because DHRs might be a way of 'thinking and reflecting on risk factors' (Mia, a DA specialist)

- *Service provision*, because DHRs might enable 'the generation of useful information for better structuring services and interventions' (Amelia, an independent chair).
- *Increased resources*, with Marie (a family advocate) describing DHRs making the case for 'investing time and money to improve services'.
- Finally, prevention *programmes* and *community-wide changes* might arise from DHRs, with Sophia (a DA specialist) identifying how DHR findings could be used to inform community engagement because they might drive a focus on outreach. More broadly, Ethan (a family member) highlighted his hope that a DHR would lead to national change, identifying a specific piece of legislation about which he said, 'I would like [that] to be changed'.

While these findings do not evidence the action generated by DHRs, which I explore in *Chapter Eight,* they do suggest that DHRs can be understood as being for making change. Importantly, for some participants, the prospect of change was framed in the context of the CCR. Returning to Victoria (a DAC), who had framed the change that DHRs might make as betterment, this meant 'mak[ing] the system work better'.

5.7 Conclusion

In this chapter, I have explored five sub-themes that capture DHRs' plurality of purpose. Importantly, these purposes are interconnected and, in discussing each, I have identified examples of how they paralleled, intersected, and overlapped. Thus, returning to Ahmed (2019), each purpose has a 'foreness' *in its own right*, yet, in turn, is necessary *for other* purposes. As presented here, this foreness has a linearity, with the chapter's structure implying a chain beginning with collaboration, which then begets other purposes in turn through to making change. However, while participants understood that some purposes had to be achieved before others – in particular, as I have suggested, collaboration is a pre-condition – these were not specifically linear.

Instead, as these purposes paralleled, intersected, and overlapped, they were understood as reinforcing one another. Illustratively, talking about the different purposes of DHRs, Bobby (a family advocate) identified this interconnectivity, before identifying those she felt were most central:

> I think they're all relatively equally important from different perspectives. I think missed opportunities and lessons is probably the most important because we need to know what's happened in order to look at how we can improve things going forward. But I don't think you can do that without also giving recognition and voice to the person who's been killed.

Yet, while this chapter has examined what assumptions underpin DHRs in terms of what they are understood as being for, it is important to highlight that the ideal types presented here are just that. In practice, participants reported that these purposes were sometimes not sought or achieved. Thus, returning to the metaphor of a building, it is as if the plan and layout of a DHR is not always consistent, introducing differences room by room and affecting the whole. This, then, is another aspect of the potential and peril of DHRs as a technology, meaning not only are there challenges and tension in their establishment, but also in what they are understood as for.

As Grace, an independent chair, highlighted when talking about the different purposes of review, 'these things… don't necessarily happen in all reviews'. Yet, given their interconnectivity, if one purpose is not achieved it affects others or, perhaps, purposes are left at cross-purposes. Most importantly, given that collaboration is pre-conditional, if this is not achieved, it can compromise the achievement of subsequent purposes, including accountability. Thus, Elizabeth (a DA specialist) highlighted how 'people's voices might be lost or, kind of, drowned out within the process' because of power dynamics between organisations. Moreover, even if collaboration was achieved, this did not necessarily lead to accountability. In this respect, Amelia (an independent chair) highlighted how, as an independent chair 'you have to put a reasonable amount of

effort into encouraging people to focus on it being a learning exercise and not a blame exercise'. Meanwhile, without accountability, telling the story was compromised, with Iris (an independent chair) highlighting 'it can be a bit easier to focus on this person as a client, as a service user, as a victim, rather than as this person at this time and their experience'. Finally, concerning family being integral, both Luna and Isabella described the different ways in which they felt the DHRs into the death of their loved ones had failed in some way, including in terms of their role as family members. Luna and Isabella's experiences highlight how a process that is imagined as having family as integral failed to achieve this; experientially, this is an example of the injustice of not being heard (Stauffer, 2015).

In effect, while DHR is for any number of purposes, these may not always be achieved. The consequence is that there can be variability in the doing of DHRs and that some individual case examinations may be rendered less useful than others. Bringing together all these issues, Emma (an independent chair) captured how she felt the plurality of purpose described here had been compromised when, as first noted in the previous chapter, she reported a changed sense of how DHRs were understood. In her account, it is possible to see that what DHR was for had been compromised, most explicitly with respect of the purpose of making change, but implicitly in terms of the process as a whole:

> It seemed to be when DHRs started, it felt more cooperative. That people around the table were trying to do the same thing that I was trying to do. Which was to figure out how to make their response better. And they could be just as surprised as I was by the response, you know. It feels more protective now.

In effect, Emma was concerned DHRs had become less useful. Notably, Mullane has described a similar shift, highlighting the risk of an 'unconscious march towards complicity' (Mullane, 2017, p. 282) if DHRs lose their ambition.

A recognition of the plurality and interconnectivity of purpose of DHRs – what Ahmed (2019) described as both functionality and what use might bring about – is a key finding of this chapter, as is the possibility that these may not always be achieved. However, this leaves unanswered the question of why DHRs do not always achieve their hoped-for purpose(s). Here, a comment from Elizabeth (a DA specialist) is useful. Reflecting on the DHR process, she said: 'well, I suppose the fact that they're happening is working. The quality, the process, and the reports, and what's drawn out of that, is variable'. What Elizabeth raises is that while DHRs have been established, it remains unclear whether they (as individual case examinations and as a system) achieve what they are meant to be for because of differences in understanding of purpose and/or how they are operationalised. To address this, in the final three findings chapters, I explore the doing of DHRs, including practices, relationality and whether DHRs are a site for action.

Chapter 6: Practices of DHRs

6.1 Introduction

> But when you've got human beings involved, different [organisations] involved, and different families involved, inevitably there are going to be differences…. There are [also] differences around CSPs, their expectations, their experience… and different interpretations chair by chair because chairs tend to come from different backgrounds (Joshua, independent chair).

Joshua's quote encapsulates the theme of this chapter, which explores the 'practices of DHRs'. Practices can be understood as norms that structure DHRs as a technology. This is because normative practice is a matter of how 'things are shaped in order to be used' and, consequently, any 'use instructions' (Ahmed, 2019, pp. 26, 28). By use instructions, Ahmed means the rules governing use, including when, how, and by whom something can be used. In this chapter, I deploy the concept of use instructions to attend to what is *used by and in* DHR and, in so doing, turn to their operationalisation. Practices of review is, as a theme, tied to three sub-themes: (a) engaging professional stakeholders (b) gathering information and (c) orientation to the victim. See Figure 7.

Thus far, I have argued that, as a technology, while the introduction of DHRs may be positive, how they became available to use is mixed in terms of the stability of their foundations and robustness of their framework. In this context, my previous suggestion that DHRs' introduction could be understood as symbolic can also be seen in terms of use instructions because 'a policy can be about what ought not to exist' (Ahmed, 2019, p. 176). That is, a policy's use may be about marking a position (i.e., that domestic homicide is a social ill that the state takes seriously), but this does not necessarily mean it is used (i.e., to fully investigate these deaths and act). Regardless, I have shown how a lack of stability and robustness produces complexity and tension and, consequently, argued that the DHR system is marked by both potential and peril.

This potential and peril are exacerbated by a plurality of purpose, that is, understandings of what DHRs should be used for. While these purposes can be reinforcing, this also means that failing to achieve any given purpose affects others and they may also be at cross-purposes. Taken together, this means that the conditions are in place for the practices of DHRs, part of what I have previously termed their 'doing', to vary. As discussed over preceding chapters, this might mean knowledge production within DHRs takes either a wide/thick or narrow/thin perspective of the circumstances of, and therefore possible learning about, DA-related deaths (Websdale, 2010; Walklate *et al.*, 2020). As the latter, DHRs may produce learning that is framed by a dominant CJ discourse (notably about risk) and be – in effect – extractive. Alternatively, as the former, DHRs may attend to subjugated knowledges from the victim or testimonial networks, and so be a vehicle through which dominant discourses may be challenged.

Figure 7

Practices of DHRs

Yet, as noted previously, DHRs' doing has been little considered, albeit there is an increasing recognition that DHRs are complex (Haines-Delmont, Bracewell and Chantler, 2022). This chapter seeks to understand who, as well as what, is used by and in DHR. This chapter therefore considers the normative practices which concern 'who gets to construct these [death] events and what materials they use' (Dawson, 2021, p. 675). Attending to practices is important because – further extending my construction metaphor as developed through the preceding chapters – they are the 'pipeline' (Hill Collins and Bilge, 2020, p. 12) for the materials used in a DHR, without which nothing can be built. Thus, the practices of DHRs are essential for knowledge generation.

To demonstrate the link between practices and knowledge generation, consider my experience of reviewing deaths by suicide. Whether review systems consider deaths by suicide varies (Bugeja *et al.*, 2017), partly because this extends the scope of enquiry beyond domestic homicide to encompass a range of DA-related deaths (Fairbairn *et al.*, 2019).[84] When deaths by suicide became reviewable, the revised statutory guidance set out that they should be undertaken where the 'circumstances give rise to concern' (Home Office, 2016b, p. 8). DARDRs are significant given this phenomenon is unresearched (Websdale, 2020), albeit the literature is developing (e.g., see Munro and Aitken (2020), Bates *et al.* (2021)). [85] Furthermore, through a gendered lens, such early deaths of (largely) women are an example of 'slow femicide' which should be accounted for (Walklate and Fitz-Gibbon, 2022).

Yet, this extension left numerous conceptual and operational questions unanswered, with this inattention literally evidenced by the single paragraph that

[84] Albeit, in England and Wales, DA-related suicides could possibly be subject to a charge of manslaughter (Munro and Aitken, 2018; Lodge, 2020).
[85] As explained in the *Introduction*, I use the term 'DARDRs' to reflect the differences between reviews into killings and deaths by suicide. Yet, under the DVCVA and in the statutory guidance, such reviews are formally 'DHRs'. In practice, a concern about naming was identified by several participants. Meanwhile, the current leaflet for families only refers to domestic homicides (Home Office, 2017).

addresses DARDRs in the statutory guidance.[86] First, what constitutes a 'concern' is not defined, with only the example of 'coercive controlling behaviour in the relationship' provided (Home Office, 2016b, p. 8). This leaves unexplicated the nature of any causal link between DA and a death and/or what degree of temporal and spatial proximity is required, thus raising the question of when to commission a DARDR (a concern identified by some participants, see Table 13). Second, and with relevance to who, as well as what, is used by and in DHR, practice issues arise, not least the status of the (alleged) perpetrator.[87] Referring to the sub-themes of this chapter, this calls into question practices like the use of organisational information; whether the (alleged) perpetrator should be approached to take part; as well as how to make sense of victim experiences, not least the link between the death event and previous experiences of DA.

As an independent chair, I have led two DARDRs. In each, I, the review panel, and testimonial networks, had to consider who we engaged, what information was gathered, and how we could achieve an orientation towards the victim. However, we had little reference to any practice norms because the statutory guidance is so limited with respect to DARDRs, and it is difficult to find or consult examples of concluded cases given the current absence of a national repository. Thus, our decisions might have been different to those in other cases, potentially introducing differences in the knowledge generated about otherwise similar circumstances.

Although this example concerns domestic abuse-related deaths by suicide, it highlights the potential for differences in the practices of DHR more broadly, with implications for knowledge generation. Thus, as in earlier chapters, this means that the technology of DHRs is itself formed by, and generative of, ongoing complexity and

[86] As noted in the *Introduction*, the U.K. Government has committed to DHR reform, with this including plans to address DARDR in the statutory guidance.
[87] In most cases, despite the possibilities highlighted in footnote 84, there will not be a criminal conviction. There may also be challenges in securing a coronial verdict of suicide (Jones *et al.*, 2022).

tensions, here in terms of operationalisation. In examining the practices of DHRs, this chapter responds to the second specific research question: what norms are employed in the conduct of DHRs? I seek to understand what is used by and in DHRs. I primarily draw on data from the interviews (Phase 3) and, to add breadth to the analysis, data from the published DHR reports (Phase 1) and the web-based survey (Phase 2).

6.2 Engaging Professional Stakeholders

The first sub-theme relates to the engagement of those involved in a DHR through their work (I explore testimonial networks in the third sub-theme). The statutory guidance sets out that a review panel should include 'relevant expertise' (Home Office, 2016b, p. 11). This ambition was reflected in participant understanding of what DHRs were for, as explored in *Chapter Five*, in terms of engendering collaborative potential. In this sub-theme, I explore how this collaborative potential is enacted to produce engaged (or useful) professional stakeholders.

Participants described successful engagement as meaning professional stakeholders were useful because they had a shared sense of practice norms. These norms included being 'open about their contact and what's happened' (Owen, a review panellist), discussing case information – including 'feel[ing] confident to ask questions' (Leilani, a DAC) – and, where needed, 'challeng[ing] each other in a constructive way' (Ella, a review panellist). For Amelia and Iris, both independent chairs, engagement also encouraged a sense of ownership and was linked to outcomes (see *Chapter Eight*). This, then, was the enactment of collaborative potential, delivering the CCR within a DHR because 'if everyone is engaged, I think it's a really positive experience… [and] really good partnership working… comes out of it' (Bobby, a family advocate).

In summary, for professional stakeholders to be usefully engaged, they must be willing to bring their *expertise and perspectives into the crucible of a DHR* which,

alongside the information they present (considered in the next sub-theme), can then be used to generate findings. Yet, how professional stakeholders *become involved* and *learn to do DHRs* varies, with these affecting norms around engagement.

Becoming Involved

Professional stakeholders first had to become involved in a DHR, and there were important variations in participant accounts. For some stakeholders, DHRs were *routine business*. This included independent chairs and those review panellists with a specific DA portfolio. However, others were drawn into *something unfamiliar*. To explore this further, I consider independent chair involvement before turning to review panellists.

Independent Chairs. Upon commissioning a DHR, a CSP must secure an independent chair to lead it. Because of the requirement for independence, chairs usually come into an area in which they are not working day-to-day and so, to become involved, must be *appointed*. I use this term to capture the purposeful selection of an independent chair, with this being important because participants felt that for DHRs to be useful, an independent chair needed to be useful too i.e., to have experience, skills, and knowledge described in *Chapter Five*. Yet, the quality of independent chairs could vary. Other researchers have reported this variability too (Haines-Delmont, Bracewell and Chantler, 2022), with this linked to challenges in appointment (Sharp-Jeffs and Kelly, 2016; Montique, 2019).

I also use appointment because, once in post, an independent chair assumes considerable latitude to shape a DHR by setting use instructions for others. This is because their leadership role means independent chairs have ‘a very particular function’ (Chloe, a DAC). Indeed, DHRs are ‘highly dependent’ on the independent chair (Haines-Delmont, Bracewell and Chantler, 2022, p. 7). This dependence has consequences, e.g., it has been suggested that differences between the standard of DHR

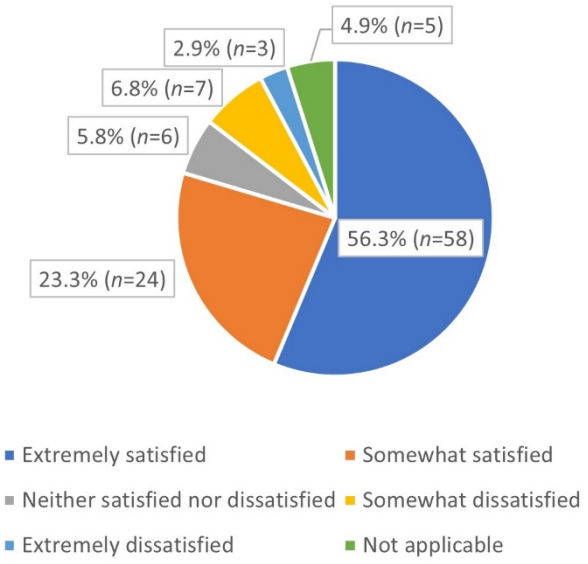
reports may be attributable to differences between independent chairs (Stanley, Chantler and Robbins, 2019). My findings explicate how this variability could be related to the assessment and/or suitability of independent chairs. In effect, this relates to the adequacy and application of the use instructions for this role.

Concerning *the quality of independent chairs*, in the web-based survey (Phase 2), professional respondents were asked whether they felt the independent chair 'led…in a way that helped everyone contribute, identify learning and make recommendations'. Levels of respondent dissatisfaction were low (only 9.7% (*n*=10) were extremely or somewhat dissatisfied). Conversely, satisfaction was high (totalling 79.6% (*n*=82), with 56.3% (*n*=58) being extremely satisfied). Thus, most independent chairs are perceived to be useful (see Figure 8).

However, that 23.3% (*n*=24) of respondents were somewhat satisfied raises the question of what aspects of independent chairs' conduct could be an issue. Moreover, many interview participants identified independent chairs with whom they had been dissatisfied. Emily (herself an independent chair, who had previously been a review panellist) described one DHR as a 'painful, painful experience' because of the independent chair. Meanwhile, as a family member, Luna felt the independent chair in her case did not have the right experience, skills, and knowledge. Finally, both Amelia (an independent chair) and Elizabeth (a DA specialist) highlighted how errors by an independent chair could extend the duration of a DHR, particularly if the QA panel did not accept a DHR report and it had to be revised. Such revisions had a direct cost (the independent chair's time) and indirect cost (reconvening the review panel). At its most extreme, two participants reported DHRs being restarted because of inadequate performance by an independent chair. I provide further examples in the remainder of this and subsequent chapters.

Figure 8

Professional Respondents – Independent Chair Satisfaction



In summary, while overall levels of satisfaction appear high, at least some independent chairs may not have the right experience, skills, and knowledge, and so are less useful. This, in turn, might make the DHR itself less useful, and perhaps even useless, because of the knock-on effect on a DHR's doing. This variability could be due to weaknesses in how independent chairs are appointed and/or who fulfils these roles.

Variability in quality may reflect *differences in the assessment of independent chairs*. Appointment processes could be robust, including the assessment of experience, skills, and knowledge, e.g., as a DAC, Victoria described appointing an independent chair specifically for their experience in working with older adults. However, this was not always the case and Joshua described how, as an independent chair, 'some [CSPs] go through a lengthy tendering process and stuff like that. Others it's just a phone call'. Such informal appointment had been experienced by most of the independent chairs interviewed: each provided examples of being contacted by CSPs based on their professional background, having previously led a DHR locally, or following another

CSP's recommendation. As Leilani (a DAC) described: 'we initially used the same chair for a couple… and then another CSP in our county used the same chair.'[88]

While there was insufficient data to examine why this variability in appointment process arises, this could reflect issues relating to DHRs' framework as discussed previously. First, while the statutory guidance includes requirements for an independent chair, it is a bullet point list of expectations (Home Office, 2016b, pp. 12–13). As such, there are no comprehensive use instructions against which to judge an appointment. Unsurprisingly, the absence of a robust competency framework has been noted as problematic (Rowlands, 2020a; Haines-Delmont, Bracewell and Chantler, 2022).

Second, this may reflect CSP oversight capability, including the availability of DACs. Indicative of this possibility were participant concerns about the robustness of appointment processes given, as Elizabeth (a DA specialist) explained, these depended 'on the knowledge of the people commissioning the review'. Explaining the link to the appointment process, Amelia (an independent chair) suggested there is 'some work that needs to be done with CSPs around improving how they allocate these contracts'. Additionally, Amelia and Peter (review panellists) were concerned that any assessment could also be compromised by cost.[89] Thus, CSPs might favour price over quality, i.e., *by assessing an independent chair as being useful enough*. Explaining this, Peter suggested that less skilled but potentially cheaper independent chairs were like a Fiat and asked, to illustrate the effect on quality, 'where['s] the incentive to go for the Rolls Royce?'

A broader issue was the *suitability of independent chairs*, specifically in terms of who is used for this role. Based on the web-based survey (Phase 2), 55.6% (*n*=5) of

[88] The re-appointment of an independent chair for multiple reviews in a local area raises an interesting question as to understandings of independence. See *Chapter Seven.*
[89] See footnote 57 for a discussion of who pays for DHRs.

respondents were self-employed (i.e., consultants), with the remainder selecting 'other' or 'local authority – community safety' (each accounting for 22.2%, *n*=2). This trend was more pronounced in the interview data where, of independent chairs, only one was working reciprocally, having chaired for a neighbouring local authority. All the others were consultants, and were either established as such or, for Bobby (a family advocate) and Cora (a DA specialist), were developing consultancy careers.[90] This is a notable finding given that it was originally intended that DHRs would be undertaken 'without the need to rely on private consultants' (Home Office, 2013b, n.p.).[91]

The web-based survey (Phase 2) did not capture independent chairs' professional background. However, amongst interview participants, there was a three-way split (33.3%, *n* = 3) between local government, the police, and the specialist DA sector. From the published DHR reports (Phase 1), data was also generated about independent chairs' professional backgrounds:[92] 50% of independent chairs were former police officers, and no other professional background accounted for more than 10% (see Appendix B). Moreover, while it was not possible to code confidently for sex/gender, most independent chairs were men.[93]

These findings are significant because they raise questions about the positionality of many independent chairs, both in terms of sex/gender (given the difference, as I reflected for myself in the *Methodology*, to the majority of those who are affected by domestic abuse) *and* professional background (given policing has a mixed

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[90] This trajectory is like my own: I began chairing when I had a substantive DAC post.
[91] Based on an expectation that independent chairs would be provided reciprocally between areas with staff being 'exchanged or loaned' (Home Office, 2011, p. 11, 2013d, p. 12, 2016b, p. 12).
[92] Coding required interpretation as background was not always clearly stated, and sometimes generic as indicated by the category of 'other'. Faced with more than one career (e.g., some police officers had retired before working for a Community Safety Team), the substantive background was recorded.
[93] Again, this required interpretation, i.e., based on any in-text pronoun and/or name. Other data, for example like ethnicity, could not be generated. However, like sex/gender, understanding the profile of independent chairs with respect to other demographics characteristics could also reveal significant patterns.

record toward DA (Serrano-Montilla *et al.*, 2021), and is dominated by carceral approaches (Whynacht, 2022)). Combined with evidence of there being a sometimes informal or ad-hoc approach to appointment, the risk is that independent chairs are used because *they are who has always been used*. Such repeated use risks replicating a particular professional habitus wherein postholders may understand what DHRs are for, and their use instructions, in specific ways. This raises questions about both the pathways to an independent chair role, as well as how appointments are made.

Thus, in terms of the norms around becoming involved, there is a mixed picture for independent chairs, including variations in quality and a propensity toward the appointment of former police officers, with this in turn reflecting the limitations of use instructions for the role, as well as the capability of CSPs. Yet, positively, it may be that norms around the appointment of independent chairs are becoming formalised: DACs like Victoria and Charlotte described the introduction of more formalised recruitment processes, with these sometimes coordinated regionally. Thus, some of the challenges identified are being addressed in some areas, though it remains possible that these may still reproduce assumptions about who is able to usefully fulfil the role of an independent chair.

However, while independent chairs occupy a decisive role in a DHR for good or ill, they must themselves make use of review panellists, who are both the link to local organisations but also, ideally, part of the dialogic democracy that is imagined to be at the heart of the DHR process.

Review Panellists. Unlike independent chairs, review panellists become involved because of their local connection.[94] Thus, review panellists are *enlisted*. I use enlisted because, unlike independent chairs – who are purposefully selected, even if

[94] Although this was not always the case, with representation sometimes coming from out of area e.g., to secure input from a led-by-and-for services or if the victim and/or perpetrator had moved.

there was variation in this process – the involvement of review panellists was less structured. Indeed, to some extent it was reported that involvement depended on who was available, including representatives being dragooned with little or no consideration as to their understanding of DHRs. There has been little research into review panel formation, although one study in London highlighted how many panels are bespoke (Montique, 2019). Reflecting this, independent chairs like Iris and DACs like Victoria described ways of identifying organisations at a DHR's start from whom review panellists would be drawn, usually through some form of scoping exercise (discussed further in the next sub-theme).

For those for whom DHRs were routine business, their role meant they already knew how to be useful, including having a sense of normative practices. For example, Chloe's role – like the other DACs interviewed – encompassed DHRs, as did Ella and Dylan's safeguarding roles in health and children's social care. Additionally, Owen and William were in police teams that supported statutory reviews. That such post holders exist is testament to how statutory organisations have, despite challenges in making DA 'everybody's business', begun to integrate DA responses (Devaney *et al.*, 2021).

Some review panellists were from specialist DA services. Thus, Cora became involved because 'I've just been asked to do it, as part of my job'. Reflecting on this, Mia explained:

> So, for me, I see that we have moved from an organisation that was really fighting to get noticed and get acknowledged, to an organisation that is a key partner in addressing [DA], which is absolutely fantastic but has been hard work.

By this, Mia meant that her organisation had come to be seen as a legitimate stakeholder in the CCR (although, as discussed in later chapters, this was not always the case). Beyond DHRs per se, Mia's account attests to the efforts made by the specialist DA sector to be seen as a useful (and equal) partner to statutory organisations, albeit it could

be argued that this has come at a cost to the sector (Hague, 2021). Family advocates also have a particular function that brought them into DHRs.

In contrast, for other review panellists, enlistment was not routine business but rather an unusual event. Thus, on becoming involved, they did not necessarily have experience and/or knowledge of DA/DHR, including practice norms, and so were less aware of how to be useful. In the interviews, few participants fitted into this category, perhaps due to the sample (this is also supported by the level of previous experience of DHRs, discussed below). As an example of someone who did fit this category, Liam was nominated by his line manager and did not have any previous experience with DHRs, albeit he was familiar with other statutory reviews. In my experience as an independent chair, it is not uncommon to find review panellists like Liam, particularly from organisations less involved in DA.

These findings highlight the different pathways to involvement for both independent chairs and review panellists, along with the potential for different levels of knowledge and experience and, thus, their ability to be useful. These differences mean the norms governing practice are not always known and/or understood. As such, an important question is how, having been identified as potentially useful stakeholders through appointment or enlistment, people are trained to do DHR.

Learning to do DHRs

Commonly, professional stakeholders had not *received instruction in how to be useful* in DHRs. Indeed, only 41.7% (n=43) of professional respondents in the web-based survey (Phase 2) had received training (meaning 58.3% (*n*= 60) had not). The absence of instruction in how to be useful is particularly relevant given reports about the potential for conflict to emerge in review as different organisational/disciplinary

perspectives come together, both in this study (*Chapter Seven*) and elsewhere (Albright *et al.*, 2013; Dale, Celaya and Mayer, 2017).

A further finding is that, where training was available, it is disparate. Of those professional respondents who had accessed training, all but one provided a free text response describing it. While some responses could not be categorised, most commonly the training accessed was DHR-specific and was delivered externally, online, and internally. However, the training varied and, where reported, the most named provider was AAFDA, with the Home Office[95] and Standing Together referenced too (see Appendix E). Summarising the challenge, one free-text response stated: 'Training is very limited in this field.' Echoing the data from the web-based survey, most of the interview participants also reported receiving limited training.

Given this limited training, *learning on the job* was important if professional stakeholders were to usefully contribute. For Cora – a review panellist who was also becoming an independent chair – this meant 'learning as I go'. For many, learning on the job meant doing several DHRs. Most professional respondents reported previous experience of DHR (75.7%, *n*=78), with only 24.3% (*n*=25) not having done so. Of those with prior experience who reported on the number of DHRs that they had been involved in, this varied considerably. The mean was 7.4, the mode was 3 (see Table 21).

[95] Notably, the Home Office's online training is not an active offer (2013a). Instead, its static content introduces DHRs and provides additional guidance for independent chairs. An earlier training programme supporting DHR roll out – which I attended in 2013 – was restricted to CSP nominees from statutory organisations and NGOs and is no longer available (Home Office, 2013b).

Table 21

Extent of Prior Involvement

		Previous DHRs
n	Valid	75
	Missing	28
Mean		7.4
Median		5
Mode		3

Despite this shared experience of learning on the job, independent chairs and review panellists had different experiences, with implications for their understanding of use instructions and, as a result, practice norms, to which I now turn.

Independent Chairs. For independent chairs, this training deficit was problematic because the use instructions for this role are scant. Moreover, as a further barrier to a consistent understanding of normative practices (and as noted previously), there is neither a competency framework nor a mandatory induction/training programme against which independent chairs can develop their experience, skills, and knowledge, or indeed against which they can be assessed. While some independent chairs had been able to access the earlier training offered by the Home Office, many had not. This was either because they were consultants (and so, ironically given the finding that most DHRs are chaired by consultants, they could not access it) or because they had started chairing after this training ended. In Henry's words, independent chair training had '[fallen] by the wayside'. In its place, Henry had completed the Home Office's online training, though this was described by Grace as 'a joke'. This is itself further evidence of how the Home Office has failed to ensure that the DHR system remained useable, as suggested already, and which I examine further in *Chapter Eight.* Speaking to the weakness of the training offer, Peter (a review panellist) suggested:

> You know what it's like. Something is launched and there's a flurry of activity and everybody's [on] trend and all the rest of it. Then it becomes business as usual.

Peter's interpretation is further evidence that the establishment of DHRs was, in part at least, symbolic and, once in place, concern with their operation fell away. In lieu of Home Office action, NGOs have filled the gap, with some independent chairs accessing specific training by AAFDA.

As an independent chair, Amelia identified the absence of training as a concern, suggesting there needed to be a way 'to reflect/share good practice/update… [independent chairs'] training'. Despite calls for improved training for independent chairs (Montique, 2019), the Home Office has been slow to respond to ensure a consistent understanding of normative practice. Independent chair training was not initially identified in the DA Bill consultation (HM Government, 2019, pp. 81–82). However, as noted in the *Introduction*, the U.K. Government has since committed to DHR reform, including plans to introduce compulsory training for independent chairs. The findings here support the potential value of such training.

Review Panellists. In contrast to independent chairs, there is no requirement concerning review panellists' experience, knowledge, and skills, beyond a broad call for 'relevant expertise' (Home Office, 2016b, p. 11). Thus, the use instructions against which a review panellist might be chosen, and indeed on which they may draw in relation to normative practices, are even more scant than for independent chairs.

In the web-based survey (Phase 2), a small number of review panellists had or planned to access training or events provided by AAFDA, or some other local training. However, the majority, regardless of their background or specific function, were in effect, as Peter (a review panellist) said, learning 'on the job'. Consequently, many review panellists were not prepared to be useful which, as I consider below, affected their first encounters with DHRs.

Noticeably, this included review panellists who were DACs, *despite* their responsibility for DHRs: only two of the six DACs interviewed had been able to access training before undertaking their first DHR. Notably, these two DACs said they felt the training had helped prepare them for being involved. As a result, Victoria, who had been a DAC when DHRs were implemented in 2011, described 'thinking on our feet' because the statutory guidance 'wasn't really a… step by step guide' (although, as noted in *Chapter Four*, other DACs like Chloe did turn to this in the first instance). Charlotte had a similar experience, saying that she and her colleagues 'just had to take a deep breath'. This may explain, at least in part, the differences described above in processes for the appointment of independent chairs and more broadly, and as discussed previously, local oversight of DHRs.

Critically, access to training was a concern. Sophia (a DA specialist), who had accessed training (albeit only after she had already sat on some DHRs), felt her experience was uncommon. She argued that training was a necessity, so:

> There's, you know, knowledge of panel members about what their role is and how they can challenge and how those power dynamics come in. I think there's real challenge … to get buy-in… or… commitment and ongoing commitment.

As I will explore in the next sub-theme, and in later chapters, by 'ongoing commitment', Sophia was referring to stakeholder willingness and/or ability to be useful which, framed in terms of normative practices, included sharing information or undertaking or being subject to scrutiny. Expanding Sophia's point, Peter (a review panellist) thought that there should be mandatory training. Otherwise, Peter asked, 'what qualifies… [review panellists] to sit around this table?'

There has been no research to date on the training available to those involved in DHRs, so little is known about the impact of the limited availability and/or variation in how those involved might gain an understanding of use instructions. Nonetheless, the

training gap in DHRs is problematic. First, speaking to Peter's question, while there is an emphasis in review on a diverse membership (Dawson, 2021), this is not solely about securing expertise from a particular professional background. As Albright *et al*. observe, being part of a review team is effectively a new task for which one must be equipped and supported if any contribution is to be meaningful (2013). Such contributions are not only technical, but they might also be about approach, e.g., ensuring cultural competence (Bent-Goodley, 2013).

Second, as in any role, training is likely to be beneficial. This echoes findings elsewhere, with Haines-Delmont, Bracewell and Chantler (2022, p. 7) noting, based on interviews with DHR participants, the importance given to 'appropriate training, [and] codes of practice'. More broadly, training is an important feature of the CCR (Hague, 2021). While the focus of this training is often around an improved understanding of DA, there can be other benefits too, including the development of a shared sense of mission (Hague and Bridge, 2008). Such a sense of shared mission is important in a DHR, not least because the ways in which stakeholders are prepared for their involvement – how they are prepared to be useful – will reflect their understanding of purpose. Neil explained this connection when, discussing training, he observed that there 'isn't a great deal, to my knowledge'. When I asked him what he thought the implications might be, he said:

> 'Well, it's simplistic. It means that the dominant culture of defensiveness and [seeking to] avoid blame comes true as the thing that influences [stakeholder] behaviour'

I explore these dynamics in terms of taking responsibility in the next sub-theme, and later chapters. As a further note, the only professionals who had consistent training were those who worked for family advocacy services.

Third, this lack of training was affecting. As review panellists, Dylan described being ‘thrown into the deep end’ and Liam reflected on feeling like a ‘novice’. Echoing this, Cora (a DA specialist) said, because she did not know what to expect, going to the DHR was ‘very, very scary’. This could affect participation and, importantly, how knowledge is generated. I explore this in *Chapter Seven*.

Fourth, and considering the preceding findings chapters, a reliance on ad hoc training is problematic given the instability of DHRs’ foundation and framework and the risk that differences in understanding(s) of purpose might pose. This finding is ironic given that training is one of the most common themes for recommendation in DHRs (Montique, 2019; Jones *et al.*, 2022; Potter, 2022).

Given the limited availability of training, a further finding is the range of solutions adopted by review panellists to try and fill these gaps. These included researching the process (e.g., by looking at published DHRs and reading the statutory guidance); shadowing (i.e., by learning from a peer); and informal support (e.g., from a line manager or other colleague, drawing on experience of other statutory reviews, or learning from other review panellists).

In summary, in engaging stakeholders, there is considerable variation in how professionals come to be involved in DHRs, reflecting the extent to which this is routine business (i.e., regular professional practice) or an unusual event (i.e., into which someone was drawn). Regardless, training is scant, meaning stakeholders must learn on the job. This is further evidence of the complexity and tensions with and within DHRs. In terms of engagement of stakeholders, the potential of a diverse membership is not commensurate to the means to ensure that those involved understand the use instructions related to their role and the normative practices employed, thereby introducing peril in delivery. Consequently, these findings support the development of

proposals to better engage stakeholders. Such a development would ensure that stakeholders are able to be useful during a DHR (which is explored in the next chapter), but also to ensure they are useful as conduits for information from their organisations.

6.3 Gathering Information

Every participant described DHRs as gathering information from organisations to build a picture of case circumstances (including any risks and needs), as well as the nature of, and limits to, organisational contact. Thus, Amelia (an independent chair) referred to 'gathering information', Bobby (a family advocate) talked about this as what stakeholders did, while Ella and Hazel (as review panellists) talked about doing this for their organisations. However, despite information gathering being fundamental to review (Websdale, Ferraro and Barger, 2019), this process is not straightforward. This means that while there may be use instructions for participants and organisations about when and how to share information, these are not always operationalised as shared normative practices. Moreover, these norms are sometimes not met. Importantly then, the gathering of information is contingent. Thus, by considering organisations' reports through the prism of use, it is possible to unpack what has been taken to be an otherwise straightforward process. As in the last sub-theme, I explore this for testimonial network participants in the third sub-theme.

In terms of norms, requests for information were usually informed by a scoping process which also enabled review panellist identification. Subsequently, substantive requests for organisations' information tended to be made after the first panel meeting, with organisations thereafter providing an Individual Management Review (IMR) or a

lighter touch report[96] and a chronology.[97] These organisational reports included a description and analysis of any contact with the victim (and any other subjects). In short, organisations are asked to 'look at whether or not they followed their policy [and] if there's anything else they could have done' (Mia, a DA specialist). Consequently, organisational reports are the 'workhorse of [DHRs]' because 'it's all rough and in there' (Owen, a review panellist).[98]

Furthermore, for best use, information had to come from across organisations. For Harper (a DAC), the information gathered then 'just slots in', enabling case building and illuminating contact both *in* and *across* organisations. That means 'you can show… who knew what when' (Margaret, an independent chair) and so, by 'getting everything together', you can analyse 'what [the victim's] life was like' (Owen, a review panellist). The manner of this use is explored in subsequent chapters.

In its use, and approached as a norm, in this way information gathering can be described *instrumentally*. Indeed, scholarly accounts of information gathering are usually instrumental, e.g., Chopra *et al*. analysed DHRs to identify risk factors in IPH and, referring to information gathering, described this simply as 'obtaining written reports from agencies' (2022, p. 2). Some participants also assumed this was the case too, particularly if they were not directly involved. Thus, Isabella (a family member) described a DHR as a 'comprehensive report' based on 'information from various different [organisations]'.

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[96] In IMRs, organisations 'look openly and critically at individual and organisational practice', identifying any changes or improvements required, or good practice (Home Office, 2016b, p. 20). As an independent chair I ask organisations with limited contact to provide shorter reports.

[97] A chronology 'charts the involvement of the [organisation] with the victim, the perpetrator and their families' (Home Office, 2016b, p. 31). Once submitted, individual chronologies are combined.

[98] Organisational reports are confidential and are not shared outside of a DHR, although there are exceptions, e.g., if a coroner requests them. It is only the final product – the DHR report – that is usually published.

Yet, another approach is to consider why this information is useful, which is because it can be *revelatory*. Thus, Marie described the gathering of information as identifying 'the pieces of the puzzle'. Meanwhile, Owen (a review panellist) felt 'the facts almost always come out' and he thought that DHRs and other statutory reviews 'work well in terms of identifying what's happened'. Marie and Owen's accounts allude to the contingency in information gathering and most participants, particularly those directly involved, recognised that this process was, in fact, complex. First, gathering information is *negotiated*, and is not always a successful process. Second, information is not simply waiting to be found and, like a DHR report, organisational reports are a documentary product that must be *prepared*. Third, in being prepared, an organisation's report can be shaped by different drivers and so contested and thus more or less useful in building a picture of a case (contestation could also occur during inter-agency dialogue, see *Chapter Seven*). These are important findings, demonstrating how, as a technology, DHRs are dependent on the conditions of their use, including the extent to which normative practices are in place, met, or challenged.

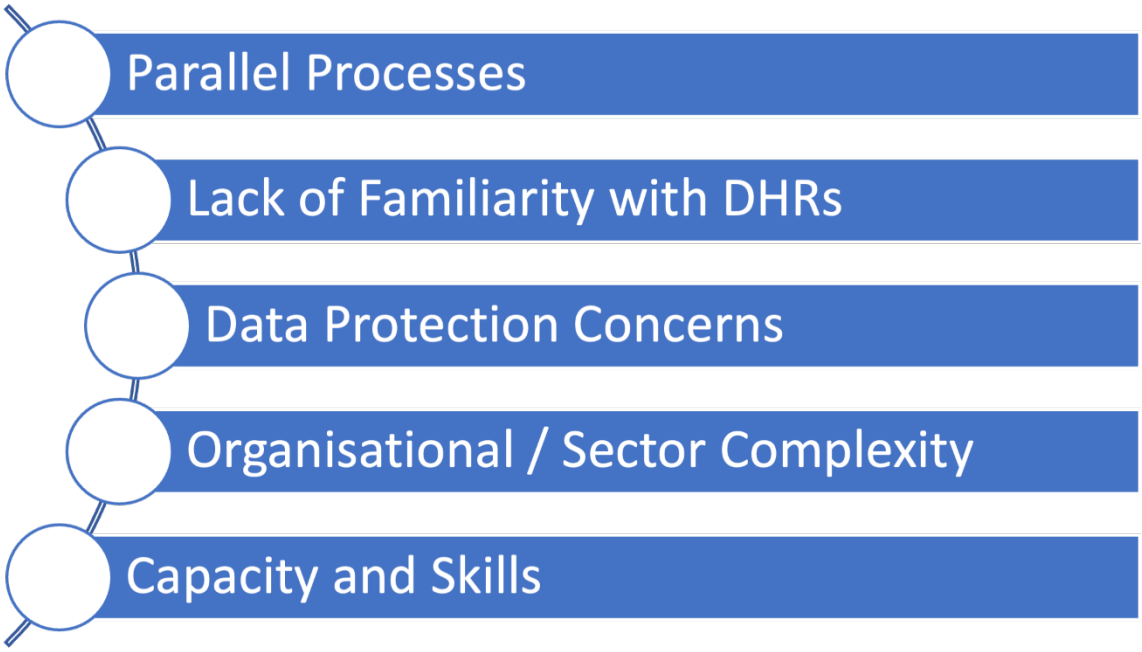
Negotiating Information Gathering

As a negotiated process, *information gathering is iterative, not linear*. First, it can take time to secure organisational reports. According to Joshua, 'depending on the complexity, it can take an organization weeks and weeks and weeks to produce an [IMR]'. As a result, timeframes had to be negotiated. As an independent chair, Hudson described how 'we'll agree who's going to provide IMRs and then I'll send all those out and then sit [and] wait six weeks… until they all come back'. Second, as indicated by Hudson, an agreed timeframe did not necessarily mean a report would be received, with this normative practice being tempered by practical challenges. Consequently,

participants described potential complexity in gathering information, meaning barriers had to be navigated to ensure that information was available for use (see Figure 9).

Figure 9

Barriers to Information Gathering



Parallel processes – including the CJ and coronial processes[99] and/or other statutory reviews – could affect what was available for use and when. The interface between DHRs and other parallel processes is identified in the statutory guidance, which suggests considering how these might 'dovetail' (Home Office, 2016b, p. 13). The CJ process was the most significant. As discussed in *Chapter Four*, it could delay a DHR's start, meaning organisational reports could not be requested and/or testimonial networks could not be approached. William (a review panellist) explained: 'nobody wants to go near a DHR until after the court case is finished'. While coronial processes

[99] This is an issue because DHRs commence so soon after a death. In contrast, other DVFR systems usually commence when these other processes have concluded (Dawson, 2017b).

and statutory reviews could also have an effect, they did not usually delay a DHR's start, albeit they might affect its progression if requirements conflicted.

There has been relatively little examination of how different statutory reviews interact (Tomczak and Cook, 2022), although Robinson, Rees and Dehaghani have identified overlaps (2019). These findings suggest, however, that there would be value in better understanding the intersections between these parallel processes, including insofar as they affect information gathering.

A *lack of familiarity with DHRs* affected information gathering because, while many organisations were confident in dealing with information requests, for some organisations (as for stakeholders) DHRs were unusual events. As a result, these organisations were unfamiliar with expected norms. Examples included general practitioners (GPs), as well as private sector organisations like private landlords, employers, and private schools.

Perhaps linked to this were *data protection concerns*, which Emily (an independent chair) referred to as the 'old nut of data protection', reporting how organisations sometimes sought legal advice before sharing information. A particular concern, returning to the discussion at the start of this chapter, was in DARDRs where the (alleged) perpetrator is 'somebody who's suspected of [DA] that led to somebody's suicide and they're not convicted' (William, a review panellist), which might mean organisations were reluctant to share information. Other examples included mental health trusts, who Alyssa (a DA specialist) described as 'notorious in providing as little information as they can' because they were often concerned about breaching an (alleged) perpetrator's confidentiality.

Organisational/sector complexity could also present challenges. Victoria (a DAC) identified how contract changes for commissioned services could make it

difficult to access information involving different DA service providers. Accessibility could also be relevant to statutory services because, for example and as also reported by Victoria, a change in police information technology had made it difficult to secure records. More broadly, multiple participants felt that gathering information could be particularly difficult across health providers. This could even be difficult within a health provider: as a review panellist, Hazel faced challenges in collating information from across community and secondary services in her trust.

Capacity and skill could also affect information gathering. Joshua (an independent chair) noted how 'timeliness' could vary for different organisations, reflecting capacity. Chloe (a DAC) also suggested quality was dependent on 'the individual that is tasked with providing that information'. Some larger, statutory organisations had 'professional IMR writer[s]' (Liam, a review panellist), making it easier to support a DHR. Conversely, other review panellists, like Liam, were allocated IMRs alongside their other roles. As a result, William (a review panellist) suggested that some stakeholders might have the production of an IMR 'dropped on them' and so it becomes 'just something else to have to fit in'. This could be particularly difficult for smaller NGOs.

These different barriers to information gathering show the possible contingency of organisational reports that are provided for use in DHRs given that, if these barriers are not overcome, organisational reports may be incomplete or limited in some way. However, these barriers are not because norms are contested per se; rather, they are *a consequence of practical challenges* in their fulfilment. This finding is also evidenced by the practical steps that independent chairs described going through – the norms they tried to convey and enable – to address these barriers.

As already noted, timeframes for the return of information were negotiated. Additionally, there was an emphasis on the importance of establishing expectations, e.g., by using templates (Margaret) and/or reminding people of the statutory guidance (Hudson). Some independent chairs also provided briefings to ensure those tasked with completing organisational reports understood the request (Cora). Sometimes, targeted support was provided. Grace described how, 'if there is somebody who's never done… [one] before, particularly if they're from a small organization, we will go out of our way to support them'. This could have positive results. Hudson described how his communication with one school enabled them to 'loosen up a bit' so they felt comfortable with the DHR process and then provided the requested information.

While these attempts to secure information were normally successful, they could nonetheless be onerous and independent chairs bore the brunt of this work. Thus, Margaret referred to the collection of organisational information as the 'bane of my life because… [it] takes ages' and noted that there were always some organisations that 'don't meet the deadline and you're forever chasing them'. However, DACs often provide support, too. Chloe described this support as part of her role:

> I suppose getting [organisations] or departments to ... [organisations] or practitioners who aren't experienced with it, and don't necessarily understand it, who've not been involved in one before, getting them to kind of understand: "You do have to provide this information, and this is why".

The potential roles for the independent chair and the DAC are further examples of the importance of leadership, including to ensure stakeholders understood use instructions, and the work that might be required to enable participation. Although, despite the positive examples here, and as set out in the previous chapter, the quality of leadership could vary.

Importantly, as will be explored in the next chapter, successfully resolving barriers to information sharing also related to review panel functioning generally. Thus, specific review panellists might be mobilised to help. As an independent chair, Hudson noted that, when unable to secure information from a GP, he might ask the local CCG to broker a solution. However, such responses were not always consistent: like Hudson, Margaret, also an independent chair, identified a concern with GP information – indeed, she felt reports from GPs were often 'very poor' – but suggested GPs did not get sufficient support from CCGs (as well as NHS England) and 'the whole set up is wrong'.[100] Regardless, resolving such barriers was important because they contributed to assurance around, and enforcement of, normative practices. Reflecting on her role as an independent chair, Grace noted: 'I think if the panel see that the chair picks that up and deals with it, then that builds the confidence of the panel.'

In summary, gathering information is not straightforward and there can be different barriers which affect the production of organisational reports. Despite these possible barriers, mostly participants reported that information was usually secured. Nonetheless, Bobby (a family advocate) felt there was sometimes a degree of 'gatekeeping', by which she contrasted those organisations that are 'really proactive' in sharing information to 'others that aren't'. In Bobby's account, this gatekeeping could be because organisations were attempting to manage their response, something I explore in the next chapter, including in terms of defensiveness. This gatekeeping went beyond the barriers already described and is the result of a contestation of use instructions i.e., *a challenge to normative practice*. In other words, some organisations either did not see a use for DHRs or did not make themselves useful in them, because 'they don't want to produce an IMR, or they don't want to be involved' (Peter, a review panellist). In part,

[100] It is beyond scope to explore this issue, which relates to NHS structures. For a summary, see Checkland *et al.* (2016).

and as noted in *Chapter Four*, this could be the result of what Hudson (an independent chair) highlighted as the lesser status of DHRs. The result was that Hudson felt some organisations 'don't buy into that [process]' meaning 'then the information doesn't come as quickly and as fully as I'd like it to'. While Hudson identified how he would work to manage this, requests for information were not always resolved. Thus, he and others identified how some organisations would simply not contribute. This leads us from the process of gathering information to consider how organisational reports, as documentary products, are produced for use.

Preparing Organisations' Information

As a documentary product, an organisation's report could be shaped by the barriers already mentioned but also how organisations shared it. In the following discussion, I provide evidence for, as introduced previously, the 'interpretative layers' in a DHR (Rowlands and Bracewell, 2022). My focus here in terms of these layers is with respect to the information shared by organisations. Thus, what might be known about a victim's experiences and/or encounters with an organisation and its staff are mediated by a series of interpretative layers. In particular, the findings here relate to *experience* (of victims and others, including their interaction with professionals/ organisations and if and how this was disclosed and recorded) and *analysis* (how individual organisations retrieve, analyse, and report this information). Across these interpretative layers, practice norms are sometimes contested.

First, *how organisations prepare their reports varies*. As an example of a norm, participants accepted that an organisational report would be based on case records about victim (and other subjects') contact. Most organisations could readily access case information, subject to the potential barriers above. However, some participants noted that 'the written record doesn't often tell you very much' because it was written at a

particular time for a particular purpose rather than ‘to provide me with a complete picture several years later’ (Amelia, an independent chair). As a result, other information – like interviews with professionals – could be useful, although demonstrating flux in practices, this was not consistent. Regardless, in most cases, the IMR author was usually reviewing case circumstances that they had not been directly involved with. This also highlights an important aspect of DHRs, which is that there is an element of trust built into the process. As Emma pointed out, the question was often whether an organisation, in providing information, had done so ‘in a believable way’.

Second, and illustrating the importance of trust, to fulfil the normative practice to ‘look openly and critically at individual and organisational practice’ (Home Office, 2016b, p. 20) there must be a process by which *organisations interpret their contact with the victim and/or other subjects of the DHR*. Yet, such interpretation is not value-free and, reflecting the earlier point about the variability of organisational reports, participants reported this could be of better or worse quality. A ‘good’ organisational report was understood as being reflective. As an example, in describing how she produced an IMR for the health provider she represented as a review panellist, Hazel said:

> Because you are looking at the records, you're already looking for those things like, what was good practice? What perhaps wasn't good practice? Did there look like glaringly obvious things that have been missed straight off, that you're just reading the records and you think, "oh, why didn't they ask about..." you know, [DA] at that point? Or was something else getting on, which is why they didn't?

Olivia (also a review panellist) agreed, describing a good organisational report as ‘honest about where the organisation’s failings have been’ but also ‘realistic about those failings and whether there’s something that can be done’. These reflections also foretell accounts of what – building on these organisational reports and testimonial network contributions – is understood to be a ‘good’ DHR report (see *Chapter Eight*).

However, participants identified how this sometimes ‘goes two ways’, contrasting open participation with organisations (and the professionals who represented them) challenging normative practice. This included organisations being ‘quite defensive… and… try[ing] to underplay things that maybe other [organisations] are, kind of, accentuating’ (Hudson, an independent chair). How this defensiveness might play out in a DHR, including between stakeholders and in terms of knowledge generation, is explored in the next chapter. Here, my focus is the effect on the organisational reports that went onto be used in a DHR. Organisations could try to either *explain away* any issues identified from their contact with a victim and/or *influence* the subsequent discussion within the DHR process by curating the information they shared. Participants identified several ways that this led to contestation (see Figure 10).

Figure 10

Issues with Agency Information

In some situations, an organisation avoided considering systematic issues. Peter highlighted this when he said:

> I mean, when there's some glaringly bad practice, and somebody has failed to do something, or has done something very bad, it's almost easier to understand that cos' you're always going to get a rotten apple, or somebody is gonna have a bad day.

Another form of this was to provide largely descriptive accounts (Joshua, an independent chair), with these perhaps focused on procedural compliance by asking 'did everyone in my [organisation] do their job properly' (Amelia, an independent chair). Both approaches averted a broader engagement which meant organisations did not have to ask, e.g., with respect to procedure, 'was it enough, was it too much, should it have been more?' (Emily, an independent chair).

Sometimes, organisations might in some way dismiss or downplay what had happened. In some examples, organisations denied that there had been a problem at all. Thus, Cora (a DA specialist) shared an example of an IMR produced by a GP after a woman died by suicide. The GP, who came from the same faith community as the deceased, reportedly claimed: 'I've never seen it happen in the whole time I've been a GP. So, I didn't think she would do that because they don't'. Alternatively, organisations accepted a problem but denied its ongoing salience. In these cases, participants noted how, during a DHR, organisations could provide new or changed information. This could change recommendations (discussed in *Chapter Eight*), but the key point here in terms of interpretation is that organisations were saying 'oh, well, that's already taking place. So, we don't need to do that now' (Margaret, an independent chair).

Finally, organisations might seek to reduce an issue's potency. Thus, as review panellists, both William and Owen highlighted the risk of hindsight bias[101] but

[101] That is, our knowledge of the outcome means decisions or actions made at the time are judged retrospectively because of an 'unperceived creeping determinism' (Fischhoff, 1975, p. 298).

recognised that a benefit of a DHR was that it was an opportunity to look back at what had happened. However, in doing that, as William noted: ‘it's easy to say, “bloody hell, they've been there 20 times. Why didn't, you know, why didn't they have an injunction or why wasn't she in a refuge? Or why wasn't this happening...?”’ Some organisations could focus on this risk of hindsight bias to undercut discussion of what might have been different.

These challenges do not arise in a vacuum and, in different ways, are the result of tensions around normative practices that lead to contestation around information as it is brought into use during a DHR. Importantly, this could reflect the professional habitus of different organisations. As an example, Amelia (an independent chair) expressed her frustration with ‘the decision-making system’ within mental health services, which she felt she struggled to understand and explain. Conversely, Hazel was conscious, in preparing information, that her organisation (a health provider) might be unfairly blamed ‘for not picking something up’ during contact with one victim, something that she felt was because of a potential misunderstanding of what was possible. In other words, norms about how information should be and is used can be different depending on one’s professional background.

Furthermore, these challenges could be driven by what organisations expected from, or were concerned about, in a DHR. So, Emma (an independent chair) felt that ‘voluntary [organisations] are very good at writing IMRs that suggest that all the changes have to happen in the statutory [organisations]’. Placing the blame on other organisations is, of course, not consistent with a norm of accountability. Hudson (also an independent chair) recognised this too, and both he and Emma put this down to the impact of commissioning with, e.g., DA services feeling vulnerable and therefore being defensive. Thus, in essence, these organisations might be concerned with *externally*

focused management, with this being an illustration of how power dynamics could challenge practice norms because of the effect on what organisations felt able to report. This is supported by the literature which has identified how commissioning arrangements can shape and constrain specialist DA services (Vacchelli, Kathrecha and Gyte, 2015).

Conversely, others felt that statutory organisations might engage in more *internally focused management*. Emma (an independent chair) gave an example of a local authority department which withdrew its initial IMR (she described this as having been 'fairly slap-dash') and submitted a new one ('they re-wrote the IMR to say, "that never happened, that was a misunderstanding"'). Emma had also experienced similar behaviour from a health provider, which initially provided information that suggested there was 'room for improvement' before later giving 'a different, better [for them] answer'.

Because of the preceding two issues, organisations' reports are not necessarily fixed. Thus, *sometimes organisations are asked to look again*. Here, Emily, Iris and Hudson described how, as independent chairs, they would review organisational reports when they were returned. This sometimes led to a request to look again. Sometimes this request was because, as Grace (an independent chair) noted, reports 'vary in quality very much'. This variability itself is evidence that normative practices in this respect are not universally accepted. This was echoed by other chairs, like Emily, but also review panellists including Chloe and Peter.

Regardless of quality, requests to look again might still be made. This could be because, on looking at other returns, it might become apparent that one organisation had 'made a referral but there is no comparison over here' (Amelia, an independent chair). Sometimes, this also brought new organisations into a DHR because 'we have found out

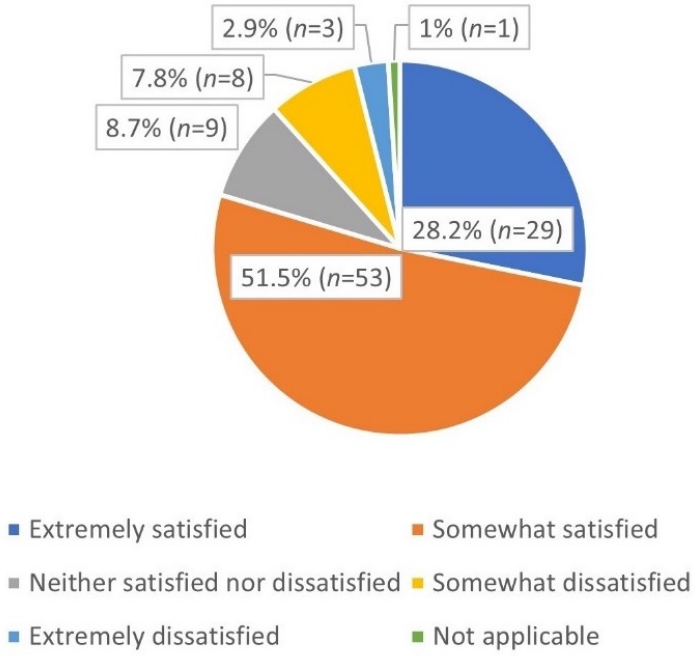
halfway through the review there's all these organisations we didn't know had contact' (Iris, an independent chair), meaning information might be requested and/or additional review panellists enlisted.

This finding is evidence of the contingency of the information that is used as part of DHR process. It is also relevant to those using DHR reports as a source of data, as the extent of this variability may not be apparent. Thus, Jade (a DA specialist) noted that, sometimes, DHR reports referred to agency report(s) being rewritten 'but often they just don't really mention it'.

Despite these challenges, participants were largely confident that, as a baseline norm, DHRs could gather the information needed, even if barriers had to be overcome and the information itself may be contested. Owen (a review panellist) observed: 'I tend to find people would be fairly open about their contact and what's happened'. This sense was reflected in the web-based survey (Phase 2) data where respondents were asked about their satisfaction with the information available in DHRs (that is, whether they felt DHRs had all the information needed to build a picture of what happened). As shown in Figure 11, most professional participants were either extremely or somewhat satisfied with the information available (79.7%, $n = 82$). While this is positive, suggesting that some of the issues identified here could be potentially be resolved, it is nonetheless notable that one in five participants were not satisfied, suggesting this was not always the case.

Figure 11

Professional Respondents – Information Gathering Satisfaction



However, organisational reports are based on information collected for a particular purpose and thus, as administrative data (Cullen *et al.*, 2021; Dawson and Carrigan, 2021), might therefore provide an incomplete picture. Specifically, organisational reports are *only a partial representation of a victim's experiences.* If this is not recognised, a normative reliance on organisational reports alone means knowledge generation is limited because it is not possible to see a victim's experiences (and so any potential learning) in the round. Thus, Harper (a DAC) described organisational reports as potentially 'one dimensional' because they could not fully account for a victim's lived experiences and thus could not, alone, see 'the whole picture'. This might simply reflect the limited information known by organisations about a victim. Suggesting this possibility, Liam (a review panellist) recalled one DHR where organisations had little contact and so 'we had a lot less about her life'.

Yet, if recognised, this possibility could itself be used as a norm to address partiality. Illustratively, Amelia gave the example of a victim where organisations had

worked on the assumption that she could not speak English. This assumption was because the victim was a migrant and had always been accompanied by her husband or a family member. However, it was later established during the process of information gathering that the victim could speak English. Thus, the insistence on accompanying her to meetings was recognised as coercive control. Additionally, while language barriers may be a significant issue for some minoritised women, this case is also an example of how abusive behaviour can be enabled by organisations' assumptions, in this case, that migrant woman would not speak English. Based on examples like this, participants identified the importance of looking beyond organisational information. In addition to being an example of concerns around statutory service responses to language, and the potential for DHRs to challenge but also sometimes reproduce stereotyped framing of minoritised victims (Chantler *et al.*, 2022), this also underlines the importance of centring victims, to which I know turn.

6.4 Orientation to the Victim

As a sub-theme, orientation to the victim captures practices to see through a victim's eyes (Home Office, 2016b, p. 7). These practices are important for two reasons. First, as discussed in the last sub-theme, orientation toward the victim is necessary because administrative data is not itself sufficient to build a picture of someone's lived experience. Thus, speaking to a normative practice that enabled a widened/thickened perspective, Owen (a review panellist) emphasised trying to find a 'window into… [the victim's] life'. Second, a tension in DHRs is that the dead are an absent subject. Owen articulated this too, observing: 'of course, you are past the opportunity of asking them about those times'. More colourfully, and in some contrast, Websdale's previously referenced imagined dialogue with a victim/survivor addresses this too, with his interlocutor declaring of DVFRs: 'This is romantic gobbledygook.

How can you see it through her eyes? She's dead!' (2005, p. 1189). These tensions speak to the previously discussed risk of objectification. Yet, participants argued it was possible to try and see through a victim's eyes through an orientation toward them, meaning a victim might continue to exercise an attenuated agency. These practices are useful because, as a norm, they are a way of operationalising what DHRs might be for as a way of telling a victim's story and, thus, the achievement of testimonial justice. In this way, participants talked about *hearing about*, *hearing from*, and *coming alongside* a victim.

Hearing About a Victim

One way to see someone's life through their eyes is by *using those who knew them as proxies*. To achieve this, the statutory guidance suggests considering:

> How should family members, friends and other support networks (for example, co-workers and employers, neighbours etc) and, where appropriate, the perpetrator contribute to the review… and who should be responsible for facilitating their involvement? (Home Office, 2016b, p. 14)

The statutory guidance goes on to explain that such contributions will enhance 'quality and accuracy', with this achieved by 'obtaining relevant information… which is not recorded in official records', as well as evidence relating to the 'emotional effect of the homicide' (Home Office, 2016b, p. 17). Thus, addressing both the limits of organisational information and the possibilities of a family's contribution, Louise (a DAC) observed 'I don't know if we can ever get a full picture of the victim, but … the only way you would is having those family involved'. This understanding of the importance of testimonial network contributions was shared by participants. However, reflecting findings by Sharp-Jeffs and Kelly (2016), in the interview sample the focus was largely on a victim's family.

In contrast, there were fewer references to other testimonial network members, like friends, colleagues, or neighbours, despite their potentially being useful as a source of information. In effect, this suggests a victim's family are privileged – perhaps because of the weight given to a kindship connection – despite the potential for these other testimonial networks to have access to additional, or perhaps conflicting, information, because 'we're different people to the people that we're connected to' (Lily, a family advocate).

There were fewer references still to the perpetrator's family – as Bobby (a family advocate) observed, 'it's not consistently that we do interview them, or even contact them' – or indeed the perpetrator. Yet, in relation to the perpetrator, there was a recognition that they *could be useful* because they might help illuminate 'what led up to [the death] and what could they have done differently' (Harper, a DAC). However, others were cautious, asking 'why are they suddenly going [to] tell us the truth? And how will we know if they were telling us the truth?' (Grace, an independent chair). This speaks to reasons why perpetrator information may *not be useful*, reflecting the evidence that perpetrator talk can minimise abuse and obscure responsibility (Kelly and Westmarland, 2015; Vall *et al.*, 2021). A further concern was that asking perpetrators to contribute was unjust given their actions (directly or indirectly) meant a victim could not: in one DHR several review panel members were resistant to perpetrator input because they felt 'well, where's [the victim's voice]? (Emily, an independent chair). Further complicating this question of usefulness was how a victim's family might perceive perpetrator involvement. Sometimes a victim's family might want perpetrator involvement, either to hear their account (Lily, a family advocate) or to put questions to them (Grace, an independent chair). Yet, Isabella, a family member, felt the perpetrator's involvement was inappropriate because it gave them too much influence.

Taken together, engaging perpetrators was a balancing act given 'that you get some learning from it, but [need to do so] without colluding in what they have done' (Iris, an independent chair). However, in practice this was often not an issue. As Emily (an independent chair) explained, while she had made attempts to engage with a perpetrator in one case, he had declined to be involved. This is consistent with my own experience as an independent chair, where a minority of DHRs have included perpetrators.

In the published DHRs (Phase 1), the levels of reported approach to, and engagement by, these other prospective testimonial network stakeholders was moderate to low, with data often not reported. These findings are important because they show how normative practices about testimonial network engagement are not consistent, and indeed might exclude some networks, meaning potentially different information is available to different DHRs, so affecting knowledge generation (see Appendix C).

Beyond DHRs, there is evidence that family can speak for and about the dead through activism following bereavement (Cook, 2022). A key finding is that, reflecting the last two-sub themes, normative practices in this respect include the *engagement of family* and a recognition of what family can offer in the *gathering of information*.

Engagement. For family, their involvement in a DHR was the result of a tragedy. Yet, the family members I spoke to became involved because they felt they might be useful to a DHR and/or a DHR might be useful to them, something Mullane has called the opportunity for families to 'contribute, receive and review information' (2017, p. 262). Yet, it is of note how ill-defined the use instructions for this involvement are. Reflecting the weaknesses in DHRs' framework as discussed previously, consider the statutory guidance. The statutory guidance includes an extensive list of considerations relating to testimonial networks (Home Office, 2016b, p. 18), with these focused on the family and practices like notification, communication, and opportunities

to contribute. Additionally, the statutory guidance is clear that a family should be assured that they have been heard, including through the opportunity to receive, comment on, and disagree with a draft copy of the DHR report (Home Office, 2016b, p. 19). However, the statutory guidance is largely descriptive. Similarly, the most recent guidance released around supporting families includes no substantive advice as to how to work with them, beyond re-stating the statutory guidance and describing a referral pathway to advocacy support (Home Office, 2021a).[102] In parallel, in terms of research, little has been reported on how testimonial network members become involved with DHRs, and the actual practices of engagement are unclear (Sharp-Jeffs and Kelly, 2016). The risk is that, in practice, such lack of clarity around practice norms and their operationalisation – how family could be used in a DHR alongside other stakeholders and, in turn, use DHR – is problematic. Although I did not collect this data specifically, from the published DHR reports (Phase 1) it was notable how diverse representations of family were, including both accounts of engagement and how involvement was recorded.

While family involvement is an area for further study, some findings shed light on family practice norms. Based on the interview data, families are most often notified via a Family Liaison Officer (FLO),[103] and sometimes by way of a letter or telephone contact from the CSP. Yet, here, practice norms were inconsistent, e.g., with FLOs not always understanding DHRs and/or CSPs not notifying family. If there were issues with notification, an independent chair had to pick this up, working to ensure families understood the DHR process (something I have experienced in practice). Thus, in terms

[102] In contrast, the most developed framework for family involvement has been proposed by AAFDA, with a 7-step model setting out key areas like raising the status of family, valuing their contribution, communication and regular updates, and delivery on commitments.
[103] A FLO supports a family through a police investigation.

of the use instructions, an independent chair had to re-set expectations around practice norms, either around the role of the family or perhaps the DHR.

Nonetheless, most of the published DHR reports (Phase 1) involved an attempt to identify family stakeholders. These attempts were often successful and, having been notified, some 61.7% (*n*=37) of families went on to be involved in some way (see Table 22). This level of involvement mirrors rates reported elsewhere, which have been reported as ranging from 56% and 77% (Montique, 2019; Potter, 2022). However, as Marie (a family advocate) noted, sometimes families chose not to engage. This could be because a family did not feel a DHR would be useful to them experientially, for example because 'they wanted to grieve in peace'. Sometimes however it could be because they did not feel a DHR would be useful as a process, e.g., in terms of its capacity to produce meaningful findings. Louise (a DAC) described one family who felt the police had failed their loved one; this negative appraisal carried through to the DHR process as 'their perception of professionals is a negative one'.

Table 22

Victim Family Involvement

Involvement	*n*	%
Approached – Declined	11	18.3
Approached – Involved	37	61.7
Approached – Involvement Missing	2	3.3
Approached – No response	7	11.7
Decided not to approach	1	1.7
Not able to approach – Other	2	3.3
Total	60	100.0

In addition to these reasons why family might choose not to take part, I also observed some evidence of specific challenges in the identification and involvement of family. In different ways, each related to norms that either prevented some family members from involvement or, alternatively, norms that were not fully established.

First, norms about what constituted ‘family’, including who should speak for a family, could have an adverse impact, potentially meaning some felt they were not able to be useful or make use of the DHR. Avery was frustrated that ‘no one had told us as a family’ and instead directed all contact through a single family member, who she said had found it difficult to manage and so ‘kept things to herself’. Meanwhile, Isabella reported feeling side-lined because, first in the police inquiry and then the DHR, another family member was identified as the primary contact. The issue of who is identified as ‘family’ and the potential for gatekeeping or conflict has been noted elsewhere (Rowlands and Cook, 2022), and this may be even more difficult in cases of AFH where the victim and perpetrator are kin (Sharp-Jeffs and Kelly, 2016). This also raises the question of if and how one might speak for others (in this case the dead) which, as Alcoff (1991) warns, is fraught with difficulties.

Second, a connected issue was whether and how to involve children and young people. In this respect, it has been reported that DHRs little engage with children and young people in their own right (Stanley, Chantler and Robbins, 2019). Although it is not possible to report substantively, several participants were concerned about the involvement of those under 18. Emma (an independent chair) felt there was a risk of *misuse*: ‘it just feels very exploitative just to go in and ask them about the worst thing that’s ever happened to them and take that away.’ This then is evidence for what has been reported elsewhere: that children are often not involved because of a concern about the potential adverse impact of DHRs (Haines-Delmont, Bracewell and Chantler, 2022), as well as more generally given an awareness of their post homicide experiences (Alisic *et al.*, 2015). The issue here, perhaps, is that norms around practice have yet to be established.

In effect, to think of this in terms of use instructions, some family members can be side-lined or indeed uninvited because use instructions are too narrow. Alternatively, for others – in this case, children – use instructions are not yet in place. While different, both are further evidence of the inconsistency of practice norms.

Having been identified, for family, *the parallel to training for stakeholders was access to support*. The provision of advocacy support has become a practice norm in DHRs (Home Office, 2016b) and, among participants, was understood as potentially important in enabling family participation. Universally, family members were positive about their experience of advocacy support (although as discussed above, this may be particular to the sample recruited in this study), which they described as useful because it provided a range of practical and emotional support, as well as assisting them to navigate the DHR process. For Ethan, advocacy gave him 'pointers', but importantly made support available as and when he wanted it because 'they didn't force us in it'. Isabella described her advocate as 'my lifeline. She was brilliant' and recounted how the advocate provided information and advice, and 'took the pressure off' when she wanted to challenge the DHR process.

Having access to advocacy support was understood as important because of the emotional impact of participation. Thus, Maria, a family advocate, highlighted the emotional impact on family participants, while as a family member Isabella also identified this, referring to '… all the emotions and effort and feelings that we've been through' during the DHR. Moreover, this could involve emotional labour because there might be a need to perform emotionally. In this way, Luna talked about the emotional impact she experienced and the effect of the DHR process, including – as an example of emotional labour – the times she felt she had to behave in a certain way to be heard.

This was also linked to power because of a concern that family may not always be treated equally to organisational/ professional stakeholders (Haines-Delmont, Bracewell and Chantler, 2022). As a response, access to advocacy support was seen as essential to guide and assist family members (Dawson, 2021). Bobby (a family advocate) made this connection directly:

> And that's quite difficult because you're trying to make sure that the family's voice is heard, that you're representing them, that you're not kind of colluding with any other kind of decisions that are happening.

In effect, Bobby's explanation was that advocacy support was intended to ensure that in DHRs families are heard while, in doing so, avoiding colluding with other stakeholders, and challenging them if necessary. Like the role of an independent chair if the initial introduction to a DHR had not been successful (discussed above), in terms of the use instructions, this relates to expectations around practice norms, either around the role of the family or perhaps the DHR itself. Here though, a family advocate has a role in *enforcing norms*. This is like the work of Independent Domestic Violence Advisors (IDVAs), who must build relationships with other professionals but also undertake institutional advocacy to address practice and system barriers (Coy and Kelly, 2011).

This finding is of note because there is, implicit within it, a recognition that DHRs can, directly or indirectly, *misuse* families and thus advocacy support provides a safety net. Luna expressed the significance of support from an advocate, saying: 'for me personally, she more than helped me carrying the weight of my grieving family, all of whom were in different places at different times'. Unsurprisingly, participants emphasised as a normative practice the importance of making sure families 'have had at least… the offer of special [advocacy] support from somewhere' (Caroline, a DA. While this is an important finding, it is of note that our understanding of the efficacy of advocacy support models is limited (Rowlands and Cook, 2022). While this study has

begun to explicate this question, what makes advocacy support useful is an area for further research.

If engaged in a DHR, participants identified several practice norms about the ways that family could be useful, including by being consulted about the ToR to help shape scope by identifying the questions they might want answered. Otherwise, family could share information about a loved one's life and experiences, often by way of an interview, which I address below.

The independent chair was usually the conduit for family engagement, with Charlotte (a DAC) reporting that 'it's the chair that actually makes contact with them, you know, to see what they would like and how they want to be involved'. In contrast, directly meeting the review panel was rare, with only one of the family members I interviewed doing this, and most professionals reporting that they had rarely or never experienced a family meeting the panel (see also Potter, 2022).

Identifying the primacy of this route for family engagement is important for two reasons. First, it highlights that – regardless of the intention in the statutory guidance (2016) and associated practice norms – a family's interaction with a DHR is highly mediated. This means, as Harper (a DAC) described it, there is a dependency on an independent chair's 'efforts… to get those involvements'. Then, if a family was engaged, as communication was largely via the independent chair, it was a case of 'pass the message' (Owen, a review panellist). Second, this emphasises again the leadership role of the independent chair. As a result, if an independent chair is not able to establish a relationship with the family, then the latter's primary route to the DHR can potentially be unusable. Notably, for the family members I interviewed, experiences varied. Thus, family members like Clare and Ethan experienced the independent chair as providing a valued connection to the DHR process. However, Luna and Isabella had experienced

these relationships as difficult. Notably, in all these accounts, an underlying issue was an expectation about normative practice, including the warmth of the relationship with the independent chair and, with that, how the family felt about the approach to their loved one.

In summary, in terms of family engagement, a family might be useful to a DHR and find it useful in turn. Such normative practice reflects the statutory guidance (2016). However, notably, the use instructions set out by the statutory guidance and enacted during a DHR are not consistently established nor are they always met. Thus, there may be a complexity and tension in engagement, with these exacerbated by a dependence on the independent chair despite, as discussed previously, variation in their quality.

Gathering information. Participants placed varying emphasis as to why family information was useful. First, it could potentially *be affective*, bringing an emotional resonance. This is something Harper pointed to, noting that 'all those emotions' helped remind a review panel that 'this is a real life'. Many participants felt this information was useful because it rounded out a victim as a person. Thus, Emily (an independent chair) reflected how a victim's mother had helped enable such a rounding out because 'she was able to talk about her as her daughter, not just a victim.' However, this was not solely during the DHR process, it might also materialise in the DHR report itself. Consequently, family involvement was also useful because it could help produce 'a really quite rich report. Because they are able to [share information, meaning] ... [the victim] was at the forefront' (Harper, a DAC). Notably, a family's affective contribution could take a specific form. This included a pen portrait, which Avery (a family member) described as 'a little bit about the person'. [104] Additionally, Bobby (a family advocate)

[104] Pen portraits are referenced in the statutory guidance but not defined (Home Office, 2016b, p. 7). I define a pen portrait as a description of someone as a person (e.g., their personality, their likes, and dislikes), their history (e.g., over their life course or more recently) as well as their needs or experiences.

described the use of family quotes as helping 'to re-centre it [the process] back [to the victim]'. [105]

However, a tendency to use family largely as a source of emotional content has been noted (Mullane, 2017). If this is the sole use instruction, family contributions may be instrumentalised, thereby robbing them of a direct influence. In contrast to this instrumentalization, participants identified a range of other normative practices around family that, while seeing family as useful in terms of gathering information, also acknowledged their influence.

Thus, and second, participants emphasised that family information could *add depth and breadth to organisational information*. This information was of use because, as Grace (an independent chair) described it, it could 'triangulate' organisational information. Bobby, drawing on her experience as a family advocate, explained:

> I guess the family will often know the severity of injuries and what happened on the night. And I think as professionals, we don't always get that same information. So, it's just helpful because you then understand how violent an assault it was or actually very clearly see this is due to mental ill health.

Thus, for example, Harper highlighted how, in the absence of family involvement, in one DHR all it was possible to say was '[the victim] went to the doctor's once a year'. Without family information, the finding would have been less useful because the DHR would have lacked testimony about a victim's lived experience. In this way, participants recognised the potential for testimonial networks to bring information that might illuminate a victim's life (Gregory, Williamson and Feder, 2017; Eriksson, Mazerolle and McPhedran, 2022).

Pen portraits may also have additional elements (e.g., reflections on the impact of someone's death or what their loved one's hope will change).

[105] In practice, I invite family to provide a pen portrait, which I include at the start of each DHR report. Within the report itself, I include a section on family information (and other testimonial networks), including direct quotes.

But family information can also challenge or supplement organisational accounts and ways of seeing, thus better attending to a victim's experiences. This possibility is important given, as Cook (2022, p. 3) has noted, sometimes family can face struggles to secure 'truth, justice and accountability'. As an independent chair, Emily explained:

> And I do think that is down to really looking at the stuff coming through and having met the family and spent a long time asking them about I daughter and about her life journey, why things went so wrong for her… and I got a sense of her. I got a sense of how difficult it had been for her family. And it just made it much easier, when you are carrying all of that picture in your head, to say to [organisations]: "are you telling me that was the best we could do?"

A challenge did not necessarily mean that family information was used uncritically. For example, Maria highlighted how this meant 'discussing the obstacles with the family' so that any issues could be resolved. In practice, that might mean a DHR report was changed to reflect family input or, perhaps, a dual perspective could be recorded in recognition that it was not possible to resolve an account.

Linked to this, and third, many participants recognised another way that information came from family, which was in the form of *the questions that they asked*. Importantly, these questions were useful. Thus, several independent chairs used these questions to drive the process. This included Emma (an independent chair) who, as I previously explained, used to ask review panellists 'so, what is your answer to the family about that one [a question from the family]'. This also links to the idea that a DHR could be useful to family, which I explore as an outcome in *Chapter Eight.*

Together, there was a recognition of a continuum of possible use of family, encompassing their being a source information that might add depth and breadth, challenge, or supplement, or bringing questions to be answered. Importantly, this also moved away from an instrumental use. Instead, it provided a use instruction that might

shape the doing of a DHR, reflecting the sense that family were integral as described previously, and possibly enabling family themselves to use the DHR process. Maria, a family advocate shared an example of what this might mean when she reflected on a specific case:

> This family knew they were equal partners… As equal partners they had the same rights as anyone else round the table. At every given point they were ... their opinions were respected even if there was a conversation about why it would not be appropriate within the DHR.

In summary, family are useful to DHRs because they can help other stakeholders hear about a victim and, potentially at least, in doing so also themselves be engaged in the process as a stakeholder. That is, in being useful, family are not misused. However, as with engagement, it is notable that there is the potential for considerable variance in normative practices and understanding of use instructions.

In addition to hearing about a victim, participants also identified how DHRs might also hear from a victim or seek to come alongside them. The following accounts are brief as they were less discussed in the interviews. Nonetheless, they demonstrate additional practice norms that might be employed to centre a victim. However, as with hearing about a victim, norms around these practices are variable.

Hearing From a Victim

Sometimes DHRs accessed an artefact from when the victim was alive: a diary, social media, or some other communication by or to the victim. Amelia talked about how, as an independent chair, she would search social media at the start of a DHR (as well as looking at media reports) or ask the police to share anything they had found during their enquiries (this could be social media but also e.g., text messages). Explaining why this was helpful, Amelia said: ‘because those were produced by the person whose life you are trying to understand’. Insofar as it made public that which

was private, Amelia described this potential encroachment in stark terms: ‘you are scrabbling around in their life… It's quite an intimate process, even though one of you is dead’. This is like the challenge of using data gleaned from online research, where ethical research practice is tested by tensions between consent, privacy and anonymity (Sugiura, Wiles and Pope, 2017).

At the same time, this information could be a window into a victim’s inner life. Thus, Margaret (an independent chair) talked about using a victim’s diary:

> MARGARET: You can back up why you say the things you say. But it is... I do wrestle with that one as to how you can do it successfully. I'm not sure it's possible to... the best one I had was some years ago where I actually had the diaries of the victim.
> RESEARCHER: Yes?
> MARGARET: And that was amazing. I mean, it was just... I could... I just felt like I could hear her talking to me. She had written things in about her relationship with her husband...

Grace (also an independent chair) gave an example of other kinds of communication, including notes and emails written by the victim. In one case, this enabled the review panel to identify abusive behaviours: the victim referred to disablist name-calling (i.e., emotional/ psychological abuse), and then promising to pay the perpetrator money for him to stop (i.e., economic abuse).

Moreover, hearing from a victim could enable an interpretative act by review panellists. As Louise (a review panellist) described with reference to reading diaries, it could humanise a victim, because: ‘you know, we got to know who she was, because of her diaries’. Louise also felt that this created an opportunity in a DHR because ‘it then made people realise that there's a human that we are discussing, rather than it just being this case… [they] made people stop, take a breath’. Yet, such artefacts are not always available. This leads to the final aspect of this sub-theme, coming alongside a victim.

Coming Alongside a Victim

While hearing from the victim can be useful, where these other orientations to a victim were discussed, participants also emphasised coming alongside a victim, usually by using a photo. Many described why they felt photos of the victim were useful. For Amelia (an independent chair), this was for two reasons. First, otherwise, all review panellists might encounter was a 'paper file' (unless the family attended a meeting). Second, photos could be used purposively to challenge negative discourses that might otherwise affect the interpretation of events:

> So, I want them to, kind of, constantly remember that this is a person we are talking about. It also helps to dial down levels of victim blaming which often ramp up in direct proportion to how defensive [organisations] are feeling.

This understanding of the usefulness of photos was recognised by other participants. As review panellists, Owen felt that – like the use of a diary or social media – pictures helped make the process 'more personal', which Louise (a review panellist) described as meaning the DHR was about a 'real human person' and 'not a name on a piece of paper, or not a crime scene photo'. In other words, the use of photos is a way of introducing or sustaining victim subjectivity into the DHR process, as well as preventing objectivization and countering a discourse of victim blame.

Yet, photos could be impactful. Review panellists reported their encounter with the subject of the DHR triggered various emotional responses. Among other adjectives, participants described DHRs as being 'sad', 'disturbing', 'horrible', and 'upsetting'. Indeed, Chloe and Victoria (DACs) talked about how review panellists could find photos difficult, while Peter (a review panellist) argued strongly for photos to be used but also recognised there was a need for participant self-care to avoid burnout.

However, despite the potential use of photos, this practice is not an accepted norm. Thus, as with hearing from a victim, coming alongside a victim was not

consistently a practice norm. As these practices are not always present in DHRs, this variation could potentially lead to different DHRs being done in different ways. For example, some participants reported that photos were rarely or never used. Importantly, this primarily reflected decisions by an independent chair. Thus, Charlotte (a DAC) said that ‘we have the photos, quite often, depending on the chair's preference’. In effect, as with hearing about the victim, there is considerable variance in normative practices and understanding of use instructions. Across all these different ways of achieving an orientation to the victim, this means there is both complexity and tension with respect to the gathering of information from family. Critically, this variance can affect what information is gathered and/or how review panellists approach its interpretation, thus potentially affecting DHR findings.

6.5 Conclusion

This chapter has explored the practices of review. It has evidenced how, as a technology, the practices used in DHRs are complex, including how DHRs engage participants, gather information, and seek to orientate to the victim. These findings are significant because despite some normative claims, including those set out in the statutory guidance, these practices can be variable, not always consistently understood, and are sometimes not implemented (often because of decisions by the independent chair). Moreover, these practices can be the cause of tension, including if norms are contested or not accepted. Together, this is further evidence of the complexity and tension, and so contingency, in the doing of DHRs. This, in turn, can affect knowledge generation as DHRs engage stakeholders, gather information, or seek an orientation to the victim in different ways.

However, the implications for DHRs have, to date, been largely unacknowledged. Importantly, this also means that, as a technology, DHRs have a

perilous potentiality which is not only related to their establishment and understanding of purpose. Indeed, combined with previous findings chapters, evidently the doing of DHRs is affected in numerous ways. In effect, while DHRs might achieve their stated purpose, equally, they might not. Further, as DHRs are ultimately delivered by those involved, it follows that there are implications for how DHRs are experienced as a mechanism to make sense of DA-related deaths. It is to these implications I now turn, with the next chapter expanding on practices within DHRs while looking specifically at the relationships between stakeholders.

Chapter 7: DHRs as a Relational System

7.1 Introduction

If you've got a dead body... that makes people nervous (Amelia, independent chair).

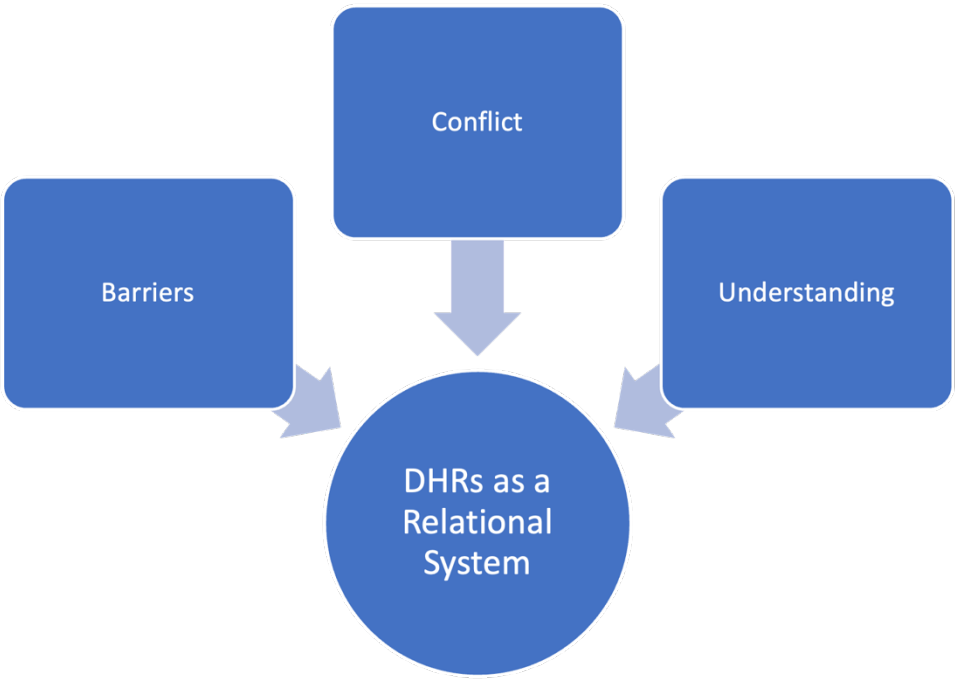
Amelia reminds us that DHRs have high stakes because, as noted previously, a victim's death may be a site of multiple 'affective investments' (Krishnan, 2019, p. 1516). These affective investments may reflect, as discussed, the conditions of DHRs' establishment, different understandings of purpose, and/or the practices involved. Amelia also speaks to the potential and peril in the use of a technology like DHRs, as well as the attenuated agency of the dead who can inspire action but at the same time pose a threat. This chapter attends to the relationships between stakeholders directly, which thus far have been discussed but not foregrounded, by exploring the theme of 'DHRs as a relational system'. My exploration is tied to three subthemes (a) barriers, (b) conflict, and (c) understanding. See figure 12.

Addressing relationality continues my interest in use because Ahmed highlights that 'use is an intimate as well as a social sphere' (2019, p. 7). By this, Ahmed means that use can be personally affecting, but also that things are often used within a wider system. Thus, users come into contact with each other, including around considerations of what constitutes 'right use' (2019, p. 29), i.e., there may be expectations about the ways in which something should be used. Ideas about 'right use' can be exclusionary. That is, there may be expectations about how something should be used, which can also reinforce power by including those who use something in the 'right way' (or have a right of use), while excluding those who do not. Here, however, I use 'right use' to trace whether the aspirations for DHRs as a site for dialogical democracy are achieved, specifically in respect to how stakeholders (including organisations and their representatives) relate to one another. Thus, using Ahmed's formulation and drawing on

the findings from the preceding chapters, a DHR is a social sphere comprised of stakeholders who are brought together in a collaborative endeavour to generate knowledge about domestic homicide. Here, ideas of 'right use' encompass how stakeholders might be *put to use* as conduits for information and/or expertise and perspectives, and also be *useful* by contributing to scrutiny and the generation of learning. To capture this sense of the use and usefulness, hereafter I use the term 'collaborative use'. I consider to what extent DHRs enable 'right use' with respect to this conception of collaborative use.

Figure 12

DHRs as a Relational System



To date, the nature of collaborative use has been largely underexplored. As noted in *Chapter Two,* one author who has sought to address collaboration is Websdale (2012). Websdale conceptualises review as a mechanism for the enactment of the dialogic democracy and, with it, the generation of knowledge about the complex issue

of domestic homicide. In turn, the idea of dialogic democracy is found in participant accounts of what DHR is for, as discussed previously. While being optimistic about the potential for review as a site for dialogic democracy, Websdale identifies how power imbalances and conflicts can affect trust between stakeholders. Consequently, Websdale suggests space for the enactment of dialogic democracy must be created.

Drawing on Websdale's account, I understand collaborative use as the way in which space is opened for the enactment of dialogic democracy. Consequently, if collaborative use is only partially or not at all achieved, this can affect the enactment of dialogic democracy and so knowledge generation. Illustrating these alternatives, Neil (a family advocate) used similar language to Websdale and described DHRs as 'an example to society about democracy, about learning, about honesty, about keeping people safe'. Yet, like Websdale, Neil also recognised the personal and organisational issues that could adversely impact collaborative use when people 'go into the room'. Taken together, this is the complexity and tension that Haines-Delmont, Bracewell and Chantler (2022) and Boughton (2022) have reported around collaboration in DHRs. My argument in this chapter is that the root of some this complexity and tension is often a dispute about 'right use' between stakeholders which then affects the enactment of dialogic democracy. Specifically, these challenges relate to the role of stakeholders and how any information gathered should be used and, ultimately, the knowledge generated, including any recommendations, i.e., a DHR's findings.

I have encountered challenges in enacting dialogic democracy as an independent chair. As noted previously, as an independent chair I have access to clinical

supervision.[106,107] My experience of clinical supervision has been profound, and it is something I and others have reflected on elsewhere (Cullen *et al.*, 2021).

Looking back at my practice journal, my focus was often about my relationship with others. Consider the following extracts. In one DHR, after a review panel meeting, I wrote: 'The panel was lively, engaging and (for the most part) participants were in full flow. It felt like a dialogue'. In contrast, in a different DHR I reflected: '[The meeting] was hard work. There was the same one individual who was strident and (to some extent) resisting, deflecting. And the local 'lead' who sat impervious and spouted platitudes. I feel frustrated'. While both accounts are subjective, evidently my relationships with review panellists affected *me* in different ways. Moreover, no doubt other review panellists were affected too: either, like me, as they interacted with other participants or perhaps *by* my response. The connecting thread between these two examples is that they are about my relationships with stakeholders (with these sometimes constructive, complicated, or difficult), my experience of collaborative use, and the enactment of dialogic democracy.

This brief practice account illustrates the value in thinking about 'right use' in DHRs as a relational system, explored here through the sub-themes of barriers, conflict, and understanding. I understand relationality as being about interactions between stakeholders (principally as individuals, but also from an organisational perspective). In a sense, these interactions around 'right use' are performative, given they encompass the who of whom is involved, interactions, as well as both public and private face

[106] Clinical supervision refers to professional development which 'supports, directs and guides' (Milne, 2007, p. 440), through normative (e.g., case management), restorative (e.g., personal support) and formative (e.g., reflection and learning) functions.

[107] In the interviews, only a few independent chairs had access to clinical supervision. Like me, these independent chairs had a professional background in the DA sector. In contrast, independent chairs from other backgrounds did not access clinical supervision. This may be because independent chairs are usually self-employed consultants. Thus, access to clinical supervision would have to be something they sought out and, potentially, paid for. There is no requirement for clinical supervision.

(Goffman, 1959). However, I draw a distinction between *encounter* and *engagement*. I understand 'encounter' to capture the consequences of *coming into contact with the DHR process*. In this way, the expression of an encounter is a *reaction to the prospect of and entry into use* because of being identified and invited into a DHR. In contrast, I think of engagement as being about the consequence of being *within the DHR process, and then what happens, including if and how one is used and might be useful*. Thus, engagement is an expression of *action taken in use*. As I will demonstrate, both encounters and engagement influence the knowledge generated within a DHR.

This chapter's contribution is that it deepens the recognition that the collaborative nature of review is both 'its greatest asset while simultaneously serving as the source of many potential ethical conundrums' (Dale, Celaya and Mayer, 2017, p. 231). This chapter responds to the third specific research question: how does decision-making and meaning-making manifest in DHRs? This chapter also begins to respond to the fourth specific research question: how is individual, institutional, or social change understood?

I begin with the sub-themes of barriers and conflict. My ordering choice is based on my experience as an independent chair but also that of participants like Neil as quoted above because, while we might hope DHRs to be a site for dialogic democracy, one must first address either the possibility or actuality of barriers and conflict (Dale, Celaya and Mayer, 2017). The first sub-theme, barriers, only relates to professional stakeholders because it concerns encounters with DHRs as a multi-agency space. However, testimonial networks are part of the relational system of DHRs. Thus, in the second two sub-themes, conflict and understanding, I consider all stakeholder perspectives. In presenting these findings I draw primarily on the interview data (Phase 3), and on the online survey data (Phase 2).

7.2 Barriers

A key finding is barriers to collaborative use. These are what Emily, an independent chair, described as 'barriers [being] put in the way' by organisations, e.g., around if and how they shared information. Emma felt these barriers affected collaborative use because they led to 'resistance to engagement'. Iris, an independent chair, explained:

> I think it is quite easy for a panel to get caught up… in those processes: "When did this happen?" "What did this happen?" "Who did what, when?" And I think some panel members are concerned. You know, some can be concerned that [they] are going to get blamed, or there is going to be some level of responsibility pinned on them, so they have those understandable anxieties over the implications for their [organisation]. But I think also it can be quite a hard experience. Some panel members I have had just aren't prepared at all for the experience of sitting and talking about a particular case.

Iris's account speaks to how encounters – be they personal, intra- or inter-organisational – could generate reactive barriers because stakeholders 'just aren't prepared', were 'concerned that [they] are going to get blamed' or were focused on '[organisational] implications' or risked getting 'caught up' in process. *The challenges these barriers present to collaborative use complicate or impede the enactment of dialogic democracy because they make stakeholders less willing or able to be useful.* Importantly however, these barriers are a *reaction* to encountering a DHR.

Personal Encounters

Barriers can be generated as individual stakeholders encounter a DHR. This finding is evidence of the importance of training and support to ensure that review panellists are prepared for DHRs.

An *individual's understanding* of DHRs meant that they might come into the process with different ideas as to purpose and so if and how they should or could be useful. Thus, Victoria (a DAC) pointed out:

> But then you get some people who really get to grips with it and who really want to learn those lessons and really want to understand why things went right or why things went wrong or what the missed opportunities were. And other people, it feels a bit more like a tick box exercise and I think that's just life, isn't it?

Henry recognised this too. Reflecting on his efforts as an independent chair to inculcate a review panel culture, he noted that barriers might nonetheless remain because: '… I couldn't hand on heart say that "yes, everybody is motivated in the same way", because for some people, it's a job.'

Moreover, encounters with DHRs could be *affecting*, with barriers arising if stakeholders questioned their usefulness. Such questioning could be internalised. Thus, Hannah (a DA specialist) reflected on her 'confidence to speak professionally' in her first DHR and, for Sophia (also a DA specialist), this involved asking, 'do I know enough?' However, an externalised assessment could also be made with respect to others, individually (in terms of status) or collectively (in terms of numbers). I consider the behaviour of these others below but here the point is that these other stakeholders could have an effect. Thus, Harper, a DAC, suggested that 'if there are very senior people there, then they [a less experienced stakeholder] feel like a junior partner in all of it'. Meanwhile, Margaret, an independent chair, noted that 'a large panel can be intimidating' thereby affecting stakeholder confidence. Consequently, others might prevent someone from speaking.

That DHRs can be affective is important because, regardless of the driver, stakeholders might come into a DHR feeling less than useful. This can be the consequence of, as Ahmed points out, the result of being defined in relation to others (2019, p. 3).

This affect was also linked to emotional labour. DHRs have the potential to be emotive with, for example, Lily (a family advocate) noting: 'that's [the production of

agency information] really difficult'. Yet, DHRs could also require emotional labour. For example, Hazel (a review panellist) described wanting to be useful. However, to be part of collaborative use, Hazel had to manage her fear of being blamed and her instinct to defend her organisation. Demonstrating the emotional performance required, Hazel explained that participation was 'easier said than actually felt'.

This fear of blame was evident across accounts and Emily (an independent chair) described how – if they perceived the process as threatening – stakeholders could come into DHRs with their 'defences up'. Thus, although Alyssa (a DA specialist) emphasised that DHRs were about 'getting that learning out', she recognised that for some people 'when they see a notification… they think it is a… witch hunting process'. Amelia, an independent chair, recognised this too and explained that, despite the aspirations to collaborative use, being asked about what one's organisation did or did not do can make it 'hard not to feel accusatory'. This speaks to the difficulty of operationalising a culture of accountability-not-blame in review systems (Watt, 2010; Boughton, 2022; Haines-Delmont, Bracewell and Chantler, 2022).

This fear of blame had an organisational context because an individual's fears could be influenced by their organisation 'know[ing] that they're not going to come out well' (Grace, an independent chair). Consequently, review panellists might come into a DHR being 'protective over the [organisations] they have come from' (Marie, a family advocate). Of course, this fear of blame might also lead to conflict, which I consider below. Here, the point is that this defensive encounter is another example of the barriers stakeholders might face in being part of collaborative use.

Barriers can arise because of an individual's *capacity to be useful* because, as Ahmed has noted, use is not static and things can have 'use status' (2019, p. 7). Here, capacity means that *just because an individual could be useful, this does not mean they*

necessarily are. One aspect of capacity is whether someone has sufficient time to usefully contribute, with this linking to the demand posed by DHRs. Thus, Jade (a DA specialist), suggested that DHRs could often feel 'like an onslaught… on top of all the other work they [stakeholders] have'. However, this also has a broader organisational context, which I discuss below, given some representatives were either appointed without a recognition of 'how time consuming [DHRs] can be' (Joshua, an independent chair) or, for Cora, (a DA specialist) did not prioritise DHRs because of their perspective on them. Regardless, if someone's contributive capacity was compromised, then they were less useful, and this impeded collaborative use. Thus, as independent chairs, Emma reported that sometimes stakeholders did not prepare (e.g., by reading IMRs), while Grace reported deadlines being missed because 'people have far too much work to do'.

However, capacity is not solely about time, it also relates to review panellist experience, skills, and knowledge (something I explored in *Chapter Six* with respect to independent chairs). In this respect, Henry (an independent chair) emphasised that 'we need to try and make sure that we get the right people on the panel'. As previously discussed, this reflects the aspirations for diverse panel membership. However, it can also relate to the extent to which an individual could fulfil their function. Here Henry provided an example of one representative who did not have the authority to represent their organisation. In summary, in encountering DHRs, it is important that review panellists have the capacity to contribute to attendant and intellectual quoracy. Without this capacity, Jade (a DA specialist) suggested stakeholders lacked the ability to 'carve out space' to contribute usefully.

Finally, barriers can be the result of *the behaviour of individual stakeholders*, with this affecting their usefulness along the spectrum outlined above (from their

personal understanding of how they could or should be, to the extent to which they feel able or willing to be useful, and/or could be useful). At worst, the behaviour of individuals meant they were useless. For Grace, an independent chair, 'an individual can change the dynamic of the panel', including review panellists who are 'just awkward and obstructive'. However, this was not solely about personality, it also linked to the understanding someone had about their role. For example, Hudson, an independent chair, said that at the start of a DHR he encouraged review panellists to be a 'little bit more supportive…rather than just a conduit through which information comes'. That is, Hudson sought to encourage stakeholders to *become useful* on coming into DHRs.

Bringing these aspects together – including understandings, affectivity, capacity, and behaviour – individual encounters with DHRs can complicate or impede the enactment of dialogic democracy. This reflects ideas about 'right use' because this complication or impediment can come about if individual stakeholders do not fulfil their role in a DHR, either because they are *less willing or less able to be useful*. This finding is a reminder that, whatever the intentions in establishing DHRs, or the framework or practice of their doing, they are ultimately delivered by individuals.

Intra-organisational Encounters.

Intra-organisational encounters also generate barriers that challenge collaborative use. (They also often provide the context to personal encounters given organisations provide an individual's 'corporate hat' (Haines-Delmont, Bracewell and Chantler, 2022, p. 6)). As a finding, recognising the potential impact of intra-organisational encounters (and the next area of inter-organisational ones) is a reminder of the need to mindfully approach the construction of review panels.

Intra-organisational understanding is important because organisational encounters can vary. Specifically, organisations, as for individuals, can come to DHRs with different ideas as to purpose. William, a review panellist, highlighted how 'I think some [organisations] are… getting better. But I still think there is a bit of nervousness'. This nervousness could produce barriers. As Owen (a review panellist) explained:

> The bottom line is we are employed by our own organisations, so part of that role is to identify and manage how, sometimes where we have got it wrong, not to hide it but to make sure we get it right in terms of press and publicity… Sometimes there can be.... that can be a dilemma for the panel. Where they are not necessarily, they are not trying to hide things, but they are out there to manage or lessen the damage to the organisation.

Owen's account illustrates how intra-organisational encounters can be affected by understandings of use, including collaborative use, but also how organisations might use DHRs. These different understandings can also lead to conflict, which I explore below. Here, however, the issue is that intra-organisational understanding of use can generate barriers. Additionally, linking back to the earlier discussion of establishment, this is a further example of the limits of convening power. That is, organisations might feel they have to *make themselves (appear) useful,* but this does not mean they approach DHRs with a shared vision of their purpose, particularly if they question the usefulness of the process (as discussed regarding perceptions). Illustratively, Emily (an independent chair) suggested:

> There's a little of the "do I want to lift that stone, cos' I don't know what's going to come crawling out from under it. Do I need the work? Do I need the agro?" I also think for some people, it's a case of, "well, we have lots of reviews, there's lots of learning generated from them, what difference do they make?"

Moreover, paradoxically, barriers can arise because of the improved response to DA generally, with organisations taking the view that they had already been *useful enough*, so feeling that no more should or could be done. Thus Iris, an independent

chair, suggested organisations (and their representatives) might come into a DHR asking: ‘we have done all this work, we've done all this training, we have got all these policies and procedures, we have got all this, and now you are questioning that?’ As a finding this shows the need to recognise what has been achieved in improving response to DA but also the need to sustain these gains (Devaney *et al.*, 2021).

DHRs are also *potentially demanding*,[108] generating barriers that mean that organisations are less able or willing to be useful. Dylan (a review panellist) reported that, on encountering DHRs, organisations may not feel able to say, ‘this is what we learnt’. Cora (a DA specialist) agreed, suggesting organisations – as much as the individual stakeholders who represented them – ‘need to feel like they are not going to be judged’. Importantly, this could influence if and how organisations made themselves useful, particularly those that were less familiar with DHRs. For example, Hazel (a review panellist) and Hudson (an independent chair) noted that organisational confidence was important. Thus, less familiar organisations could find the prospect of a DHR daunting; these organisations’ concerns about blame could shape subsequent intra-organisational encounters.

Competence is also an organisational issue that can lead to barriers to collaborative use. Partly, this relates to capacity. Even if organisations are committed to DHRs, a lack of capacity can constrain their usefulness. For example, Charlotte (a DAC) reported her local police force struggled to manage multiple DHRs and so they had ‘become a process for them’, meaning they were less able to usefully engage because different cases concertinaed into each other. Jade, a DA specialist suggested that such burdens could generate barriers because organisations began (consciously or not) approaching DHRs thinking ‘Ok, what’s the bare minimum that I need to do in

[108] I use demanding here because while organisational responses may structure an affective economy (Ahmed, 2004), organisations cannot experience emotions per se.

order to, kind of, get this done so we can move on?" This meant organisations might approach DHRs by being *just useful enough*. Capacity constraints also affect organisations directly. Caroline (a DA specialist) suggested that specialist DA services might struggle if 'running on very small budgets'. That possibility seems likely, given the enduring under-resourcing of these organisations (Dawsey-Hewitt *et al.*, 2021).

I refer to this as competence not capacity because an overriding issue is often an organisation's perspective vis-à-vis DA itself. In effect, *some organisations must be convinced to engage with an issue that is not their primary focus*. If unconvinced, this might compromise the extent to which an organisation feels their participation and/or a DHR is useful, including their allocation of a representative to support their involvement (as discussed above). The determinant is whether DA is an organisational priority. Thus, Amelia (an independent chair) highlighted how, for most statutory organisations, '[DA] is a slither of their work. And so, you are really, kind of, dragging them into a world that they don't spend much time hanging out in'. The result could be, as Alyssa (a DA specialist) suggested: 'I think there seems to be a view from lots of agencies that… [DA] isn't that important'. These echo calls beyond DHRs to ensure DA is embedded in organisational practice (SafeLives, 2015).

Finally, as for individuals, so too the *behaviour of organisations* can generate barriers, again affecting their usefulness. Here, the issue related to what Henry (an independent chair) described as 'organisational arrogance', whereby some organisations view multi-agency and partnership working through their own lens, giving examples of the police, health providers, and children services. Importantly, Peter, a review panellist, suggested this could affect organisational approaches to DHRs. So, individual review panellists, reflecting their organisational culture, might 'see themselves in a very different light (and their agencies in a very different light) to perhaps other panel

members'. Importantly, Margaret (an independent chair) suggested this also meant that statutory organisations might not see 'things from a service users' point of view', something that specialist DA services often corrected, thus further demonstrating their leadership role.

In summary, organisational encounters can, like individual ones, generate barriers reflecting both what DA/DHR means to those organisations and considerations like competence with respect to the process. Thus, as with individual encounters, organisational encounters are affected by the extent to which organisations accept and fulfil ideas of 'right use'.

Inter-organisational Encounters

Barriers can also be generated collectively, that is, inter-organisationally. While inter-organisational encounters inform and are informed by the individual and organisational encounters discussed so far, they are also generated with reference to the local CCR. This was because the CCR frames the multi-agency and partnership working which organisations and their representatives encounter in DHRs. Illustrating this connectivity between personal, intra-, and inter-organisational encounters, Peter (a review panellist) described how the DHR process 'depends [on] who is sitting around the table and in what role'. The issue for inter-organisational encounters was the extent to which DHR functioned as a site for dialogic democracy and whether this space was *underutilised* because of barriers to collaborative use.

First, how stakeholders come into a DHR can affect its conduct because organisations might collectively want to move through it as quickly as possible, potentially reflecting their understanding and experience of DHRs. This can make DHRs less useful for accountability. So, Cora (a DA specialist) said:

> There's a lot of people that just want to get the meeting over and done with. There's a lot of people that's like... a lot [of] group think going on. You know, one person says something, they all agree.

However, second, sometimes underutilisation can occur if stakeholders were too familiar with each other, impeding challenge. Thus, Henry, an independent chair, described how DHRs could be experienced as 'a little cosy arrangement within the safeguarding community' that could affect if and how conversations were had, including about difficult issues. This finding supports Boughton's suggestion that, while familiarity can build trust, it can be a double-edged sword (2022), because a collegiality might become a congeniality that mutes scrutiny and/or challenge.

This risk of over-familiarity is relevant to independent chairs. I will not lead more than two DHRs for a given CSP because, as much as my familiarity might help (with stakeholders, as well as local ways of working), it might lead to a degree of comfort that could affect my independence (because I might perhaps make assumptions). In Ahmed's (2019) terms, my fear, and perhaps Henry's, is that those involved might become less useful because they start to take the usual or the easy path. This is an additional consideration with respect to, as found in *Chapter Six,* concerns around the appointment of independent chairs, including the limited pathways to this role.

Underutilisation can also be the result of power. At its most extreme, as I address below, power can generate conflict. However, at a minimum, power can generate barriers, often flowing in and through the individual and organisational examples above. On one hand, power can limit or prevent dialogue on coming into a DHR. For example, Chloe (a DAC) noted how there could be no, limited, or constrained challenge between review panellists from within the same local authority. Talking about her work to prepare review panellists Chloe noted this was because: '… we are…

talking about people who are colleagues, who have to work with each other... there are power dynamics'.

Power can also affect NGOs, particularly given the potential dominance of statutory services, with Owen describing 'the big three' as children services, health, and the police. Indeed, the prospect of an encounter in a DHR might leave specialist DA service representatives feeling exposed. Bobby, a family advocate, linked this to a potential hierarchy. This affected both Bobby's confidence in her initial encounter with DHRs as an individual but, importantly, she felt she was seen in a certain way because 'I was working in… a [VAWG] service'. This could affect led-by-and-for services too, with Caroline (a DA specialist) suggesting that these organisations were not always 'heard equally' when coming into DHRs.

As an independent chair, Grace explained how power could affect collaborative use, describing looking to specialist DA services to support her in-room, but sometimes finding 'they can be quite reluctant to do that'. This reluctance could be because specialist DA services might come into DHRs feeling defensive because they are 'protecting their position as a commissioned service' (Hudson, an independent chair) or 'nervous to speak in front of their commissioners' (Iris, an independent chair). Notably, defensiveness can also affect relationships between specialist DA services. Thus, several participants reflected on difficult relationships between services, with Margaret (an independent chair) describing the 'tricky' relationships that had to be negotiated because of differing commissioning arrangements.

The findings here demonstrate that inter-organizational encounters – along with individual and intra-organisational ones – can challenge collaborative use, because they generate barriers that make stakeholders (individually or as organisations) *less able or less willing to be useful* to DHRs. While how review operates as a relational space has

long been attributed to the importance of stakeholder selection (Dawson, 2021), these findings add depth – personal, intra- and inter-organisational thickness – to understandings about what may complicate or impede collaborative use, including the extent to which those involved can fulfil or accept what is understood to be 'right use'.

Importantly, as suggested here, these barriers arise as stakeholders are brought into a DHR and so are a reaction to the *prospect of or entry into use*. The consequence is barriers can complicate or impede the enactment of dialogic democracy. In turn, this complication or impediment can affect knowledge generation. Thus, these findings further evidence the contingency of DHRs.

7.3 Conflict

Conflict can also affect collaborative use. However, while barriers come about because of encounters with DHRs, conflict is generated by engagement with them. That is, conflict is the result of what happens *within the DHR process and the experience of being in use*. This distinction is important because while barriers indirectly complicate or impede the enactment of dialogic democracy (because they reactively make stakeholders less able or willing to be useful), in contrast, conflict is *active*. Thus, conflict can *disrupt* the enactment of dialogic democracy because of struggles over collaborative use and, consequently, affect knowledge generation. These findings demonstrate the challenge of bringing together multiple stakeholders with different organisational and/or disciplinary perspectives (Albright *et al.*, 2013). Indeed, as a finding, this demonstrates the paradoxical nature of dialogic democracy, given the fulfilment of a collaborative potential is necessary for the doing of DHRs, yet this same convention about stakeholders may also be its undoing.

This sub-theme also addresses experiences of testimonial networks. As with organisations, this relates to the enactment of collaborative use, with relationship

formation and negotiation recognised as challenging in practice (Mullane, 2017; Haines-Delmont, Bracewell and Chantler, 2022; Rowlands and Cook, 2022). Illustratively, Bobby, a family advocate, highlighted areas of possible conflict for families, including 'hearing [information] for the first time' or if '[there were] critical things the family want[ed] to know, [but] they still don't get answers to'.[109] In the following, I consider conflict *between organisations* and *with testimonial networks*.

Conflict Between Organisations

For organisations, conflict can be generated during collaborative use. Thus, Iris (an independent chair) suggested that 'the panel meeting can become the venue for gripes'. These gripes could reflect the wider CCR given, as Cora (a DA specialist) observed, 'a lot of… [organisations] are at loggerheads all the time'. However, reflecting the complexity of collaborative use, the drivers that can affect willingness and ability to be useful in encounters with DHRs can also shape engagement within them. Here, Iris explained: 'Everybody['s] got a caseload. Or everybody is trying to deal with particular pressures in their organisation'. As elsewhere in this chapter, this illustrates the challenge of multi-agency space.

Regardless of its cause, the result is that multi-agency space can be *misused* because stakeholders seek to manage their position within it and/or the scrutiny of information and/or any findings, and so disrupt the enactment of dialogic democracy. Thus, DHRs can become a site of conflict as organisations (and their representatives) deploy different tactics as a way of 'protecting' themselves (Charlotte, a DAC, and Liam, a review panellist). This protection can encompass both *understandings of what happened* and/or *who should take responsibility for it*. Illustratively, Henry described

[109] This may be because families are seeking answers to questions that are beyond the scope of the DHR. In some DHRs I have chaired, families have been unhappy with the outcome of the criminal trial, but this is not something a DHR can consider.

how a disagreement about a perpetrator's licence conditions became an issue in a DHR he had chaired, with organisations becoming defensive, in part because the family felt there had been failings. The result was a dynamic that he described as 'quite destructive'.

Based on participant accounts, there are four tactics that can be used by organisations to protect themselves: *avoidance*, *defence*, *distancing*, and *attack*. Ironically, these tactics are like those used by abusers, being referred to as Deny, Attack, Reverse Victim and Offender (DARVO) (Harsey, Zurbriggen and Freyd, 2017).

Avoidance is the lowest cost way to disrupt dialogic space. I have coded avoidance as an active tactic because, in use, it was intentional and involved active steps to disrupt collaborative use. Numerous participants described avoidance tactics which affected knowledge generation. Thus, Emma and Emily (both independent chairs) recounted scenarios whereby organisations chose not to participate or where information was missing or incomplete. Meanwhile, respectively, Amelia and Hudson (independent chairs too) described how information could be 'perfunctory' and misdirecting given 'they [organisations] will *try to underplay things* that maybe other agencies are, kind of, accentuating' [emphasis added]. These accounts perhaps identify one possible driver for Boughton's observation that sometimes review panellists make minimal contributions as a way to avoid accountability (2022).

However, there are other ways to disrupt dialogic space, including going on the *defensive*. Neil (a family advocate) spoke about the active basis for this defensiveness, describing how 'what happens is they go into the room and *get* defensive' [emphasis added]. This defensiveness meant organisations (and their representatives) did not admit to errors and/or the possibility of learning. Alyssa (a DA specialist)'s account draws attention to how defensiveness could also be used to avoid accountability, noting how:

> There's particular [organisations] that will come along, and it seems like they've decided before they got to the panel, "well, we did nothing wrong". And that's their stance through the whole DHR. So, anything they are asked to comment on, then they're not willing to think of different possibilities. "It wasn't our fault" kind of thing.

Importantly, and demonstrating the potential challenge to collaborative use, Alyssa explained that such defensiveness, 'inhibits conversation'. This inhibition could affect knowledge generation. For example, Louise (a DAC) reflected on the difficulties of a review panel discussion where a mental health service had not responded to a perpetrator's disclosures ('they didn't take 'em seriously'). While Louise described how, with effort and care, it was possible to reach a place of understanding (to which I turn as the final sub-theme), initially she felt that the organisation's representative 'didn't want to be blamed'. The result was an initial position of 'well, you know, my worker didn't do anything wrong'.

Another tactic is *distancing*, whereby active steps are taken to neutralise concerns. Margaret, an independent chair, described how one organisation's representative 'kept trying to minimise things' (a strategy more akin to avoidance) but then, when recommendations were identified, switched to 'oh no, we've changed it now' (thereby neutralising the issue). Amelia, also an independent chair, described this as the phenomenon of 'oh, everything changed last Thursday, we don't do that anymore'. A final version of this tactic was reported by Bobby, a family advocate, who noted that there could be attempts to place distance between learning and recommendations: 'So… an organization has maybe put loads of recommendations [into its IMR] and then, once they're in the report, they want to remove them all.' Bobby said this tactic was sometimes justified with reference to resource implications, which is something I consider in the next chapter. Notably, there is scalability in these forms of distancing, but ultimately with the same effect of disrupting collaborative use.

Finally, *attack* sees organisations (and their representatives) actively targeting others and/or the DHR process. Attacks on others might reflect existing organisational dynamics. Thus, Emma (an independent chair) described how one organisation might 'suggest that all the changes have to happen' in another. For example, Dylan (a review panellist from children services) described a case where he felt there was a 'lot of finger pointing' at his organisation but argued that the same concerns were left unstated for health and police. For Dylan, this meant the knowledge produced 'wasn't consistent across the whole multi-agency piece'.

Organisations sometimes target the DHR process too. This can involve attempts to manipulate the process. As noted in *Chapter Six,* Emma described how one organisation rewrote their IMR, thus challenging the DHR's integrity (notably, in the re-written IMR, the strategies of avoidance and distancing were employed, with Emma summarising the changes as saying 'that never happened, that was a misunderstanding'). Echoing Emma's points, Bobby, a family advocate, suggested that DHRs could be marked by 'division of opinions' and, as a result, it could make 'professionals much more hostile and… confrontational with other panel members'. Such targeting can also see organisations 'belittl[ing]' DHRs. Thus, Emma (an independent chair) contrasted organisations that identified and acknowledged learning with those that instead attacked the DHR process e.g., by asking, 'what's it going to achieve?'

Taken together, conflict affects collaborative use because multi-agency space is misused, thereby disrupting collaborative use as stakeholders try to protect themselves. The result is to call into question what is possible in terms of 'right use'. Thus, Emma, an independent chair, described how conflict could affect collaborative use, and so

knowledge generation, using an example relating to faith.[110] In this DHR, Emma felt review panellists had pushed her to 'spearhead' a conversation with a local faith community, something she felt ill-suited to do considering her own positionality. While subsequently engaging with the faith community, when Emma did so, 'they didn't really engage with the subject matter, cos' [they said, "DA] doesn't happen here"'. Here, Emma experienced conflict with review panellists (about her suitability to make an approach) and then community representatives (when she found they did not want to participate). Emma's example also illustrates the effect on knowledge generation. The reluctance of the faith community to acknowledge DA limited opportunities to explore issues like spiritual abuse and/or religious coercive control (see Mulvihill *et al.*, 2022), while Emma also faced a dilemma about how to represent this.

These findings provide direct evidence of the difficulty around 'decision-making moments' in review (Albright *et al.*, 2013, p. 437). Indeed, the operation of conflict could be seen as a further example of how, as a technology, DHRs may be useful to the state and its agents because they minimise or contain the risk posed by a DA-related death. Moreover, as with other findings, this underscores the complexity and tension within, and contingency of, DHRs and the need to ensure stakeholders are supported and enabled to participate. Finally, the active generation of conflict also illustrates why DHRs need a shared vision, and in particular strong leadership, to ensure that organisations and their representatives understand 'right use' and do not disrupt the enactment of dialogic space, which risks making DHRs less useful.

Conflict with Testimonial Networks

Conflict with testimonial networks (here family) was also reported, although theoretically family are integral to DHRs both as a source of information and as

[110] I discussed this example in *Chapter Four* an illustration of the assumptions about DHR's statutory foundations.

stakeholders. However, as previously noted, the nature of this contribution and role can be uncertain and is not always achieved because of tensions in and around how family are engaged in DHRs (Mullane, 2017). The findings here evidence this precariousness because, concerning collaborative use, conflict can be generated both around *family information* and *family role*.

Emma (an independent chair) shared an example that demonstrated how conflict can be generated around family information. During one DHR, Emma felt some organisations attempted to avoid scrutiny (she described this as organisations having 'gone very vague on me', providing a further illustration of avoidance tactics). To try and re-focus the discussion, Emma would return to family questions. Emma's approach was purposeful: she was using family information to drive scrutiny ('the family had some big questions' that needed to be answered), and she also wanted to be useful ('I feel a real obligation to answer as many questions as I can'). Yet, during one review panel meeting, Emma reported that a review panellist said, 'this report is not just for the family you know'. This is an example of how an attempt to make full use of family information and enact their role as stakeholders could lead to conflict.

However, conflict was directly relevant to testimonial networks too. First, a DHR can *lead to conflict with respect to the process writ large*. Harper, a DAC, pointed out that, while stakeholders might seek to prioritise family involvement, this was not necessarily welcome. Harper thus highlighted how some families may 'just want to move on from it really'. Avery, a family member, suggested that whatever the aspirations for dialogic democracy in DHRs, family – like individuals and organisations – could have different understandings of their purpose (that is, how DHRs could or indeed if they would be useful). Thus, Avery felt that DHRs could be difficult, and

engagement with them challenging, because families might seek to identify blame, with this potentially 'upset[ting] you more I think'.

Second, there can be conflict *within a family* because of what and how information is shared. For example, in respect of the DHR, Isabella's family had 'gone our separate ways'. Meanwhile, Luna often had to take point for her extended family, creating tensions within her own life, including ill health.

Third, there can be conflict *during the DHR process*. Several family participants reflected on their participation, illustrating the precarity of their opportunity to be part of collaborative use. Notably, Isabella described how constrained her opportunity was:

> We had to physically go visit their office. I couldn't read it at home. We [sat] in a quiet room, locked and we had a short time frame - I think it is two hours, although maybe 3. A very short timeframe - to read through that in detail. I felt very rushed.

Meanwhile, Luna reported having a meeting with the review panel which she felt was poorly handled. These situations left Isabella and Luna feeling the DHR process was conflictual.

Fourth, there can be tension and conflict around a *DHR's finding*, i.e., the knowledge that is generated. This can reflect if and how any information is used. At one extreme, Joshua, as an independent chair, identified how a family might challenge aspects of a DHR report, perhaps on a matter of record or by disagreeing with a finding. However, the issue for Joshua was the limits to a family's rights concerning collaborative use. Here, Joshua made a distinction between family input and the DHR report being 'the panel's report'. In other words, Joshua respected family involvement but did not see them as equal stakeholders. From another perspective, as a family member, Isabella was angry about the perpetrator's contribution to the DHR, which she felt had distorted its findings. In these examples, conflict was generated vis-à-vis family concerns about DHR findings.

These findings highlight that the aspiration that family are integral to DHRs is not always be achieved and, in fact, can generate conflict. This evidences the need to better understand the role of families in DHRs, including what is required to support their involvement, but also to ensure that they are genuinely seen and treated as integral.

Thus far, I have explored the sub-themes of barriers and conflict. Through the prism of use, I have explored the challenges to the enactment of dialogic democracy by identifying the barriers and/or conflicts which can affect collaborative use. Many of these challenges relate to 'right use', including different ways of understanding or experiencing aspects of a DHR. The effect can be significant with, for example, some participants being concerned about the quality of DHRs overall. Indeed, Iris, an independent chair, recounted that 'strong panels are in a minority'. Echoing this, Emma, also an independent chair, reflected that 'I wanted the panel to hold each other to account more. I wanted that dynamic to be kind of there'. Thus, a greater understanding of the barriers and/or conflict that can be generated because of how organisational and individual stakeholders are used and are useful to DHRs ('collaborative use') is important. As a finding, this has implications for how the role of stakeholders is understood, experienced, supported, and delivered.

Taken together, the challenges in enacting dialogic democracy point to the necessity of recognising the complexities and tensions within DHR given it is dependent on useful stakeholders who are then used. Yet, ironically, to date, there has been little attention to *how* to enable and ensure stakeholder participation. Further research would improve understanding of how to avoid or manage the risk of barriers and conflict in DHRs as they seek to generate knowledge about a complex issue. This therefore also supports calls for a more robust competencies and training framework for those involved (Rowlands, 2020a). It also underscores the need to consider more fully

the ways of understanding and operationalising family involvement in review (Roguski *et al.*, 2022; Rowlands and Cook, 2022).

Finally, these challenges are also further evidence of the potential and peril of the statutory foundation of DHRs as a technology. Thus, many of the issues discussed so far – such as differences in understanding of purpose, capacity/competence, and the lack of preparation and support for those involved – demonstrate the instability of the framework for DHRs. This is further reminder of how DHRs are dependent on the state and the risks that follow. These risks include the possibility that, at best, DHRs are in some sense symbolic, with a weak or inconsistent commitment to their actual doing. At worst, the findings here could be taken as further evidence of how a technology could be misused, most notably by organisations to protect themselves. Nonetheless, despite these challenges, these were not insurmountable, and many participants reported that dialogic democracy could be achieved. It is to this I now turn.

7.4 Understanding

Many participants described experiences that could be understood as examples of the enactment of dialogic democracy, i.e., they were able to work together to achieve the visions of DHRs previously described and thus reach understanding. This possibility was described by Chloe, a DAC, who observed:

> I find it very positive when panel members are very good, and very engaged, and when panel members say, "we didn't do well". You know, when they are honest or open. I find it difficult if that is not the case. If people are defensive. But I can, I do find it quite heartening, that people reflect and share.

Thus, returning to my definition of collaborative use, stakeholders can feel and be useful and be willing to be used as part of a collective endeavour. Based on participant accounts, collaborative use can be achieved through *meaningful participation*, the finding of *common ground*, and *shared decision-making*. Together,

these enable a process that is ‘analytical enough, and is transparent and honest enough, that agencies feel able to be properly reflective on what they have done’ (Emily, an independent chair). Importantly, these findings support Websdale's account of dialogic democracy i.e., that DHRs can be a mechanism to bring together different interests to discuss a complex issue outside pre-established mechanisms of power. However, critically, as Giddens highlighted in his conception of dialogic democracy from which Websdale drew, these findings also highlight the importance of curating conditions to enable ‘active trust’ to ‘open up’ space for dialogue (1998, p. 17). Here, I argue, that opening up depends on ‘right use’.

Meaningful participation

Meaningful participation enables stakeholders to feel they are part of a DHR and so should and can be useful. In practice, this means:

> Everybody having involvement and being able to bring forward the information that they have and being open and honest about things that didn't work or didn't go right or didn't, you know... it's very much about making sure that we get the whole story, really, including the gaps’ (Leilani, a DAC).

On one level this was an outcome of ‘meeting management’ (Owen, a review panellist). In other words, *well operated multi-agency space* means stakeholders feel they are, and can be, useful because they are successfully engaged, and information is then gathered and scrutinised. For example, ahead of one DHR, Harper (a DAC) described her involvement being enabled by efficient administration including ‘support around… what people needed to do to get prepared’. Meanwhile, during a DHR, Hazel (a review panellist) emphasised that, because there was a ‘lot going on’, ‘quite a logical approach’ was needed to support engagement. In these examples, the management of multi-agency space enabled meaningful participation.

Meaningful participation also relates to how stakeholders encounter and engage in DHRs, again encouraging them to feel they can be of use. Thus, a 'good' DHR is dependent 'on your panel, your chair, the CSP: all the different people involved' (Bobby, a family advocate). In part, these conditions were informed by the *health of the wider CCR*, because this ensured a shared understanding of the DHR process. So, Louise (a DAC), in part, attributed meaningful participation to the broader impact of partnership working because that helped inculcate a shared understanding of DHRs: 'We've trained quite often, and we talk about DHRs and what the purpose is'. However, as discussed in the previous sub-themes, the risk of well-established relationships (what Harper, a DAC, called 'professional friends') was that they could lead to multi-agency space being underutilised. To prevent this, an open approach was necessary. This included ensuring new stakeholders could join DHRs. For example, Ella (a review panellist) felt that her area had a good balance between regular review panellists and 'new additions depending on the specific [organisations] involved'. It also meant ensuring that existing panellist engagement was refreshed, which could prevent ossification. Illustratively, Bobby, a family advocate, reflected on an experience of being a new review panellist. When she joined a review panel with many stakeholders who knew each other, the independent chair nonetheless facilitated a 'scene setting' discussion. Taken together, this emphasises how use – being prepared to be useful, being used in a DHR and usefully contributing – is not a singular event. Rather, *being part of a DHR is iterative*.

In facilitating meaningful participation, the leadership role of the chair has been evident. That role was recognised by independent chairs. For example, Henry described how he set out to build a 'shared partnership approach'. Linking back to the previous discussion of visions of DHRs, multiple overlapping purposes might flow from this

approach and are evident in Henry's account, including a desire to achieve collaboration, accountability, and make change. Furthermore, Henry's account demonstrates how he tried to address potential barriers, as well as conflict:

> And you would hope that, by the way that we run the meetings, by the way that we try to make a shared partnership approach, and really sort of spend quite a bit of time going through the ethos of what a review is about, that you can engender that same spirit. And I think in general terms we do, because we really, you know... I… try and provoke discussion, because actually if you get people talking, you'll get them out[side] that defensive, almost organizational comfort zone, into what their belief is and whether they really want to make a difference.

While participants gave different accounts of an independent chair's role, when done well this involved facilitating what Peter (a review panellist) called 'a safe space'. This included explaining the DHR process, making old and new review panellists alike feel welcome, as well as building relationships with testimonial networks.

However, to curate meaningful participation, an independent chair also needed to *de-centre their role*. As an independent chair, Hudson described this as 'mak[ing] it really clear at that panel meeting that the product of the report, the product of the review, is our report, not my report'. By de-centring their role, an independent chair yields space to other stakeholders. Demonstrating how this could ensure that others felt able to be useful, Ella described the importance of being 'treated as an equal contributor... the chair is a facilitator really, and… we are collectively making decisions'. In similar terms, Sophia (a DA specialist) described one independent chair leaving her feeling 'it was very much a partnership rather than him leading and then… us just being there'.

A specific element of meaningful participation related to the DAC and specialist DA and led-by-and-for services. As previously discussed, the DAC and specialist services may have leadership roles. If these roles were fulfilled, some participants identified the potential benefit to meaningful participation. Thus, for example, a DAC

could assist in the facilitation of multi-agency space. In this respect, Emma (an independent chair) observed that ‘it's the [DACs’s] relationships often that will make this happen or not happen’. Moreover, Mia, a DA specialist, highlighted how a DAC’s presence could be indicative of a well-functioning CCR. In her area, the DAC was both a link for individual DHRs and involved in the wider partnership, which brought together ‘people… that really care about [DA]’. Importantly, this also supported Mia’s role as a DA specialist, because she felt her organisation was recognised as ‘a key partner in addressing [DA], which is absolutely fantastic’.

Finally, meaningful participation encompasses family too. In contrast to the more negative experiences of Luna and Isabella described above, Peter (a review panellist) identified that testimonial network participant should be meaningful. For Peter, this was partly about timing. In other words, testimonial networks were ‘not just as an afterthought, not just as a "Well, we'll get them in at the end", type of thing’. Caroline (a DA specialist) felt the same. For Caroline, meaningful participation meant the capacity to influence the DHR report and, if needed, to change it. Together, Peter’s and Caroline’s reflections suggest an understanding of meaningful participation as being the opportunity to be involved *throughout* a DHR. Thus, as above, *use is an iterative not a singular event*.

Importantly, this means family are not simply being used (i.e., as a source of information). Marie, a family advocate, supported this interpretation, emphasising that in discussion with an independent chair it was possible to ‘get a sense of the stage that the family were at and their concerns or if they disagreed with anything’. Critically, for Marie, resolving issues could help build trust, meaning the family felt more able to engage.

In summary, meaningful participation means ensuring that all stakeholders feel able and willing to be useful and so participate in collaborative use. This can, potentially, address the barriers and conflict that can be generated within DHRs because there is a shared recognition of what is required for 'right use'. Importantly, this can also be about the right to use DHRs. That is, stakeholders feel involved and do not feel misused, including family.

Common Ground

In addition to meaningful participation, a sense of finding common ground was also generated from participant accounts, i.e., a space in which stakeholders can be open and collaborate. Here, Amelia illustrated the leading yet de-centred role of the independent chair when she described how, as part of the discussion about a DHR's ToR, she facilitated a discussion about how 'we are all teachable'. According to Louise (a DAC), such openness helped stakeholders to move beyond blame to realise 'we are all playing our part together' and that a review panel is 'a little team around working out what went wrong, what can improve'. In this way, Bobby (a family advocate) recalled being a review panellist where common ground enabled a robust debate:

> Health… felt really confident in potentially challenging some of the information that police, or children social care involvement. So, it meant that in a really constructive way, those discussions could be had in terms of, "I would have expected from this information that this should have happened". And just some of the, we don't know the practicalities and processes, whereas all of these panel members will. So, it just brings much more of that kind of specialist and local knowledge and a really helpful discussion.

Critically, common ground enables a shared understanding to develop, both of other stakeholders and what is possible, with this in turn providing the foundation for shared decision-making (which I address shortly). While recognising the potential for conflict, for Owen (a review panellist) this meant that professional stakeholders had an

‘understanding of where the other [organisation] sits in the process. What they are capable of doing. The resources they have’. Talking about these kinds of exchanges, Hazel (a review panellist) described them as involving ‘to-ing and fro-ing’ which, viewed as collaborative use, is an example of the enactment of dialogic democracy because it involves stakeholders ‘saying… their piece and then somebody asking another question and clarification’. Finding common ground was also evident in family involvement. Claire described how, in the DHR into the death of her loved one, she was able to identify her concerns and then ‘he [the independent chair] took… what I was saying in[to] the discussion of the review’. In addition to being a further example of the leadership role of the independent chair, Claire shows how a family could contribute, even from a remove.

Thus, common ground is important because it enables an open space. Critically, and in contrast to the discussion of barriers and conflict, common ground means that stakeholders are less likely to feel the need to protect themselves and thus feel able to utilise multi-agency space to its fullest potential. In terms of ‘right use’ this means that stakeholders are willing to be part of a DHR, rather than complicating, impeding, or disrupting, dialogic space. This utilisation, in turn, fosters the opportunity to generate knowledge through shared decision-making.

Shared Decision-making

Together, meaningful participation and common ground facilitates shared decision-making, specifically regarding the knowledge generated. Again, this is often heavily influenced by the independent chair. Each independent chair addressed decision-making in the interviews and, reflecting their leadership role, recognised that they were, ultimately, the final decision-maker in a DHR. Thus, Joshua said:

> I think you have to be pretty single minded sometimes. You are the chair… And although it is the panel's review and the panel's report, someone has to steer in the process.

However, echoing their leading yet de-centred role, independent chairs reported acting as the first-among-equals and described how they sought to guide decision-making. Thus, Grace reflected:

> We would always hopefully have had a conversation with the panel about our thinking, and we've worked that through with the panel, before we get to the point of taking the final report.

In the context of collaborative use, Grace's account shows how responsibility for the enactment of dialogic democracy is premised on stakeholders working together to resolve the complex issue of domestic homicide and to generate knowledge.

Shared decision-making includes the *exploration of case circumstances*. Hudson (an independent chair) described this as asking of organisations questions like: 'why was it this was missed? Why was it that information wasn't shared? What's it about the internal or intra-agency system that prevented that from happening?' But, where appropriate, this might also require *challenge*, potentially pushing stakeholders to be useful. Amelia reflected on how, sometimes, she might ask 'so, given we have now looked at all the IMRs, you know, what do people think are the emerging themes here?". However, Amelia also sought to encourage shared decision-making:

> And then I will sit there. And I will wait. And I will wait. And I will wait. And I won't fill the silence. I will make them work. I kind of do that quite a lot and that's part of me trying to encourage ownership of it.

Finally, shared decision-making also involves *negotiation* because it did not necessarily mean stakeholders have to agree, because you will 'always try to come to a consensus, but sometimes you've just got to agree to disagree' (Owen, a review panellist). Thus, collaborative use does not necessarily mean that everyone must take

the same perspective, as Cora (a DA specialist) noted: ‘because actually in real life, we don't always agree, and in real life, things don't fit neatly into nice little criteria and boxes.’ Where there is disagreement, it is necessary to resolve or articulate this. As an independent chair, Margaret provided an example of a disagreement where ‘the police have wanted me to take something out and I haven't wanted to’. The police’s reluctance was because of the lack of intelligence about a particular community problem which testimonial networks had suggested was relevant. Ultimately, Margaret worked with the police to ‘persuade [them]… that the information should go in because it explains the culture of that community.’ Showing how negotiation might work for family members, Lily (a family advocate), described a case where the family disagreed with some findings. This was managed by treating family as an equal stakeholder: while the findings remained, the DHR report included a statement setting out family concerns.

In effect, shared decision-making is at the heart of a DHR, with this underpinning understanding alongside meaningful participation and common ground. In this summary, I have shown that dialogic democracy can be enacted. This enactment is despite the complexity and tension within DHRs, including disputes about ‘right use’, which can generate barriers or conflict and mean stakeholders and/or the information gathered are under- or mis-utilised. Achieving understanding in this way is possible because possible challenges around ‘right use’ are overcome, so stakeholders feel able and willing to be useful. This shows how, as a relational system, DHRs operate.

Looking at these three sub-themes collectively, a further finding is that there is evidence of considerable variability around whether dialogic democracy is achieved. Indeed, many participants reported good and bad experiences both between but also within DHRs. In the web-based survey (Phase 2), 103 professional respondents were asked about their satisfaction with their opportunity to contribute (i.e., feeling able to

speak and be heard); the contribution of others (i.e., feelings others had the opportunity to speak and be heard); and the quality of the discussion (i.e., feeling the DHR was an open process, and everyone's contribution was considered'). As shown in Figures 13-15, overall levels of satisfaction were high, ranging from 87.4% (*n*=90) for their contribution and that of others, to 83.5% (*n*=83) for the discussion in-room.

Yet, closer examination reveals variability of experience. For example, although levels of satisfaction were high, with most respondents being extremely satisfied with their opportunity to contribute, the majority were only somewhat satisfied with the contribution of others and the discussion. Moreover, while only a few participants were somewhat or extremely dissatisfied, this increased from 4.9% (*n*= 5) being somewhat dissatisfied with their own opportunity to contribute, to 6.8% (*n*=7) for the contribution of others, to 9.7% (*n*=10) for the quality of the discussion. The findings presented in this chapter might explain some of these differences, including why respondents might be satisfied with their contribution, but concerned with the contribution of others and the discussion. It might also explain why the highest level of dissatisfaction was with the quality of the discussion overall. Such an explanation would again speak to the contingency at the heart of DHRs as a relational system because, as Grace (an independent chair) observed: 'No two panels are the same'.

Figure 13

Professional Respondents – Opportunity to Contribute

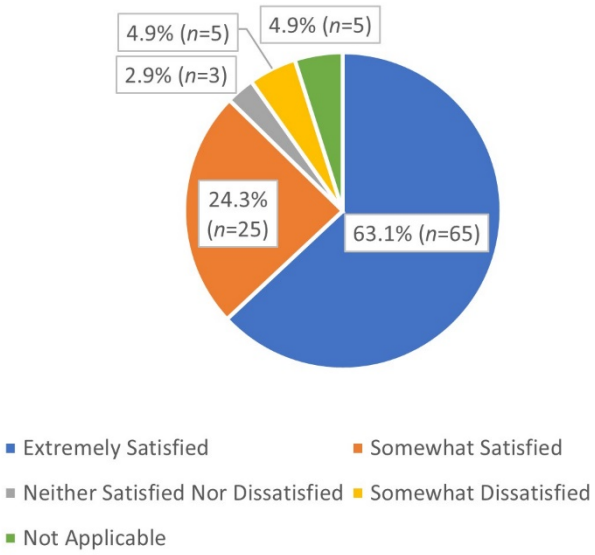


Figure 14

Professional Respondents – Opportunity for Others to Contribute

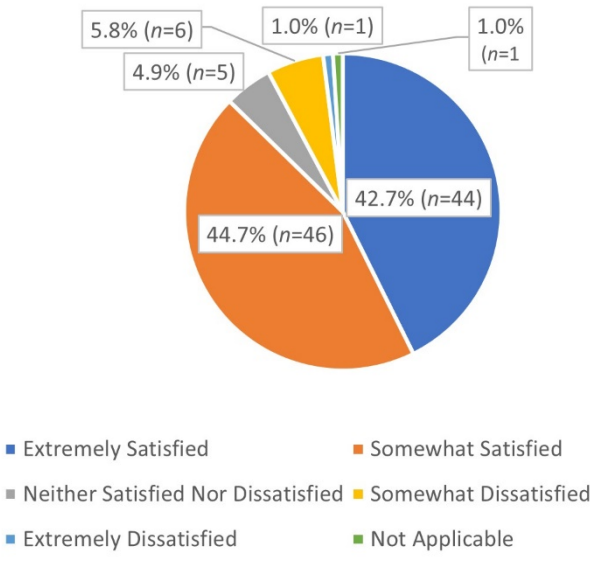
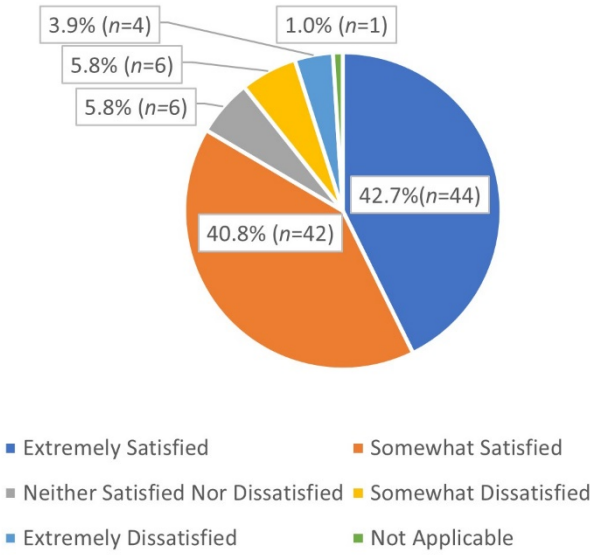


Figure 15

Professional Respondents – Quality of the Discussion



7.5 Conclusion

In this chapter, I have considered use and demonstrated how DHRs are a technology that brings both potential and peril. With respect to DHRs as a relational system, this potential and peril arise from how and if dialogic democracy is enacted. Specifically, the encounter and engagement of stakeholders within DHRs can generate barriers and/or conflict, which in turn, can complicate, impede or disrupt the enactment of dialogic democracy. Critically, this can affect knowledge generation because stakeholders are less willing or able to take part in collaborative use, or the multi-agency space within DHRs is in some way under- or mis-utilised.

Yet, at the same time, participants also recognised that dialogic democracy could be achieved if stakeholders are meaningfully involved, common ground is found, and decision-making is shared. If achieved, this means stakeholders can be part of collaborative use in a DHR, as a bespoke and time-limited manifestation of the CCR, and this can enable the generation of knowledge about domestic homicide.

By approaching DHRs as a relational space, that is attending to them as a social sphere and an ongoing process (rather than a single event), I have shown the need for a considered reflection upon, and engagement with, their doing. This includes understanding how 'right use' is operationalised, and whether the aspiration for DHRs as a site for dialogical democracy is achieved or not. This finding highlights how it is not sufficient to simply promulgate DHRs, make claims as to their purpose, or indeed implement practices to engage participants, gather information, or to seek an orientation toward the victim. It is also necessary to attend to the relationships within DHRs.

However, in this chapter – as in the proceeding chapters – while I have illustrated how knowledge generation can be affected, I have not explored the knowledge generated itself nor how any findings are used and to what effect. Yet, given DHRs' stated purpose, these are critical questions. Moreover, the risk is that DHRs may be limited in this respect. This possibility was suggested by Peter (a review panellist). Despite having high hopes for DHRs, Peter suggested that DHRs might not achieve their goals because, among stakeholders, there was often either an insufficient challenge to victim blaming or a failure to grasp systemic issues that structure the occurrence or response to domestic homicide. Peter also highlighted that 'it's one thing to go through the process, but it's another to then have the desire or the will to make the changes. Or even to perceive of how those changes would make a difference.' To explore this further, in the next and final findings chapter, I consider if and how DHRs achieve their ambition to illuminate the past to make the future.

Chapter 8: DHRs as a Site of (In)Action

8.1 Introduction

> It feels like you are just putting out the [fire] in the back garden and you really need to know that you are contributing to addressing the big problem (Emma, independent chair).

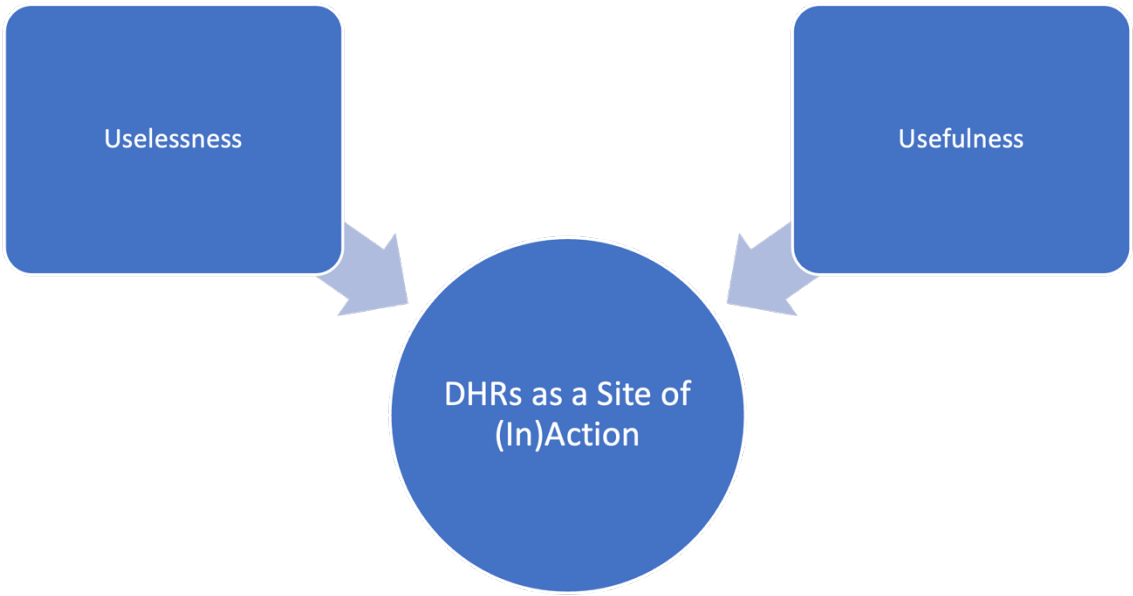
Emma's quote relates to use of DHRs, that is, the outcomes achieved. Emma highlights positive outcomes because actions are taken (by 'putting out' the fire), but also suggests that changes may be restricted (because the 'big[ger] problem' is left unresolved). At a minimum, Emma raises questions about the *nature of the outcomes achieved* and *if, how, and the extent to which DHRs are useful*. Furthermore, Emma's comments point to DHRs' peril as a technology. That is, DHRs might manage the risk a death poses to the state because a concern with 'the back garden' may be, as discussed previously, the result of a narrow/thin perspective that focuses action on individuals within a framework of risk. As a result, a DHR may be a site of inaction because the wider context of DA-related deaths is left unaddressed (Whynacht, 2022).

As discussed in *Chapter Two*, one way to think about how use is structured and structuring is to think of it as a path leading to a particular destination. Thus, by being well-worn, a path can be 'restrictive as well as directive or restrictive by virtue of being directive' (Ahmed, 2019, p. 42). Alternatively, a different path may be taken, perhaps even to a different destination, but this requires effort given its prior lack of use, and indeed this may itself be seen as misuse. This is relevant to DHRs as a technology because the destination reached by travelling any given path is their outcome. Moreover, a journey implies action, given it involves a decision to take one path or another or, alternatively, to restrict or direct the path others may follow. Developing this idea of use, this chapter is organised around the theme of 'DHRs as a site of in(action)' and the two sub-themes of (a) uselessness and (b) usefulness. See figure 16. Thus, this

chapter responds to the titular question Ahmed posed by asking, of DHRs, 'what's the use?' (2019). As with the last chapter, I have chosen to begin with uselessness to recognise the challenges of DHRs' doing.

Figure 16

DHRs as a Site of (In)action



Writing this chapter led me to reflect on how, as an independent chair, *for any given DHR I lead*, I do not routinely know its outcome. Amongst participants, independent chairs reported this too, including Iris and Amelia, with the former explaining: 'there is always that feeling of will it all really happen?' That is because an independent chair's role ends when a DHR report is completed. Instead, participating organisations and the local CSP are responsible for disseminating learning and implementing an action plan in response to any recommendations. (And nominally the family should also be 'invite[d]… to help create… change after the review' (Home Office, 2016b, p. 19)).

Thus, at best, I can only glean a DHR's outcomes. Yet, even from this partial perspective, I have seen how the path chosen in response to recommendations can be symbolic. By symbolic, I mean that sweeping (often pre-existing) actions may be identified, yet these could be best described as giving the appearance of doing something rather than necessarily achieving the desired outcome(s). Conversely, I have seen the identification and delivery of concrete, targeted actions.

My ability to understand outcomes *across* DHRs is also limited. This is something Grace (an independent chair) recognised when she asked of published DHR reports with frustration, 'well, where do I look?'. Both I and Grace's concerns reflect the limited accessibility of DHR reports. Thus, the potential findings of DHRs are less useful because they are siloed.[111] This is compounded by a lack of evidence about the implementation and/or impact of recommendations.[112]

The building metaphor I have used in earlier chapters can help make sense of my experience. As previously suggested, an independent chair is like an architect, given they are responsible for planning and designing a building and then working with other stakeholders to bring it about. Yet, once the building is completed, an architect's role ends. Thus, like an independent chair, they may have no idea as to what happens next, including if the building they leave behind stands up to subsequent use, and indeed whether it is used as intended and by whom (i.e., a DHR's outcomes). Owen (a review panellist) captured this emphasis on the use of DHRs when he referred to the

[111] This was not always the case. Victoria, a DAC, highlighted that 'we obviously share learning on a county basis', while Bobby (a family advocate) highlighted how some CSPs worked together under 'one overarching organisation that oversees all the DHRs'. In this manner, Mia (a DAC) described how CSPs in her area had recently developed a new way of working to share responsibility for oversight, including the identification of themes. However, the issue is that such efforts were dependent on the response of CSPs, which varied, and can at best partially address the absence of a national repository.

[112] As noted in *Chapter One,* and as I will explore below, a national repository and an oversight mechanism are being developed as part of DHR reform.

conditional nature of their 'next phase', which included 'how good the action plan is and how well that's put into place'.

In reporting these findings, it is useful to highlight that, if achieved, any actions taken are the culmination of a DHR. To return to Ahmed's metaphor of the path (2019), in considering (in)action, the question is whether the path taken leads to the desired outcome and, if not, what prevented this. As in other findings chapters, I draw on the interview data (Phase 3). To add to the analysis, I also draw on the web-based survey (Phase 2). As a chapter, the findings build on the previous chapter's initial engagement with the fourth specific research question: how is individual, organisational, or social change understood? It also addresses the fifth and final research question: how are learnings and recommendations produced?

8.2 DHRs and Uselessness

By useless, I mean that the hoped-for outcomes of DHRs are not achieved. Thus, instead of action, 'what usually happens still happens' (Ahmed, 2019, p. 152), i.e., there might be no or only superficial changes to practice, policy, or systems. In this respect, Emma, whose quote opened this chapter, was particularly critical, saying she was stopping as an independent chair 'because I feel a bit burnt out by the whole thing'. Partly this fatigue was because doing DHRs 'just feels a bit Sisyphean really… without the sense that you are making a difference'.[113] In this sub-theme, to structure my discussion of uselessness, I approach DHRs as a *process*, a *product,* and a *system*. This approach enables me to bring together, but avoid duplicating, the findings from previous chapters.

[113] Emma's decision speaks to the emotional labour involved in doing DHR. In effect, Emma had decided she could no longer pay the price. Henry, also an independent chair, anticipated Emma's decision for himself too, saying: 'I think there is a finite shelf life, if you like, with doing this type of work. I think that will probably arise in the next year or two for me. I'll probably say, "enough is enough"'. This is something I recognise from my own practice.

DHRs as a Fallible Process

A first finding with respect to uselessness is that DHR is a fallible process. Sometimes there could be *failure to deliver in part or in full the DHR process* because the path taken was problematic. While this perceived failure could reflect perceptions of DHR per se (*Chapter Four*), it often reflected issues like information quality (*Chapter Six)* and/or review panel dynamics (*Chapter Seven*). Regardless, the result was that knowledge generation was affected. Sophia (a DA specialist) shared an example of a DHR where she felt the learning was incomplete. Sophia reported making repeated attempts to try and 'get to the bottom' of an issue about child residence. However, these had been unresolved, leaving her feeling that 'this is[n't] an accurate reflection [for the] report' (I consider DHR reports as a product below). Thus, the DHR was rendered less than useful because, as a process, it was fallible.

A DHR could fail to be delivered as a process because an independent chair was ill-equipped to lead it, reflecting issues with their experience, skills, and knowledge. Thus, aspects of the process could be *incomplete*. Here, an independent chair might misdirect a DHR. For example, Jade, a DA specialist, recounted a DHR where the independent chair did not provide leadership and stakeholders were 'not really clear what… to do'.

Yet, an independent chair is first among equals, and review panels could also be the cause of a failure to deliver the DHR process, thereby *limiting learning*. As an example, Amelia reported a desire in one review panel to 'make her [the victim] two dimensional'. In Amelia's account, this desire was because of a reluctance to engage fully with the victim's lived experience – what Gordon (1997) has called someone's 'complex personhood' – 'as if, somehow, that removed her victim status'. Amelia felt that review panellists had wanted to sanitise the victim's experience to 'make her more

"worthy"'. Notably, in addition to echoing Christie's 'ideal victim' (2018), this bears comparison to Ferraro's argument that normative assumptions about 'good' and 'bad' DA victims can limit the development of policies to increase safety and well-being (2006). Similarly, Emma recounted a case where 'the perpetrator of record [was] the one who's been killed'. Emma felt that some review panellists struggled to understand the alleged killer's status as both an offender and as a victim, despite many women who kill having experienced DA themselves.[114] As independent chairs, both Amelia and Emma felt that they had only partially resolved these struggles.

Finally, as a process, DHRs could marginalise the family, meaning they might fail to achieve their purpose (both in terms of outcomes, but also in terms of the fulfilment of family's nominally central role as prescribed in the statutory guidance, see Home Office, 2016b). Both Luna and Isabella reported how their relationships with independent chairs were *compromised*. Thus, Luna described how the independent chair had not listened to her concerns and then mismanaged a meeting with the review panel, leaving her feeling respectively marginalised and patronized. Consequently, the learning was less useful because it focused on her loved one's mental health rather than what she felt was important, including evidence of coercive control.

Whatever the cause, these examples demonstrate the potential for DHRs to be fallible if the process is incomplete, limited or compromised. Framed in terms of Ahmed's path metaphor (2019), the usefulness of any actions can be affected if, procedurally, those involved want the quickest and easiest path, resist taking alternative routes that may be more difficult but potentially important, and/or are unconcerned whether all stakeholders joined them on the journey.

[114] For a discussion, see footnote 122.

DHRs as an Imperfect Product

As discussed previously, a DHR report is a product. In the web-based survey (Phase 2), there were high levels of satisfaction with the quality of DHR reports (see Figure 17). To conceptualise a 'good' DHR report, continuing the metaphor of a path, one could think of a DHR report as both an account of the path taken *during* a review, but also a map for those who *come after*, providing directions in the shape of findings from which others might learn or act. Thus, a 'good' DHR report is useful because, in documentary form, it materialises the enactment of dialogic democracy within a DHR and sets out actions to improve DA responses. Encapsulating the doing of DHRs as discussed in the preceding chapters, a good report:

- Reflects the *engagement and involvement of stakeholders*, i.e., it is a manifestation of dialogic democracy because, for Charlotte (a DAC), '… [a DHR report] belongs ultimately to the panel, doesn't it? … it's got to be a collective, what the findings are'. This could include testimonial networks too: Ethan described positively the independent chair's willingness to 'come and sit with us and go sort of go through it [the DHR report]'.
- Enables scrutiny because it is *underpinned by robust analysis*, both of case circumstances and of DA. A good DHR report also represents a victim as fully as possible by attending to Gordon's previously mentioned conception of 'complex personhood' (1997). Thus, Owen (a review panellist) said of one DHR report: 'I think it was [a] fair representation of the challenges they faced. And the lack of opportunities that they had to influence that'.
- Provides the *basis for action*, generating learning or recommendations that can be used. Examples are discussed in the second sub-theme.

However, participants also identified DHR reports can be an imperfect product. Indeed, Iris, an independent chair, felt that the ‘quality of them [DHR reports] needs sorting out’. Key concerns were the quality of individual DHR reports (which could be ‘poor [in] structure and content’, Mia, a review panellist) but also the consequences of their collective variability (because there ‘isn’t a consistent picture at all’, Peter a review panellist). Critically, if a DHR report is imperfect, this can be both because of the path taken during a DHR or its usefulness as a map for what comes after.

Some reported that independent chairs had been *little concerned with the engagement and involvement* of stakeholders. Caroline (a DA specialist) suggested that ‘some authors don't really want the input of the panel… It's almost like a formality’. This was something Bobby (a family advocate) had experienced too, describing CSPs and independent chairs as ‘gatekeeping… access… so, some families [are] being told that they have no right to see the report, they have no right to contribute…’. Even if able to access the report, this was not necessarily a positive experience for family members. Although she had been able to read the report, Isabella described having only a few hours to do so. In this way, any aspiration of collaboration was rendered symbolic. Finally, even if independent chairs were open, there could be a failure to convert the discussions in-room into a documentary form. For example, Louise (a DAC) described discussions of a victim’s experience of isolation but ‘that curiosity was [not] there as much as it probably should have been in the report’. Connecting this finding to earlier discussions, Iris (an independent chair) argued that ‘people need to be not allowed to be DHR chairs if they produce that number of victim blaming reviews’. Thus, this finding is also further evidence of how, as noted previously, independent chairs could impede usefulness.

Sometimes DHR reports were not *underpinned by a robust analysis*. This might reflect process fallibility as already discussed given, as a product, DHR reports could only capture the knowledge generated. Thus, if the independent chair and/or review panel had made specific decisions about process – perhaps because of their understanding of the purposes of DHR, or a lack of knowledge of DA – this manifested in the DHR report. For example, some DHR reports were written 'entirely through agency eyes' (Amelia, an independent chair), meaning there was little/no orientation toward the victim. This meant a victim's own story was *unused*, leaving the DHR report 'a bit dry or, you know, just a list of a series of interaction[s]' (Lily, a family advocate). Alternatively, a victim's story was *misused*. For example, Elizabeth (a DA specialist) highlighted a DHR where everything was an 'examination of the victim's actions' and marked by 'victim blaming language'. This could also leave a family feeling their loved one had been misrepresented. Isabella was frustrated that some agencies had said her loved one was 'aggressive', something she disputed, and which she felt distracted from the perpetrator's actions.

Importantly, in these examples, a lack of robust analysis meant DHRs were less useful because they generated a two-dimensional approach that, at best, was individualising and at worst blamed a victim. In effect, as a map for use by others, DHR reports can be lacking and thus less than useful.

This was linked to the final concern, which was whether recommendations in DHR reports provided a *basis for action*. Ella (a review panellist) described recommendations as being 'very variable'. Participants identified how the development of recommendations and/or associated action plans could be understood to be sites of inaction.

This inaction could be because of the quality of recommendations due to the issues I have already discussed. Thus, Bobby identified there could be ‘loads and loads of very clear missed opportunities and areas for learning’ which were then ‘just… not feeding through to kind of recommendations and action’. Alternatively, if any findings are victim blaming then so are the recommendations because they would reflect a finding that this is ‘just a person's issue and it's not a system [one]’ (Jade, a DA specialist).

However, recommendations can also lead to inaction because of how they are developed. First, participants identified concerns with the SMART method used, as noted in *Chapter Four,* for recommendations and the responding action plan (Home Office, 2016b, p. 22). While the SMART method has been mainstreamed in programme evaluation, Victoria (a DAC) observed, ‘recommendations are an art, aren’t they’. Amongst participants, there was criticism of the SMART method. Thus, Jade (a DA specialist) suggested that action plans were often ‘not creative’, focusing more on outputs (like training) rather than outcomes (like broader changes to professional culture). Alternatively, Alyssa (a DA specialist) felt an independent chair’s lack of familiarity with a local area might mean recommendations were not ‘specific enough’. This finding supports scholarship which has noted the SMART method can be compromised if it is applied without contextualisation to the specifics of delivery and/or treated mechanistically (Bjerke and Renger, 2017). Consequently, a DHR might be a site of inaction because of poor execution.

Second, recommendations can also be less than useful because of challenges with the doing of DHRs. Thus, recommendations might be unambitious because of an attempt to manage the relationships discussed in the last chapter. A lack of ambition could reflect a desire to secure organisational agreement (Neil, a family advocate)

and/or the constraints on individual organisations and bodies like CSPs because, rightly or wrongly, ‘agencies don't want to commit to that because that takes money and that takes a lot of time’ (Jade, a DA specialist). This, in turn – or perhaps because of the level at which scrutiny was conducted – might lead to a focus on ‘bread and butter’ issues like training rather than larger, more substantive actions to address underlying causes (Cora, a DA specialist).

Timeliness too can affect recommendations. This could reflect the time taken, with Joshua (an independent chair) noting that recommendations could become ‘secondary to the process’ because ‘people are fed up with the bloody thing by the time they get to that’. Moreover, recommendations might be superseded, with agencies saying ‘we’re already doing it now. So, we don't need to have it as a recommendation’ (Charlotte, a DAC).[115] Timeliness also related to QA panel functioning. Taken together, Charlotte noted that: ‘if it's one that's happened three years ago, it's, you know, it's lost its momentum.’ Indeed, for Luna, the DHR into the death of her loved one felt like a site of inaction because she saw a lack of ‘realness’ in terms of outcomes, by which she meant the absence of any ‘local impact of any of these changes’.

In summary, as a product, DHR reports can be less useful as a map, both in terms of what can be learnt from a death and any action taken in response. Thus, in Ahmed’s path metaphor, the usefulness of DHR reports can be compromised because the route they marked out did not ‘even scratch the surface’ (2019, p. 153). Consequently, as with the process, the route taken was not all that different from that which had been taken before. In effect, rather than being a counting mechanism that led to change, DHR reports can became a site for ‘busy work’. That is, speaking to their

[115] As an independent chair, my response is to insist that, even if a recommendation is not made, if the change had not been introduced or planned before a death, it should still be discussed in the DHR report to show learning.

peril as a technology, DHRs might be useful as a way of being a conduit of apparent action, while at the same time not fundamentally addressing underlying issues (Gurran and Phibbs, 2015). Importantly, recognising this peril also avoids locating drivers solely at the level of individual stakeholders or any given DHR, a level of scrutiny that, as I have also shown, can compromise DHRs' findings if there is a focus on individuated responsibilisation. Instead, while these findings about the fallibility of the DHR process and its imperfect product are important, participants felt that these issues were systemic.

DHRs as a Constrained System

Participants identified the DHR system as both less than usefulness and a cause of uselessness, with this connecting to local and national oversight (*Chapter Four*). This too could be understood through the path metaphor. Here, the landscape through which a path could be taken and/or cut was the problem. Consequently, echoing Ahmed's account of the restriction and directive potential of paths (2019), the use of DHRs was constrained.

Local Oversight. Many participants suggested DHRs could be less useful due to issues with local oversight. For Leilani (a DAC), a CSP's role was to make sure DHRs were 'acted upon and implemented in a timely manner'. Yet, the capability of CSPs to achieve this was often constrained. Thus, participants reported considerable variety between CSPs, with Margaret (an independent chair) observing: 'it depends on the area and how proactive they are and how organized they are'. For participants, this led to concerns about what happened with any findings.

While many CSPs tried to 'get… [DHR reports] out there and publicize them' (William, a review panellist), numerous participants raised concerns about *publication and dissemination*. First, there was a question of whether DHR reports were published at all. DHR reports do not have to be published if there are 'compelling reasons relating

to the welfare of any children or other persons directly concerned' (Home Office, 2016b, p. 24). Some participants shared examples of this, including Grace (an independent chair) who described non-publication to protect an older relative and Luna (a family member) who had asked that the DHR report into her loved one's death not be published because 'it was thought to be safer' for the children.[116] However, multiple participants reported that, oftentimes, publication and dissemination were problematic. Notably, Iris (an independent chair) felt that sometimes DHRs went unpublished 'for no good reason'. Iris's concern has merit: as discussed in the *Methodology,* nearly a third of the DHR reports in phase 2 could not be found.

Second, DHR reports might simply be published with little or no further action taken.[117] Thus, Isabella (a family member) highlighted how DHR reports were often just put 'on…[a] website' and asked, 'who knows it's there to read?' Isabella's question speaks to a wider ambition for DHRs. While there is no research into the dissemination and/or impact of DHR reports, Peter, a review panellist, noted that 'the public don't know jack shit about DHRs', suggesting that DHRs are underused as a tool to raise awareness and create social change.

Third, publication itself was seen as insufficient. Thus, Emma (an independent chair) questioned the efficacy of DHR reports given their oft length and complexity.

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[116] Some participants expressed a concern that the publication of DHR reports might adversely affect family either because of concerns about publication itself and/or how this was managed. Grace (an independent chair) described publication as 'really stressful for families', not least because – as Victoria (a DAC) noted – 'some families don't want it shared'. Even if families supported publication, DHR reports are identifiable despite a pretence to anonymity (Websdale, 2020; Jones *et al.*, 2022), something William (a review panellist) noted because it is 'not difficult to go on a website and identify which homicide is which homicide'. This left families, like Clare who recognised the value in publication, feeling publication was nonetheless a 'catch 22'. In terms of managing publication, Lily (a family advocate) suggested there could be a lack of 'sensitivity' around publication including not discussing plans with family. Finally, even if family wanted a DHR published, they did not necessarily want this to be available indefinitely. Illustratively, Isabella (a family member) was concerned that the DHR report into her loved one's death remained available online and was frustrated about a lack of communication about when or if it would be removed.

[117] Technically, this is compliant with the statutory guidance which simply sets out a requirement on CSPs to publish DHRs (Home Office, 2016b, p. 24). The statutory guidance does not address dissemination per se (i.e., publication is the sole output).

Consequently, some questioned whether a DHR report was itself useful for a wider audience, something attested to by Isabella who felt the DHR report into her loved one's death was less than useful because it read like a 'legal document… [full of] jargon'. Meanwhile, others suggested more pro-active efforts needed to be made to disseminate learning, with Owen (a review panellist) suggesting there '… has to be more than [publication]'. Yet it was not clear if and how effectively CSPs took these steps. For example, Luna, (a family member), explained she had unsuccessfully argued for the CSP to commission some work to illuminate the findings from the DHR into the death of her loved one. Meanwhile Liam, also a review panellist, provided direct evidence of this failure of dissemination. Reflecting on what a DHR might bring about, Liam noted:

> I've not seen that impact… if I haven't noticed it, it probably hasn't happened. Or if it has happened, it did in a narrow way… You put all that resource into doing it and then you don't drive through the change as the consequence of the learning. The whole point is learning is change and without that, you know?

Taken together, DHRs can be a site of inaction if they are not published and/or learning is little disseminated, thus preventing the achievement of the actions described in the next sub-theme, particularly around increased awareness and/or changed attitudes. Effectively, as a map for what comes after, this meant a DHR as a path to learning ended in a cul-de-sac, *because publication is not the same as ensuring a report is used.* The underlying point is that not everyone comes to the destination in the same way, thus different potential audiences need access to the path in ways that suit them. This raises questions about knowledge transfer and mirrors concerns in other statutory reviews, including into the death or injury of children and adults, where a need for more creative dissemination of learning has been identified (Rees *et al.*, 2021), and it is unclear whether learning leads to change (Preston-Shoot, 2021).

Sometimes the *implementation of recommendations* was linked to inaction. Among participants, there was an understanding that DHRs should and could lead to change. For Maria, a family advocate, change required a 'robust action plan to prevent another tragedy'. However, like many other participants, Maria recognised that 'this doesn't happen in all cases', because recommendations were compromised (i.e., 'watered down' according to Hudson, an independent chair) or were not carried through (i.e., implementation was 'the luck of the draw', Emma, an independent chair).

First, action plans could be *compromised*, perhaps because of limited organisational 'buy-in' (Emma, an independent chair), either from the start and/or in terms of any recommendations. For example, Chloe (a DAC) – who, as described in *Chapter Four*, identified the necessity to negotiate over action plan implementation – said she was not always successful. Moreover, a lack of buy-in could also reflect challenges with resources and timeliness as discussed above.

Second, sometimes action plans were not *carried through*. This was important because, for DHRs to be useful, 'it's not about just making recommendations; it's about actually doing something about it' (Claire, a family member). Such inaction could reflect buy-in as already discussed, but it could also be driven by the extent to which CSPs exercised oversight. As Hazel, a review panellist explained, CSPs needed to be able to go back and ask 'how will you do that? How will you know?' Yet this did not always happen, and Bobby (a family advocate) suggested that this could be because a CSP was 'not invested in the action plan'. As a result, 'actually implementing it… can be quite difficult'. In effect, a lack of local oversight limited action.

In this way, DHRs can be a site of inaction because, as Amelia (an independent chair) noted, this means that – because of inadequacy of publication/dissemination and/or recommendation implementation – a DHR is reduced to 'an interesting diversion

but it's not really going anywhere, is it?' Importantly, this has implications too for family, because, as Lily (a family advocate) highlighted, 'it's hard to have a benchmark' against which to judge success. In effect, the path upon which DHR stakeholders' journey can be interesting but ultimately inconsequential because it leads nowhere or gets bogged down.

While this finding supports a focus on addressing weaknesses in local oversight capability, approached through the prism of use, this also highlights why that is at the same time insufficient. Thus, these findings are evidence of how, in doing DHRs, the investment in their establishment has not been matched by efforts to ensure that they are effectively delivered. Thus, while the statutory guidance emphasises CSP responsibility for 'completing the action plan', their powers are simply defined as being to 'monitor the implementation of the actions set out in the action plan' (Home Office, 2016b, pp. 22–23). This vague requirement has been compounded by the attrition of CSPs' capability more broadly, because DHR implementation in 2011 coincided with a period of austerity. Thus, effectively, despite a national commitment, delivery on the ground has been compromised by funding cuts and policy decisions reflecting a neo-liberal and localist agenda (Ishkanian, 2014). The delegation of responsibility for DHRs to CSPs is perhaps then evidence of what Gilling *et al*. (2013, p. 329) called the third phase of community safety ('localised and devolved'), with the state giving responsibility while also taking away (or denying) capacity and resource.

This broader context of austerity is important too because, as Emma (an independent chair) pointed out, sometimes local areas – including CSPs – 'don't have the money' to act. Furthermore, other changes have also limited the capability of CSPs, notably the introduction of PCCs, to whom significant funding and influence have been diverted (Davies, 2020). Summarising the impact of these changes, Peter (a review

panellist) described how ‘CSPs have been utterly emasculated’ because ‘they’ve got no budget. They’ve got no power’. It is perhaps understandable then that local oversight is constrained because the capability of CSPs is limited, meaning DHR may be rendered less than useful or indeed useless.

This finding is important because it also speaks to the functioning of DHRs as a technology, including how they might, as I suggested earlier, have a symbolic aspect. To understand this, we must also consider national oversight.

National Oversight. Discussing whether DHRs led to change, Iris (an independent chair) pointed out that ‘[CSPs] are just not held accountable for what they’re doing with them’. Here, Iris points to national oversight which, for many, was lacking and a source of inaction, and which contributed to the DHR being less than useable or useful. This meant there was both an overreliance on CSPs to drive change (as discussed above) and, at the same time, a lack of national ownership (underpinned by inconsistent or absent leadership by the Home Office). Consequently, national oversight was seen as leading to – and the cause, in part, of – inaction.

The *absence of a national repository* has compromised learning from DHRs, individually and in aggregate, and participants saw a national repository as essential to share and bring together findings.[118] In addition to affecting individual DHRs (discussed above), this also means findings cannot be brought together to inform practice, policy, and systems. Encapsulating these concerns, Marie (a family advocate) highlighted that the Home Office was ‘sitting on an awful lot of research’. Participants felt the absence of a national repository impeded the usefulness of DHRs, preventing the identification of trends and allowing the duplication of recommendations, because it was difficult to look at the ‘high level stuff… either at county level or national level… [which could be]

[118] As noted in the *Introduction*, the U.K. Government has committed to DHR reform, including developing a national repository and oversight mechanism.

addressed' (Harper, a DAC). In effect, the lack of a national repository reiterated the salience of the quote from Emma (an independent chair), with which I opened this chapter, if one assumes a single DHR or a local CSP is the back garden in which fires were put out.

Participants also identified the extent to which the *DHR system itself was a site of inaction* and, indeed, many felt the DHR system had been neglected. As Bobby, a family advocate, put it: 'I think my concern is that we've been doing these for 10 years now and we are still seeing lots of the missed opportunities repeating themselves time and time again'. Looking forward, participants were also frustrated because, for Henry (an independent chair), 'the Home Office keep talking about that they are working on this, but I don't see it'. Importantly, this was not an abstract issue. Thus, for Joshua (an independent chair), if the DHR system was not working well, it means 'the Home Office is failing victims of [DA]', because DHRs did not consistently lead to action.

This inaction is apparent in many ways, including with the absence of a national repository but also, as documented in *Chapter Four*, DHRs' establishment and framework. However, two key areas dominated participant accounts and were emblematic of the DHR system as a site of inaction: the quality of independent chairs and the lack of assurance of action.

Concerning *independent chairs*, while recognising that appointment was the responsibility of the commissioning CSP, there was a sense that the Home Office had an unfulfilled enabling and enforcement role. For enablement, participants wanted to see the Home Office take proactive steps to ensure the quality of DHRs, something Henry (an independent chair) described as focusing on 'consistency across the piece' by addressing variability in independent chair quality. This was something participants felt had been lacking given the absence of any sustained or substantive efforts around skills

and knowledge (*Chapter Six*) or, as discussed with respect to DHR reports, continued underperformance by some independent chairs.

Concerning the *assurance that DHRs led to action*, first, this related to assurance about CSP oversight. Elizabeth (a DA specialist) was critical that the DHR system was operating without 'direction', given the Home Office was not 'using the weight of central government to really get local authorities to change their practices'. This included the ability to look across CSPs and address underperformance through what Bobby (a family advocate) described as the 'sharing [of] good practice'. Second, there was a sense that the Home Office had a 'reluctance' (Leilani, a DAC) to act as a clearinghouse for national recommendations. This was a recurring frustration, with participants describing limited responses to national recommendations. The Home Office was implicated because sometimes it was the target of recommendations but also because there was no mechanism to seek assurance from other U.K. government departments and/or public bodies. Referring to the inaction at this level, Victoria (a DAC) described the uselessness of this attempt: 'we write a letter… saying, "what about this? what about that?" You know, we usually get some trite answer back.'

As with CSPs, we might use the metaphor of the path again. Here, perhaps it would be more apt to say that national oversight has, to date, only intermittently strayed onto the path and, at other times, has become lost.[119] Thus, national oversight has been less than useful. Yet, more critically, while this may be understood and experienced as uselessness, in fact this may be why DHRs are useful as a technology. In this respect, DHRs might be delivering their intended function. This is something that Ahmed has described as 'nonperformativity' (2019, p. 153), which is when something either has no effect or it is used precisely to avoid an effect (Ahmed uses this to understand why

[119] In saying this, it is important to recognise the commitment of many of those involved, both in the Home Office and in the QA panel, and the issue is perhaps a lack of capacity. See *Chapter Four*.

diversity policies may stake out certain ambitions but, in doing so, hides a lack of intention to enact changes).

Collectively, these issues with local and national oversight – and DHRs as a process and a product – reflect the research base, where it remains difficult to demonstrate the impact of DHRs (Payton, Robinson and Brookman, 2017; Jones *et al.*, 2022). Thus, this sub-theme provides further evidence of the complexity and tensions with and within DHRs, including the extent to which they generate action. However, I interviewed participants before the publication of HM Government's *Tackling DA Action Plan* (2022), and so they were unaware of the proposals for DHR reform. Yet, nonetheless, the findings here are of note. Specifically, participants wanted improvements, suggesting there will be a positive response to DHR reform. However, the Home Office has ground to make up. As Claire, a family member, talking about the response to domestic homicide generally observed: 'it always seems to me that they are two steps behind where they should be.'

8.3 DHRs and Usefulness

Despite concerns about their usefulness, DHRs can lead to action. This is an important finding given, as noted previously, the limited evidence of impact. Indeed, Elizabeth (a DA specialist) suggested that DHRs 'probably achieve lots of things on lots of different levels, actually'. Elizabeth's reference to 'levels' aligned with participant accounts of individual, organisational, system, and societal level actions. Across these levels, use can be bifurcated between action that was focused on *professionals/agencies* or *victims*. This bifurcation is partly an analytical artefact, and, in practice, these foci overlap. However, recognising this duality is important because a focus on professionals/agencies can be at the expense of a victim's experience. This is a risk inherent in the DHR system including, as I have previously argued, in its policy

foundations (Rowlands, 2022a). Finally, action at these different levels can occur together and separately. Returning to the path a DHR might take, these findings are important because they speak to the possibility of multiple destinations.

It is important to note that the findings here are accounts by participants and are not, for example, the findings of a process evaluation. Thus, the evidence here about usefulness is, as is often the case with review, anecdotal (Websdale, 2020). This means a key question about review systems like DHRs is unanswered, with this exacerbated by the absence of a requirement to report on, or mechanisms to track, change (Jones *et al.*, 2022).[120] Thus, as for review generally (Chanmugam, 2014), DHRs' impact is unclear. This is an important finding because, viewed through the prism of use, an inability to evidence impact necessarily limits the extent to which a case for the usefulness of DHRs can be made.

Enabling Personal Victories

DHRs can trigger actions that lead to individual outcomes. The possibility of individual action, regardless of wider impact, is important. Ahmed has noted this possibility in the context of higher education diversity work, whereby diversity workers 'make do with what is available to them' and act as 'institutional mechanics' by using a system to achieve an outcome or indeed by achieving an outcome regardless of the system (2019, pp. 147, 156). In DHRs, this might mean there is a path to an individual outcome(s) regardless of if and how the wider DHR system facilitates or impedes this.

For professionals, DHRs can lead to improved *understanding*. Hudson, an independent chair, described how stakeholders could gain an improved understanding of

[120] There has also been little evaluation of the DHR process, although some findings were recently reported in a master's thesis, which used FOI requests to follow up on a sample of DHR and the recommendations made for agencies (Robinson, 2021). Despite study limitations, including nil returns by some agencies and a subjective assessment of changes, this study was a valuable demonstration of one way to evaluate the extent of changes brought about by DHRs.

'who does what… and the limitations and the capabilities of different agencies and in different systems and partnerships.' Sophia recognised this too, emphasising her improved understanding of other agencies, but also – given her senior role within a specialist DA service – that DHRs were 'a chance to look inward'.

In these examples, usefulness was focused on professionals/organisations. However, DHRs can also be useful for individuals with a focus on victim/survivors. Thus, professionals might leave with a greater understanding of DA and victim experience. For Leilani (a DAC), stakeholders left with 'a greater understanding… of what [DA] is', potentially changing their thinking about victim/survivors. As an example, Sophia (a DA specialist), described how an independent chair had said a DHR had involved the 'steepest learning curves', which she felt related to a positive change in attitudes towards a victim with a particular lived experience. In part, this change was driven by challenges by Sophia and a colleague, illustrating specialist services' leadership role.[121]

Regardless of their focus on professionals/organisations and/or victims, DHRs can be useful because understanding can also lead to action in terms of *practice*. Here, Peter (a review panellist) emphasised the potential impact of practices to achieve an orientation toward the victim (as discussed in *Chapter Six*), which he hoped meant professionals:

> Strongly empathize with the victim and think, "Ok. I'd never want myself to be in that position. I don't want anybody else to be in a position. How do we prevent individuals from getting into that position again?"

Peter's example also demonstrates that while action can be bifurcated between a focus on *professionals/agencies* and *victim*s, this division is not discrete. Echoing this

[121] As discussed, I do not identify the specific case circumstances for reasons of confidentiality.

potential, Victoria described recursive usefulness in her role as a DAC (which further underlines the leadership provided by such posts). Victoria said she was useful in a DHR because she understood 'how things play out in practice and how these services work'. In turn, Victoria's ability to support the CCR was assisted by her participation because she gained an 'amazing snapshot into how agencies work and how individuals experience agencies'.

Thus far, I have discussed how DHRs can be useful for professional stakeholders, identifying how this can be focused on professionals/organisations and/or victims, and trigger changes to both understanding and practice. Taken together, Neil (a family advocate) captured this potential for action when he reflected that: 'at the end of the process, there is some learning in the persons who took part in it, so they can bring that to their work'. Using the metaphor of a path, this means perhaps in future professionals might take a different route with respect to their work.

However, DHRs can also be useful to testimonial networks, specifically families. Perhaps understandably, family action was focused on victims, with Hudson (an independent chair) describing this as a concern with a loved one's 'legacy'. Such concern speaks to how bereaved families may seek to ensure that something comes from death (Scarth, 2016). Thus, as for professionals, DHRs can be useful because they led to improved understanding, and paralleled changes in professional practice too.

In terms of improved *understanding*, DHRs were a way of 'helping families understand what happened' (Emma, an independent chair). Importantly, this was not simply a transfer of information. It was, in part, the outcome of a family's role in DHRs. Thus, Amelia (an independent chair) emphasised that one outcome might be that 'a family member can read and understand that logic governing the decisions [of organisations]'. This is evidence of what Mullane has emphasised is the importance of

families being part of the whole DHR process (2017). Indeed, this sense of DHRs as useful because they can be a site of action structures the role of family advocates. Illustratively, Bobby described how ‘our role is to make sure that the family's views and questions are answered’. Such an outcome was evident in some family accounts too, with Claire describing how ‘[the DHR] did give me answers to a lot of things and I suppose it made me recognise more of the signs and things as well’. In other words, the DHR was useful because – like professionals – it increased Claire’s understanding of what happened.

Improved understanding can also be useful to a family because it enables sense-making about a death. This can trigger action more broadly, paralleling changes to professional practice, in terms of a family member’s *sense of self as a co-victim* and/or *the achievement of some goal* (Armour, 2003). This sense-making could be cathartic. Many professional participants expressed ambivalence about this possibility because of concerns about the potential impact on family, including the risk of re-traumatisation (i.e., being reminded of loss, during participation in the DHR itself, or if they learned new information) or if they were unsatisfied with the outcome (i.e., while a DHR might answer their questions, it may not always be able to do so, or not to their satisfaction). Nonetheless, while accounts of family experiences and choices varied, participants recognised a potential therapeutic outcome if DHRs were done well. Dylan (a review panellist) and Ethan (a family member) both described this in terms of ‘closure’. Catharsis was not the only possibility, however. Isabella (a family member) did not feel her experience had been cathartic (‘I wouldn’t say it’s part of my recovery’), but her participation nonetheless led to a new sense of self in which she took on the role of a defender (‘I would describe it as standing up for my [loved one]’).

Finally, individual use can extend to include action vis-à-vis the state. For example, DHRs could be used to help ensure support for any surviving children (Margaret, an independent chair), or with the hope of influencing a coronial inquest (Luna, a family member).

In summary, DHRs can be useful because they can lead to action through improved understanding and/or changing practice (or for family, a change in sense of self and/or the achievement of some goal). However, while these individual outcomes are important, they are nonetheless only personal victories. As such, they can be paradoxical because, alone, they are insufficient. Thus, as Ahmed points out, while we might use what is available to achieve an individual outcome, we might be 'trying to transform the institutions that employ us' (2019, p. 195). Making this connection, Hazel (a review panellist) explained that her motivation was that 'I can't save that person anymore, but how can I save the next person?' This idea of wider transformation speaks to organisational change.

Driving Organisational Changes

DHRs can also bring about action as organisations started 'looking at what they had done in a different way' (Emily, a review panellist). As a result, DHRs can be useful because they prompt *intra-organisational* change with, Isabella (a family member) describing action to address the 'key areas that [organisations]… missed out on or needed to improve on or develop on'.

In striking contrast to the magnitude of a domestic homicide, several participants identified organisational change (including to practice or policy) as prosaic. Neil, a family advocate, described DHRs changing 'little things in organisations that they hadn't realised were going wrong. As an outcome, these smaller challenges may seem insufficient: Victoria (a DAC) acknowledged that it 'feels a bite trite' to suggest

'changing some procedures is in honour of that person's death'. However, many participants felt that such changes were important not just for the individual outcome but also for their accumulation. That is, DHRs can be in part useful as a site of action because they lead to the accumulation of gains. Returning to the metaphor of a path, this then is useful because repetition – the possibility that learning(s) are identified and action(s) taken – can mean each DHR in turn deepens an existing path or helps to further open a new path.

These included actions on *practice and policy* which, for Chloe (a DAC), meant DHRs were useful because they enabled agencies to say these 'are the six things we can do differently' (e.g., Chloe identified changes to case management systems or processes for assessing risk). Notably, Claire, a family member, identified this kind of change as significant too, reporting her satisfaction with changes to police call logging.

While positive, these actions were largely professional/agency focused given they concerned changes to practice and policy. Yet, participants also identified how DHRs might lead to action to improve organisational response to DA victims more specifically. Such action could relate to how professionals worked. Here, Ella (a review panellist), shared how the police changed their practice relating to male victims because a DHR identified that:

> … although he was clearly the victim, they ended up doing a [risk assessment] with her and treating her as the victim and him as the perpetrator. So, there was quite... quite a strong… element of learning around men as victims.

This is significant, given the evidence of the barriers that (here heterosexual) men can face in disclosing DA (Huntley *et al.*, 2019).[122]

[122] Albeit this is not necessarily straightforward given the gendered nature of DA, e.g., some men who call the police may be an abuser (Hester, 2013). This has consequences too for domestic homicide. E.g., a male decedent may have been an abuser. In these cases, the perpetrator of the homicide is simultaneously also the victim of domestic abuse, potentially killing in self-defensive or retaliatory violence (Lysova and Salas, 2020). To capture this distinction, the DVFR system in Aotearoa New Zealand examines both the

Concerning policy, Sophia (a DA specialist) explained that DHRs could be a way of interrogating effectiveness. Sophia gave an example of a policy in a health care setting which required staff to routinely ask about DA. However, she felt the policy's operationalisation had failed to take account of a victim's specific needs because, if a victim had been asked and had said 'no', their non-engagement could be used to justify no further action because 'we did everything we [could]'. For Sophia, a DHR was an opportunity to challenge this policy to ensure it was 'inclusive of all potential victims'. This is significant, given evidence of the barriers to the identification and response by health care professionals, partly because of inadequate training (Hudspeth *et al.*, 2022). This possibility reflects findings elsewhere, e.g., Barlow and Walklate (2021) have demonstrated how the implementation of risk assessment tools can lead to a procedural, incident-based focus to the detriment of victim/survivors needs. Giving a specific example of the action that might be taken, Amelia (an independent chair) described how an improved understanding of the needs of Eastern European victims in one DHR led agencies to act in terms of policies concerning that community.

Training could also be an outcome, with Claire (a family member) reporting with some satisfaction that 'I know they are putting a lot out there now, so.... in [local area] they are making awareness of it and training within services i.e., police'. Importantly, while training could be procedural (perhaps addressing more generic changes in practice and policy) it could also be victim focused. Thus, Iris (an independent chair) suggested that DHRs could identify where an understanding of a victim's lived experience was missing. Iris's point was that this could enable, reflecting the potential complexity of the best ways to respond (Devaney *et al.*, 2021), the

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death event (involving a deceased person and an offender) and the abuse history (which may reveal a predominant aggressor and a primary victim) (Family Violence Death Review Committee, 2017).

recognition that ‘you need that bit more understanding of how someone might present and how some might behave’.

Taken together, these findings evidence that DHRs can be useful in promoting action by organisations, with this being important given a multi-faceted response is needed to enable victim safety, including addressing the structural barriers that arise from existing organisational responses (Storer, Rodriguez and Franklin, 2021). However, without dismissing the value of such actions, returning to Emma’s opening quote, these could also be examples of fires in the back garden that are put out while bigger problems remain unaddressed. Thus, calls to recognise the potential role of health providers in terms of DA have been long standing (National Institute for Clinical Excellence, 2014), while police responses have consistent weaknesses, albeit with evidence of improvement (HM Inspectorate of Constabulary, 2014; HM Inspectorate of Constabulary and Fire & Rescue Services, 2019). Moreover, a criticism of DHRs (and other review systems) has been that the same recommendation is made repeatedly and there is a lack of tracking of change over time (Jones *et al.*, 2022), something Cora (a DA specialist) was frustrated by, observing the same recommendations are ‘still coming up’ (I return to this below).

In addressing organisational action, I have, as with individuals, drawn attention to the potential difference between a focus on professionals/agencies and victims. Iris (an independent chair) explained why this division is important:

> I would say over the course of the seven years of doing DHRs, the discussions that we are having at panel meetings have moved from "ok you need a pathway" or "you need to be doing risk assessments" or "you need to do this, or get training"… it's a bit more nuanced almost, about saying "Well, you have got a response, but your response now needs to take account of the trauma impact of abuse on some victims".

Here, Iris draws attention, on the one hand, to evidence – beyond DHRs – of the improvements in the response to DA (Devaney *et al.*, 2021). Yet, on the other, she also

highlights how the apparent commitments to better respond to DA, which have in part enabled these gains to manifest, do not necessarily meet the needs of victim/survivors (Aldridge, 2021). This paradox was captured by Victoria (a DAC) when she observed: 'It feels like we have moved on, but it [also] doesn't feel like we've moved on'. I address this paradox, which Cora, Iris and Victoria articulated in different ways, at the end of the chapter. Nonetheless, participants believed DHRs could be useful in bringing about organisational action, through the honing of practice and policy, particularly if this meant a greater focus on victims rather than professionals/agencies.

However, the actions taken by individuals and organisations do not occur in a vacuum. Thus, Mia (a DA specialist) identified that, in respect of recommendations, a key development was a CSP quality assurance group that oversaw their implementation. This leads to the next level at which DHRs could be useful.

Evaluating Systems

As described by Victoria (a DAC), system change could be understood in two ways. The first concerned multi-agency and partnership working, i.e., the CCRs' operation. The second related to the DHR system and the extent to which it was able to trigger action. (This mirrors the distinction drawn by Jones *et al.* (2022) in their systematic review of review systems recommendations). I address the CCR here, having already addressed the DHR system.

Among many participants, there was a sense that DHRs enabled a perspective on the CCR, which Jade (a DA specialist) suggested could facilitate 'blue sky thinking, and fundamental systems change', which is 'just so difficult to do when you're more on the front line'. In this way, Louise (a DAC) felt DHRs were useful because, by facilitating collaboration, as discussed previously, they could also trigger action by helping agencies 'realise… we can't work in silos'. This could be useful for families too

because, in the same way that organisational change was important, so too was systems change. Thus, Marie described how 'CSPs taking on board the recommendations' benefited families because 'it's always good for the family to see this and feel the DHR process and emotional impact was worth it as there has been real change'.

These examples could also be expressed through the metaphor of the path. Here, a new path leads to a different outcome because it enables evaluation or new ways of working, and this is further evidence that DHRs can be useful. However, while DHRs can lead to *strengthened multi-agency and partnership working*, as with other levels of action, this could be focused on either professionals/agencies or victims.

Concerning professionals/agencies, DHRs enable an examination of ways of working, with Hudson (an independent chair) explaining that 'I'll talk to [the review panel] about how we use the practice issues that may or may not have arisen to highlight system issues behind that'. Thus, system change addressed *inter-agency* practice, policy, and training. Illustratively, Hudson described a dispute between children's services and the police about information sharing. Demonstrating the leadership role of the independent chair – and, as discussed previously, the risk that a focus on professionals/agencies could distract from broader questions – Hudson explained how he had worked to turn the focus to the underlying issue. This, he felt, was different agency interpretations of the same guidance, and ultimately the DHR made a recommendation to address this. Other participants shared examples of action to resolve referral pathways between specialist DA services;[123] improve joint working between mental health and probation services; address case transfer arrangements

[123] This was in response to what Margaret (an independent chair) described as a 'very complicated referral system', which she attributed to unhelpful commissioning decisions.

between boroughs; and the links between the police and immigration authorities.[124] While these changes were useful, they were procedurally focused because the paths taken led to outcomes that were of interest to organisations.

However, system change could also be focused on DA and victims specifically, thus ensuring all possible paths are identified and explored. For example, as discussed in the last chapter, Louise (a DAC) said that learning had been identified for mental health services in a DHR, despite some initial resistance. Specifically, a staff training gap was identified, and this was then addressed in partnership with specialist DA services. Thus, the DHR elicited an organisational and a system response by laying the ground for joint working.

Others identified thematic actions. In an example provided by Chloe (a DAC), a DHR identified differences in the understanding of protective orders, an issue that can lead to considerable difficulties for victims (Bates and Hester, 2020). As a result, a recommendation was made to develop a more consistent response to protective orders. Meanwhile, Iris (an independent chair) described a case involving family members which highlighted how local responses were geared towards IPH. This is something the analysis of DHRs has also demonstrated (Bracewell *et al.*, 2021). The result, Iris said, were recommendations that will 'make a difference locally to how services are responding to family situations of DA.'

DHRs can also *drive investment*. While investment could be agency specific – e.g., William (a review panellist), described his police force rolling out new victim safety equipment following a DHR, and others identified recommendations around funding for specialist DA and led-by-and-for services – I include it here because most

[124] In this example, given by Henry (an independent chair), improved joint working may have detected an abuser sooner. Yet, cooperation between the police and immigration authorities is a double-edged sword, particularly for those with insecure immigration status (Day and Gill, 2020).

examples reflected multi-agency and partnership working. For example, Charlotte, a DAC, highlighted how a DHR had recommended the introduction of Health-IDVAs.[125] Moreover, to sustain this provision, DHRs across the region were used collectively to 'keep the momentum' in terms of longer-term funding.

DHRs can also seek to bring about national actions. For example, Emma (an independent chair) highlighted that recommendations could be broader than a locality because 'sometimes you can see that local authorities just don't have the power to make the changes that need to happen. Or they don't have the money.' Yet, almost universally, participants reported little change in this respect, echoing the point I noted in *Chapter Four* about the potential limits of CSPs' authority and speaking to the Home Office inaction noted above.

In summary, DHRs can be useful as a driver for actions to improve systems, with either a professional/agencies or victim focus. This can be taken as evidence of DHR potential usefulness as a means of ongoing feedback or (quasi) evaluation of the CCR (Payton, Robinson and Brookman, 2017; Rowlands and Bracewell, 2022). It is possible then that, returning to the idea of DHR reports as a map for learning and action, DHRs can usefully drive change.

Affecting Society

Some participants also talked about societal level action, which Emma (an independent chair) explained meant 'the general population learns something'. However, this level was largely victim-focused and was coded least commonly. This was perhaps because participants saw social action as potentially greater than any given DHR could achieve, that is, something that individual DHRs could not be used for.

[125] Health-IDVAs are specialist DA workers based in health settings like Accident and Emergency Departments. These roles are an example of a systems response because their success is contingent on multiple factors, including joint working between a health trust and a specialist DA service (Dheensa *et al.*, 2020).

Indeed, Peter, a review panellist said that some review panels took a view that ‘it’s too much of a problem for us to be tackling on a local basis’, which he felt was a ‘defeatist attitude’. However, this may also reflect differences in emphasis in DHRs, including understanding of purpose.[126] Nonetheless, societal action was seen as important.

Iris (an independent chair) captured this distinction when she said: ‘So, I think there are two facets for me, both telling the story [linked to action at a societal level] and saying: "this is what needs to change" [linked to the previous levels]’. Meanwhile, Amelia (an independent chair) described DHRs as being a way of memorialising the dead: ‘one of the unacknowledged functions of the DHR is to honour the dead. To honour our fallen’. In both these examples, Amelia and Iris located their attempts to centre victims within a culture where DA has traditionally been marginalised (Bjørnholt, 2021). Thus, Amelia referred to how DA-related deaths often ‘escaped notice’ and suggested that, for her, DHRs – along with other efforts like femicide observatories (Walklate *et al.*, 2020) – were one way to account for these deaths. Similarly, Iris (an independent chair) suggested that domestic homicide victims are ‘brushed under the carpet’, reflecting what she felt was their often-invisible status in life, where they were ‘not… “innocent victims”, because they knew their perpetrator’. In making her argument, consciously or not, Iris enunciated the concept of an ‘ideal victim’ (Christie, 2018), a status which can be unachievable for a DA victim because of their intimacy with an abuser (Meyer, 2016).

Accounting for the dead is linked to societal change because it meant DHRs might trigger action. Thus, participants – including DACs like Leilani and Harper – described societal change in terms of increased awareness. This was something family

[126] There is limited evidence relating to this issue specifically, although what have been described as ‘community wide changes’ are the least common recommendations from DHRs/DVFRs (Haines-Delmont, Bracewell and Chantler, 2022). In the U.S., Reif and Jaffe (2019) reported DVFRs often place varying emphasis on the need for training and awareness, including among the public.

members felt too, with Claire saying she wanted her loved one's story 'out there', explaining that this was useful because it was about 'raising the awareness… real stories… cases… people'. Significantly, for Claire, this was not solely about professionals or the community, it was also a response to the media portrayal, supporting suggestions that DHRs can be used to challenge forensic narratives of domestic homicides (Monckton-Smith, 2012). Albeit, while DHRs may be used by family following a death, it is important to recognise that this use also sits within the growth in, and potential tensions from, victim testimony in social policy (see: McGarry and Walklate, 2015).

Regardless of whether one or both dimensions are the outcome, this means that DHRs have the potential to useful in efforts to address DA. This has two dimensions relating to awareness and then pathways to help and support, reflecting findings reported elsewhere (Jones *et al.*, 2022). At an individual level, DHRs can potentially bring about an improved understanding of DA, albeit the emphasis may be on society at large. Neil, a family advocate, described how 'the family *and the community* may receive a degree of education' [emphasis added]. Lily, a family advocate shared an example of this, noting a campaign following a DHR involving the victim's family was something 'tangible'. Additionally, DHRs can potentially also raise awareness about sources of support, so ensuring people – DA victim/survivors, and those around them – know where to go. This was what Hudson (an independent chair) described as 'broadening the understanding of what the landscape is out there to support victims and perpetrators'. Awareness raising could also take the form of new or alternative help-seeking or reporting routes. For example, Grace (an independent chair) described an initiative to develop community-based reporting sites.

In summary, DHRs can be useful and, in reaching one or more destination, might trigger individual, organisational, system, and societal level action. These findings suggest then that DHRs have the potential, like DVFR generally, to lever change (Storer, Lindhorst and Starr, 2013; Jones *et al.*, 2022), including improving understanding and professional practice (Robinson, Rees and Dehaghani, 2019) and (inter) agency working (Stanley, Chantler and Robbins, 2019).

These findings also add to existing approaches because the identification of different levels of change expands on existing approaches to measuring impact, given the limited extant literature has often focused on categories of change (e.g., the systemic review by Jones et al. (2022) reported on five categories of recommendation in terms of DVFR/DHR: Training and Awareness; Service Provision, Resources, Prevention Program; Communitywide changes). This is most significant for individual and societal change and builds on studies that have addressed organisational and system change in review (Storer, Lindhorst and Starr, 2013).

8.4 Useless or Useful?

Bringing together these two sub-themes, the usefulness of DHRs was mixed. Thus, while DHRs – as a process, product, and a system – are not always useful, they can at the same time be used to effect action across several domains. This mixed picture is not surprising given any actions generated by a DHR are the end of what, in preceding chapters, I have demonstrated is a system and process marked by complexity and tension.

This finding is supported by the web-based survey (Phase 2). Here, professionals were asked about their satisfaction with the outputs of the DHR process, including the quality of the report (Figure 17) and, regarding the possibility for the levels of action detailed above, the learning generated (Figure 18) and recommendations

(Table 19). Notably, levels of satisfaction with the DHR report and the quality of the learning were high, totalling 76.7% (*n*=79) and 78.6% (*n*=81) respectively. Reports of dissatisfaction were not more than 10%. However, there was a small but noticeable fall in satisfaction with the recommendations, which was defined as 'whether you felt the recommendations… addressed the learning', with total satisfaction being 68% (*n*=70). Levels of dissatisfaction also rose to over 10%. While this suggests that most respondents are satisfied with the DHR process in terms of its capacity to generate action by identifying and capturing findings and then producing recommendations, notably there was nonetheless a level of concern.

Figure 17

Professional Respondents – Quality of the DHR Report

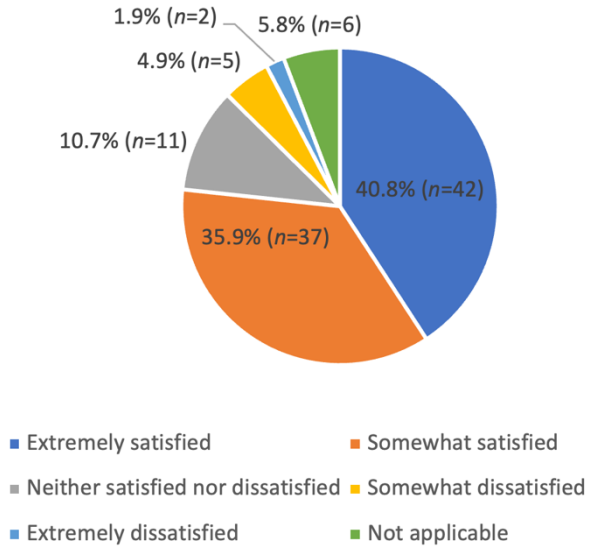


Figure 18

Professional Respondents – Quality of Learning

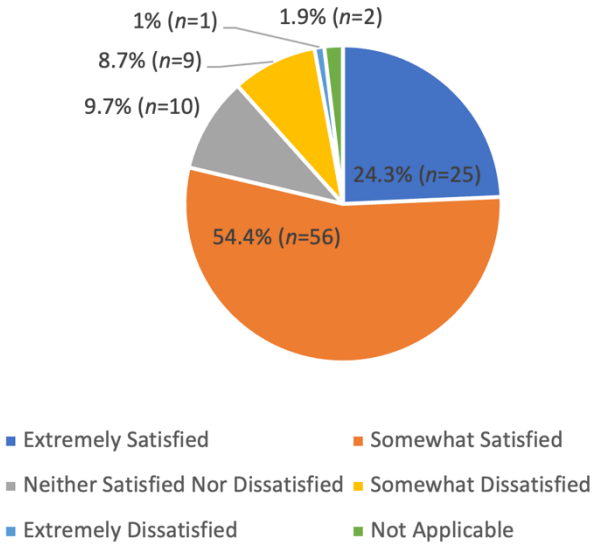
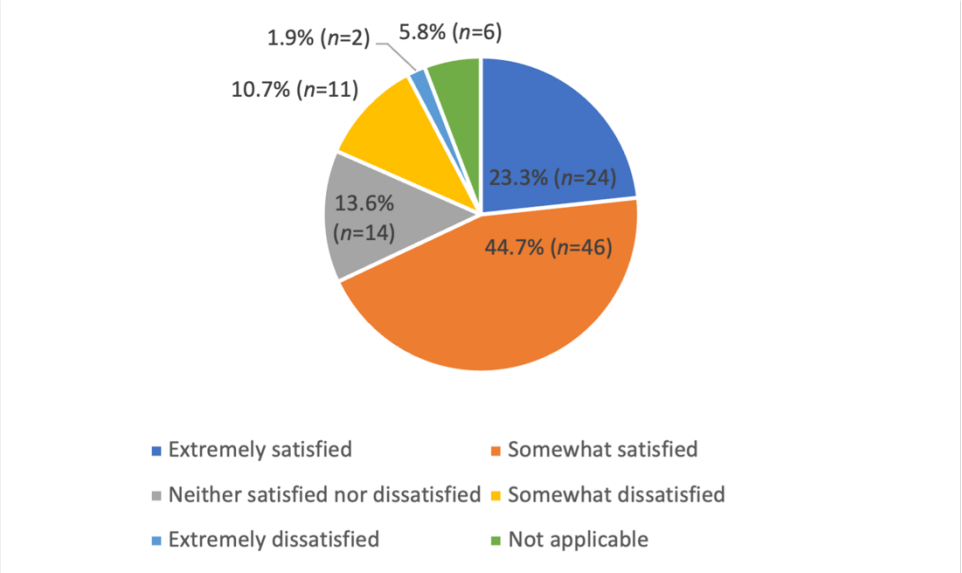


Figure 19

Professional Respondents – Quality of Recommendation



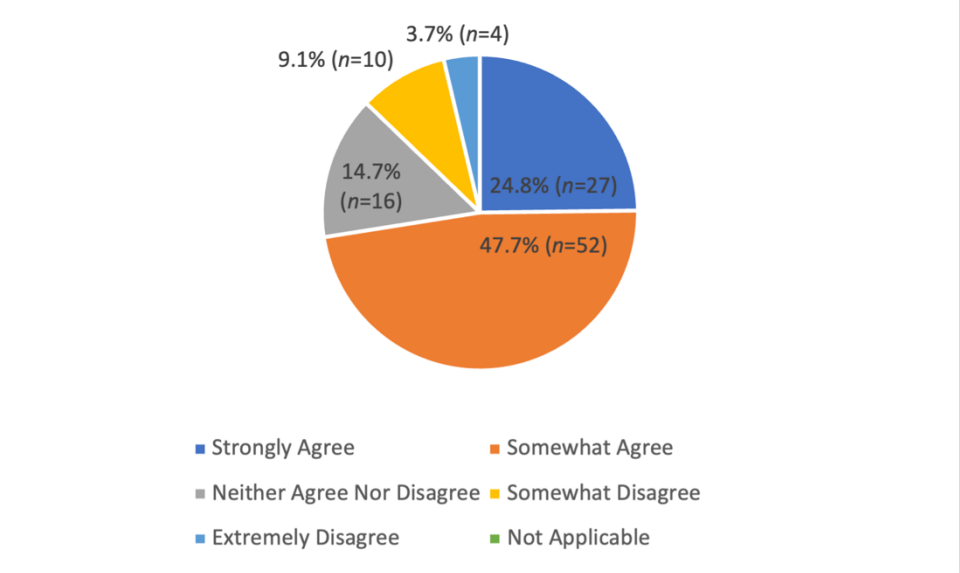
These concerns about the quality of DHR outputs may reflect the impact of some of the complexities and tensions discussed in the preceding chapters. Additionally, these concerns may also relate to the recommendations themselves if

respondents did not feel these could or would trigger action. Thus, issues with what was used and how may therefore comprise the extent to which DHRs are useful.

Providing further evidence of this mixed picture, concern about the outcomes of DHRs was also evident in respondent answers to questions about whether DHRs lead to improved understanding (Figure 20) and help and support (Figure 21) and/or prevent future homicides (Figure 22).[127] As these questions included reflections on the DHR process as a whole, these data include professional and family respondents. Notably, there was a downward trend in terms of agreement, with this falling from 72.5% (*n*=79) for improved understanding, to 64.2% (*n*=70) for improved help and support, and to 54.1% (*n*=59) for the prevention of future homicides. Together, these concerns about output and outcomes speak to what changes DHRs brought about, that is, to their use.

Figure 20

All Participants – Improved Understanding



[127] If I were to do this research again, I would have asked about future DA-related deaths. This change reflects my more explicit consideration in this thesis of deaths other than homicide in DHRs.

Figure 21

All Participants – Improved Help and Support

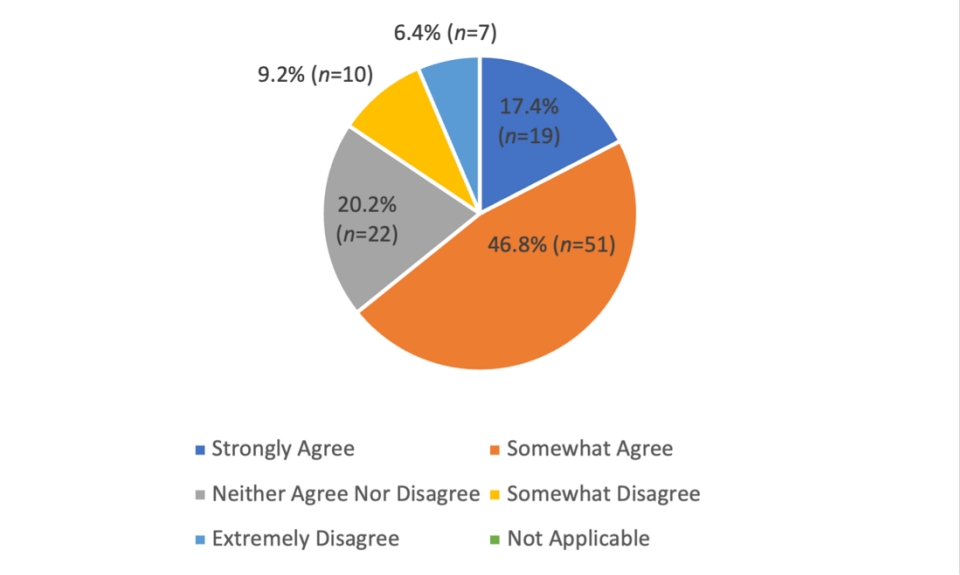
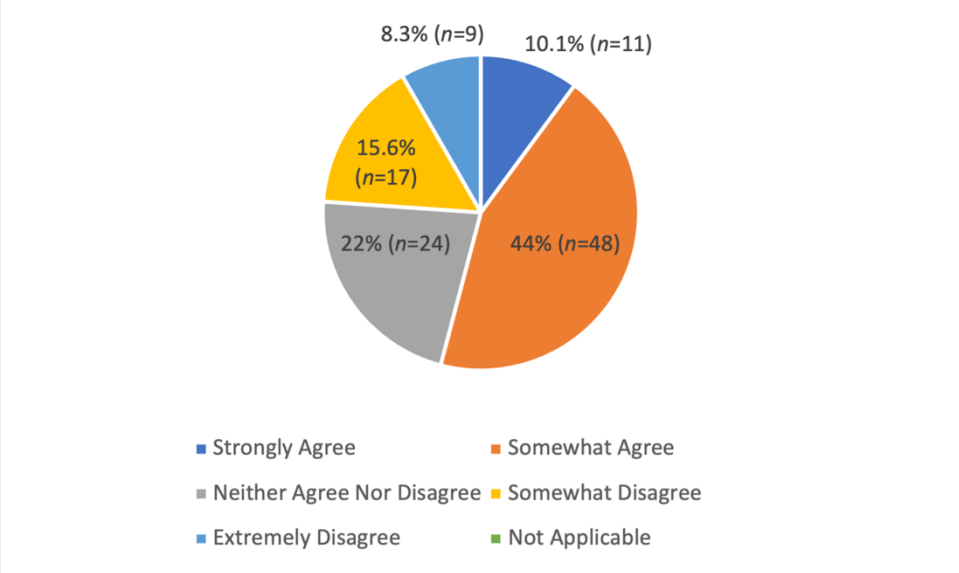


Figure 22

All Participants – Prevention of Future Homicides



8.5 Conclusion

In this chapter, I have explored DHRs as a site for (in)action. I demonstrated that DHRs can generate action, and thus have considerable potential as a mechanism to bring about change. However, DHRs can also be less than useful and, because of the

complexities and tensions with and within them, be a site of inaction. In effect, returning to my building metaphor, despite the efforts that go into DHRs, what happens thereafter is not a given, including if the building left behind stands up to subsequent use, and indeed whether it is used as intended and by whom. Victoria, a DAC, captured the resulting sense that DHRs were not as useful as they could be when she reflected: 'It feels like there's a massive resource there that isn't being properly used at the moment'.

This then is further evidence of the perils of DHR, showing how, as a technology, DHRs can be limited or constrained. Importantly, returning to the issues first explored in *Chapter Four*, for many participants, the absence of Home Office leadership was a driver of, and itself evidence for, inaction. Thus, as a statutory review system, DHRs are not necessarily able to bring about change.

However, there was also the recognition of the possibility of action, which could come from the within the DHR system itself. As Luna (a family member) observed, 'my hopes are that some of the learning from the DHR are not just the agency learning, but the learning from the actual process'. As noted above, DHR reform is therefore an opportunity to address some of the complexities and tensions explored here.

Chapter 9: Conclusion

9.1 Introduction

> ISABELLA: There are a lot of questions. A lot of unknowns. So, I was fighting... I was trying to find a way to win. Trying to find a way to get some justification for [my loved one].
>
> RESEARCHER: I see.
>
> ISABELLA: So, I found the process of the DHR for me was part of that fighting mechanism I had in me.

I start this final chapter with Isabella's quote because what she had to say as a family member is emblematic of the complexity and tension that I have demonstrated exist with and within DHRs. This complexity and tension mean that, as a technology and in use as a counting mechanism, DHRs are a source of potential and peril. Isabella expresses DHRs' potential as a way of answering 'a lot of questions' about her loved one's killing and so achieving 'some justification'. Yet, Isabella's experiences also demonstrate DHRs' peril. Thus, as discussed across previous chapters, for Isabella, the DHR into the death of her loved one was problematic procedurally (e.g., in terms of her encounters with the independent chair, opportunities to contribute, and concerns about perpetrator involvement), and in terms of outcomes (e.g., she was unhappy with some findings, and was also uncomfortable with how the findings had been shared). Isabella's account resonated with me because, as an independent chair, such an assessment would leave me feeling that I had not been useful or, in some way, had mis-used her contributions. Isabella's account then leads us back to use, including what DHR is for, what is used by and in DHR, and how DHRs are themselves used.

9.2 Contribution to Knowledge

To date, DHRs have largely been seen as a positive development and a means of responding to DA and enabling prevention by identifying gaps in, and making changes to, practice, policy, and systems. As part of this, DHRs have also been understood as offering some solace to testimonial networks and to be a way of telling a victim's story. I share these aspirations as to what DHRs could be for. Moreover, in this thesis, I have provided evidence that, at times at least, these aspirations are achieved. However, by approaching DHRs as a technology through the prism of use (informed by Ahmed's (2019) analysis), I have also explored the doing of DHRs which, as a counting mechanism, have until now been largely a black box. As a result, in addition to providing evidence of DHRs' potential uses, I have explicated the genesis, sustainment, and consequences of their peril, both as individual case examinations and as a system. I have also shown how this potential and peril arises because of the complexity and tension with and within DHRs and how, in turn, this can compromise knowledge generation. While the limitations outlined in *Chapter Two* mean my research is not generalisable, through a mixed methods approach, I have generated a rich and nuanced dataset that has made an original contribution to knowledge and opened new avenues for inquiry. Each findings chapter has addressed a different aspect of use and has been based primarily on data from interviews (Phase 3) and, to add depth, data from published DHR reports (Phase 1) and a web-based survey (Phase 2). In summary:

(1) *Establishing DHRs:* While a statutory basis ensured that DHRs *became available for use*, I have found that it has not provided a stable foundation. I have also shown how this instability is compounded by a less than robust framework for delivery because of, despite the efforts of many of those involved, limits to the efficacy of

local and national oversight. Consequently, and perhaps unsurprisingly, I have demonstrated that perceptions of DHRs' usability and usefulness are mixed.

(2) *Visions of DHR*: I have found that there are multiple ways of understanding *what DHRs are for* and that these different purposes – spanning collaboration; accountability; family as integral; telling the story; and making change – are interconnected and reinforcing. However, I have also shown how this plurality of purpose is not always achieved and, if one purpose is not achieved, others can be affected or be at cross-purposes. Together with their less than stable foundations and framework, I have argued that this means the conditions are in place for variability in the doing of DHRs.

(3) *Practices of DHRs*: By examining what is *used by and in* DHR, I have explicated the practices of DHRs, including the engagement of stakeholders, the gathering of information, and the steps that can be taken to seek an orientation towards victims. I have demonstrated how these practices are essential in doing DHRs but, in their delivery, are multi-faceted. Critically, I have found that there are impediments to delivery that can affect the extent to which these practices are useful in providing the materials needed to do DHR and thus affect knowledge generation.

(4) *DHRs as a relational system*: I have shown how DHRs are *useful* as a site of dialogic democracy. Yet, I have also found that, because DHRs are a collective endeavour involving multiple stakeholders, dialogic democracy can be difficult and contested in practice. Thus, while dialogic democracy is possible, its enactment is not always (fully) achieved. As with the previous findings, I have also shown how this affects knowledge generation.

(5) *DHRs as a site of (in)action*. I have demonstrated that DHRs are not always useful because they sometimes became a site for inaction because of the complexity and

tensions in their doing as a process, as a product, and in terms of their efficacy as a system. The result, I have argued, is that DHRs can be less than useful or, at worst, useless. Yet, at the same time, DHRs can be a site for action, with this potentially operating at multiple levels, meaning DHRs may be useful in myriad ways. In short, the use of DHRs is as contested as understandings of what they are for and what is used by and in them.

Taken together, the complexity and tension with and within DHRs shape their doing and affect their findings and impact. First, as individual case examinations, DHRs can be rendered less than useful. I have shown that the resulting peril is significant: the learning generated might be constrained – drawing on a formulation by Walklate *et al*. (2020) and Websdale (2010) – because a DHR is *narrow/thin* rather than *wide/thick*. Consequently, DHRs' potential to account for individual DA-related deaths can be underused and, at worst, mis-used. Both these types of use focus learning on individuals, de-risk agencies, or deliver a process rooted in crime control and/or which objectifies the dead. Such under- or misuse is to the detriment of learning but also to stakeholders, not least the family, and the story told about a victim and their death.

Second, I have also shown the peril posed by the relative neglect of the DHR system since its introduction, which has compromised its usability and usefulness. This neglect is most manifest in the weakness of stewardship of the DHR framework (e.g., in ensuring the statutory guidance is robust, as well as the functioning of the QA panel), and what has been absent (e.g., a national repository). This neglect over time – what Ahmed refers to as a 'continuity of… use patterns' (2019, p. 184) in terms of how power operates – is also evidenced by the fact that these perils are well known. This is demonstrated by the frustration I have reported from stakeholders, but which has not been addressed over the first decade of DHRs' existence. A critical reading of this

neglect is that this is evidence of an unwelcome use of DHRs. That is, the establishment of DHRs was useful because it served a symbolic purpose but was thereafter not sufficiently a priority to guarantee the commitment of time and resources to ensure the DHR system remained useful. Collectively, these reflections highlight the fundamental peril of DHRs, which is that they may be useful to the state because they are a means of being seen to respond to domestic homicide while simultaneously containing it.

Yet, just as importantly, there is also considerable potential with and within DHRs. This is because DHRs can be a site for action. Thus, DHRs – individually and collectively – can be used to achieve collaboration and accountability, during which testimonial networks (principally family) are seen and treated as integral, while also telling a victim's story and making change. Most notably, the achievement of these purposes can be despite the complexity and tension I have explicated, and in the face of system neglect described above. Such achievement speaks to the hope and ambition that is implicit and perhaps necessary within this work.

Throughout this thesis, I have drawn on a building metaphor for two reasons. First, I have found it to be a valuable heuristic device to explicate use. Second, it speaks to my practice experience as an independent chair. In summary, while every DHR has similarities, reflecting their shared foundations and framework, each is unique in its doing because it is anchored in time and place by the death of an individual. Moreover, each DHR is also unique because of how it is planned and laid out, constructed, fitted out and then used, not least because of the effect of power. The DHR system too has been built, albeit as I have addressed, there are many questions about its stability, doing, and efficacy.

Beyond its explanatory potential, the use of a building metaphor has a broader symbolism. This is because domestic homicide is a fatal manifestation of DA, which

itself is often associated with the home. Thus, the title of the influential account of the opening of the first refuge for women and children escaping DA in 1971 in Chiswick, West London, was '*Scream quietly or the neighbours will hear'* (Pizzey, 1974).[128] Yet, feminist scholarship has transformed DA into a public concern (Bjørnholt, 2021), doing so by challenging the 'protective cover' offered by the home and thus opening up to examination that which was previously private (Liem and Koenraadt, 2018, p. 1).

In the same way, by approaching DHRs as a technology through the prism of use, I have drawn attention to, and partially removed, the protective cover under which DHRs operate. Consequently, I have corroborated and added to the work of others – including Boughton (2022) and Haines-Delmont, Bracewell and Chantler (2022) – in unpacking DHRs as individual case examinations and as a system. However, by approaching DHRs as a technology through use, I have also developed a new conceptual framework through which to understand the operational, discursive, and symbolic practices at play. This has also enabled me to answer my overarching research question about how DHRs operate as a technology to generate knowledge. Finally, I have a researcher-activist identity. This thesis has meant I have been 'working *out* [DHRs] as well as *working on* [them]' (Ahmed, 2019, p. 3). As a formulation, 'working out/on' captures the duality between my practice and research. Thus, I make a further contribution by demonstrating the role researcher-activists can play, not least because such an identity calls for both the production and mobilisation of knowledge (Hale, 2008) (I respond to the latter in the next section). There is a long tradition of DA researchers with a deep relationship with practice (Hague, 2021), and so in this respect,

[128] Erin Pizzey has since rejected a gendered based view of domestic abuse and is thus a 'highly problematic foundational figure' (Simic, 2020, p. 111).

I am not unusual. However, my contribution as an independent chair affords a unique perspective from inside the black box of DHRs.

9.3 Implications for Policy, Practice, Research, and Theory

What Next for Practice?

The key implications for practice relate to how the stakeholders involved in DHRs can be useful, and how DHRs are themselves useful and can be used. First, by advancing our understanding of the tensions and complexity with and within DHRs, I have shown the risk of losing focus on the victim to whose death a DHR is a response. *Thus, I recommend that it is essential to recognise that, in the same way each death is a unique tragedy, so each DHR, to meet its fullest potential, must be used to craft a unique response*. To enact this recommendation, returning to Back (2007), we might ask everyone involved to engage in the imaginative act of thinking of the victim as next to them. In doing so, each participant might ask their imagined interlocutor what they should seek to achieve in the doing of *their* DHR and then whether the subsequent DHR is useful both in terms of the story told and any action taken.

Second, *I recommend those who are identified as stakeholders and engaged in DHRs must understand how they can be useful and to what uses a DHR can be put.* This includes ensuring that professional stakeholders do not treat DHRs as business as usual and that testimonial networks (particularly families) are assured an equal status. To achieve this recommendation, support is essential, be that training for professionals or advocacy support for testimonial networks. In providing this support, practice could also be improved by ensuring that all those involved in the doing of DHRs have an opportunity to engage in a 'reflective conversation with the situation' (Schön, 1983, p. 268). Such a perspective allows both the recognition of aspirations for DHRs while also providing an opportunity to consider any tacit assumptions and practical limits.

Reflexivity is, of course, demanding. It requires both time and space to be undertaken, and it is ongoing. However, reflexivity would bring much about what DHR is for, what is used by and in DHR, and how DHRs are themselves used, into view. This would enable those involved to work individually and collectively to reduce the risk of DHRs becoming a 'cursory, convenient, and statistical' mechanism (Websdale, 2005, p. 1199).

Alongside this, greater attention must be paid to the appointment of independent chairs; the constitution of a review panel (including specialist DA and led-by-and-for services); and the engagement and involvement of testimonial networks. Thus, third, *I also recommend that CSPs take steps to provide more rigorous local oversight for DHRs, both with respect to components of the DHR process but also, like individual stakeholders, by being reflexive as to how useful their oversight has been and what might need to be sustained, developed, or changed*. This recommendation would help ensure DHRs are useful. Of course, CSPs require the capability to do this, which may be lacking, both because of the demands generally on them (and the community safety teams that underpin them) but specifically on DACs (who are, in fact, sometimes absent). This thesis then adds to the recognition of the important but often unsung role of CSPs and DACs and the necessity of ensuring they have the resources required to provide local oversight. Such dedicated capability is also necessary to ensure CSPs can develop and monitor action plans. I also address this in respect of policy shortly.

Finally, while such reflexivity is sometimes already happening, this is not consistent, either in terms of individual practice (e.g., by independent chairs) or between areas (e.g., between CSPs). In speaking with participants, it was evident that many wanted the opportunity to talk about their experiences and discuss DHR practices. In other words, there is demand for a space to discuss how DHRs are and can be used and what this means for stakeholders. Thus, I *recommend opportunities to share learning*

from DHRs, both in terms of their doing and their findings, are developed. There are positive steps in this regard, including the establishment of AAFDA's DHR Network, which brings together professionals involved with DHRs.[129]

What Next for Policy?

Practice does not exist in a vacuum and is dependent on a supporting policy framework. I have demonstrated how the policy framework to date been both lacking and neglected, affecting the useability of the DHR system, and contributing to the under- and misuse of DHRs. It is welcome that policymakers have belatedly recognised this and made proposals for DHR reform, as detailed previously (HM Government, 2022). More broadly, measures like a role for the DA Commissioner for England and Wales (and perhaps PCCs) may bring greater rigour.

However, while reform is welcome, as proposed it does not address the underlying challenge around the capability of CSPs to usefully provide local oversight, as discussed above. This concern about capability also relates to how CSPs (and perhaps also PCCs) will meet the new demands that will come from these proposals, including servicing the oversight mechanism that is being established by the DA Commissioner. Also unaddressed is the question of how to meet the cost of DHRs, particularly as more deaths by suicide are reviewed. Thus, first, in terms of policy, *I recommend that national government should look to better support, equip, and fund CSPs (and PCCs) so that they have the capability to fulfil their oversight function*.

Moreover, DHR reform proposals are overdue and unambitious (Rowlands, 2022a), and it is striking what is excluded. At a micro-level, the focus on independent chairs continues to prioritise a single, overarching figure (Boughton, 2022). Ensuring independent chairs can be useful in so far as they have the skills, experience, and

[129] https://aafda.org.uk/dhr-network.

knowledge to fulfil their responsibilities is important. However, this prioritisation must not be at the expense of actions to support the equally important but more diffuse wider stakeholders who are involved in and useful to DHR, not least review panellists and testimonial networks. Thus, mirroring the practice recommendation, second, *I recommend further consideration about how to prepare and support those involved in DHRs*.

More broadly, the proposals to establish a national repository and an oversight mechanism are promising. Depending on their final form and delivery, a repository (the Home Office) and an oversight mechanism (the DA Commissioner) could enable a marked improvement in our ability to ensure DHRs in aggregate are both used and useful by helping disseminate case-specific learning; identifying local, regional, and national trends; and ensuring action is taken. However, these measures do not address the need to evaluate the functioning of the DHR system (Robinson, Rees and Dehaghani, 2019; Rowlands, 2020a; Boughton, 2022; Jones *et al.*, 2022). This is a critical step, yet one that has not yet been grasped by the U.K. Government, meaning the running in this respect has largely been made by the scholars responsible for the literature cited in this thesis and to which my findings add. Yet, as important as these scholarly contributions are, they cannot alone address some of the key questions that need to be answered for the DHR system's future. To sustain the DHR system, as a final policy recommendation, *I recommend that action is taken to ensure that we understand if and how DHRs are useful*. This means evaluating impact, including the contribution to the CCR and responses to DA more generally (Storer, Lindhorst and Starr, 2013; Montanez, Donley and Reckdenwald, 2022). There may also be valuable learning from other statutory review systems in the U.K that could be used to inform how DHRs are delivered in the future (Robinson, Rees and Dehaghani, 2019). Examples that may be

relevant to DHRs include changes to reviews into the serious harm or death of children in terms of methodology (Fish, Munro and Bairstow, 2008), to adults in terms of questions like how we ensure that review systems drive meaningful, sustained action (Preston-Shoot, 2021), and deaths in custody with respect to family satisfaction (Tomczak and Cook, 2022). Meanwhile, the introduction of DHRs in Northern Ireland, and their planned introduction in Scotland, means these nations may benefit from the learning for good and ill of over ten years of DHRs in England and Wales. In turn, the implementation of DHRs in these nations may generate learning that is relevant to England and Wales. Finally, in Wales, the progress and impact of the SUSR will be of great importance.

What Next for Research?

As discussed throughout this thesis there is a developing DHR scholarship, and this has begun to explore stakeholder experience of DHRs, notably concerning review panel functioning (Haines-Delmont, Bracewell and Chantler, 2022); the experience of family and wider testimonial networks (Rowlands and Cook, 2022); the functioning and impact of the QA panel (Boughton, 2022); and the development and impact of recommendations (Jones *et al.*, 2022). My findings have added to this literature. Yet, more needs to be done and *I recommend further work on all these areas, as well as research into if and how DHRs lead to increased awareness among professionals and agencies, but also the wider public.*

However, I have also been critical of how researchers have often undertaken secondary analysis of DHR reports with little consideration to their doing. In this thesis I have provided evidence of the interpretative layers that shape the findings of DHRs (Rowlands and Bracewell, 2022). Considering this, *I recommend that researchers critically engage with DHR as a contingent process and product.*

Nonetheless, there is an ongoing need to use DHRs to understand domestic homicide. This includes ongoing work to understand the profile of those who are killed or die, those who are ultimately – as (alleged) abusers – responsible for these deaths, and the death event itself (Chantler *et al.*, 2020; Chopra *et al.*, 2022). Additionally, addressing examples I have identified throughout this thesis but which I have not been able to fully explore, this should also include using DHRs to consider intersectional perspectives, not least to better understand the commonalities and differences between the experiences of different populations (Jaffe, Scott and Straatman, 2020b). Linked to this, a key limitation with this study, and one of my biggest regrets, is a failure to reach a more diverse range of respondents and participants within the web-based survey and the interviews, despite attempts to ensure a wide dissemination of the initial web-based survey. Building on the work of Chantler *et al*. (2022), *I recommend examining these different perspectives on the DHR system, including how stakeholders experience use within and of DHRs, as a key area for further research.*

What Next for Theory?

To date, DHRs/DVFRs have primarily been conceptualised as a way to achieve a culture of safety, with an emphasis on individual and collective accountability and no-blame learning cultures (Websdale, Town and Johnson, 1999)**.** Where review has been theorised, looking inward, this has been as a site for dialogic democracy (Websdale, 2012) and, when looking outward, contextualised regarding the risk society (Neil Websdale, 2020), and/or feminist perspectives (Sheehy, 2017; Dawson, 2021).

By approaching DHRs as a technology through the prism of use and drawing on Ahmed's analysis of the same to do this (2019), I have developed, built upon, and extended these existing conceptual and theoretical accounts. Importantly, by thinking from use, I offer a way of examining how DHRs generate knowledge about, and then

materialise, very different ways of understanding DA-related deaths and our individual and collective response to them. As a way of approaching DHRs, my approach can inform future theorisation about reviews systems. It will hopefully also encourage those engaged in research to attend to the DHR system as a technology. With this in mind, and building on my previous recommendation for research, *I recommend researchers reflect on their role in reproducing problematic elements of the functioning of DHRs if their findings are used uncritically.*

A Tentative Logic Model

Following Ahmed (2019), I have shown how use is structured and structuring. Moreover, in tracing different aspects of use, I have delineated the operational, discursive, and symbolic aspects of DHRs as a technology, and the potential and peril in the use of DHRs as a counting mechanism. In short, as a technology, DHR's effect is varied. As Cook has pointed out in terms of family experiences after fatal violence, this effect goes beyond the death of a loved one because once the stories of the lives lost enter the public sphere they can 'take on lives of their own' (2022, p. 149). While this may have positive implications, it may also mean these stories can be used in unintended or unwelcome ways. My concern is that despite the plurality of purpose of DHRs, in practice, the goal of preventing DA-related death exerts a disproportionate influence. In other words, the origins of DHRs, as a means to identify risk factors in a risk-focused policy framework – what Walklate and Hopkins described as a 'locked in' response (2019) – I fear, locks us into instrumentalism about what DHRs are for, which, in turn, could occlude other purposes and impede their doing. This possibility is something I have identified as having informed my choice of thesis title because I have come to recognise that implicit within it is a focus on learning about risk and on preventability. Both are, of course, important purposes. However, the consequence of

this framing is that, perhaps, other potential purposes are understood as associated benefits (not primary goals) or are not understood as a goal at all. Yet, DHR is a mechanism that can be of use to *all* victims, including survivors and those victims who have been 'perpetually silenced' (Lodge, 2020, p. 274), given they might lead to improvements to practice, policy, and systems and tell a victim's story.

To engage with these possible purposes, Ahmed's analysis of use offers a final boon because she also identifies the potential to dismantle particular ways of use, and in their place 'widen the routes' (2019, p. 196). In this way, Ahmed suggests that even if something offers only a narrow route, a queer use – by which she means the use of something in a way that was unintended in terms of how something can be used and by whom – is still possible, calling this 'queer use as coming after' (2019, p. 200). For Ahmed, this queer use can be achieved through a release of existing potentiality.

What might a release of potentiality with and within DHRs look like? To answer this question, I offer a tentative logic model that might more adequately speak to the aspirations for DHRs as a mechanism to account for DA-related deaths. This tentative model is inspired by my research and practice, and offering it here is a way to conclude the dialogue between these two aspects of myself through praxis and, moving forward, bring together practice, policy, research, and theory.

I have realised, in reflecting on my experience of clinical supervision, that a recurring aim in my practice has been a desire to contribute toward justice for victims. I have also, in finalising this thesis, recognised that the idea of justice re-occurs throughout my data, although I did not specifically code for it. As I noted in the *Methodology*, if 'feminist work is justice work' (Olufemi, 2020, p. 12), and should DHRs lead to injustice, then it is possible to reimagine their doing. Thus, a concern with justice might also speak to what I introduced in the *Methodology* as a widened ethical

lens. This idea, based on the work of Clark and Walker (2011), challenges those researching victimisation to avoid narrow or formulaic approaches, and instead adopt a 'pluralistic spectrum of approaches' to avoid the risk of exploitation (2011, p. 1503). In the context of DHRs, I suggest that a pluralistic approach to justice might have merit.

To engage with the ideas of what justice might be in this context – how DHRs might, as a mechanism, be useful for victims and, by proxy, their loved ones and broader society – I draw on the findings from a research project which investigated how 'justice' is understood, sought and experienced by victim/survivors and practitioners (Williamson *et al.*, 2019). The project – data for which included the analysis of 251 interviews with victim/survivors – aimed to inform policy and practice in terms of what a victim-focused justice response would look like. The project generated a model of what justice means across 10 aspects of a victim/survivor-focused justice, operating on two axes: the individual to macro/systemic, and process to outcome. Broadly, these could be delineated into 'justice as process' (recognition/being believed; agency/voice; fairness/equality of process;) and 'justice as outcome' (protections from future harm; accountability; affective justice;[130] reparation; empowerment; social transformation; fairness/equality of outcome).

The project's findings resonated with me because they capture some of the potential and peril that has run through this thesis. My tentative logic model identifies inputs to, as well as the outputs and outcomes from, the DHR process, framed by their contribution to procedural or outcome justice. To be developed further, my model would require engagement with the different aspects of what a victim/survivor-focused justice would address. This seems achievable because my findings speak directly to these aspects, e.g., that one outcome of a victim/survivor-focused justice would be

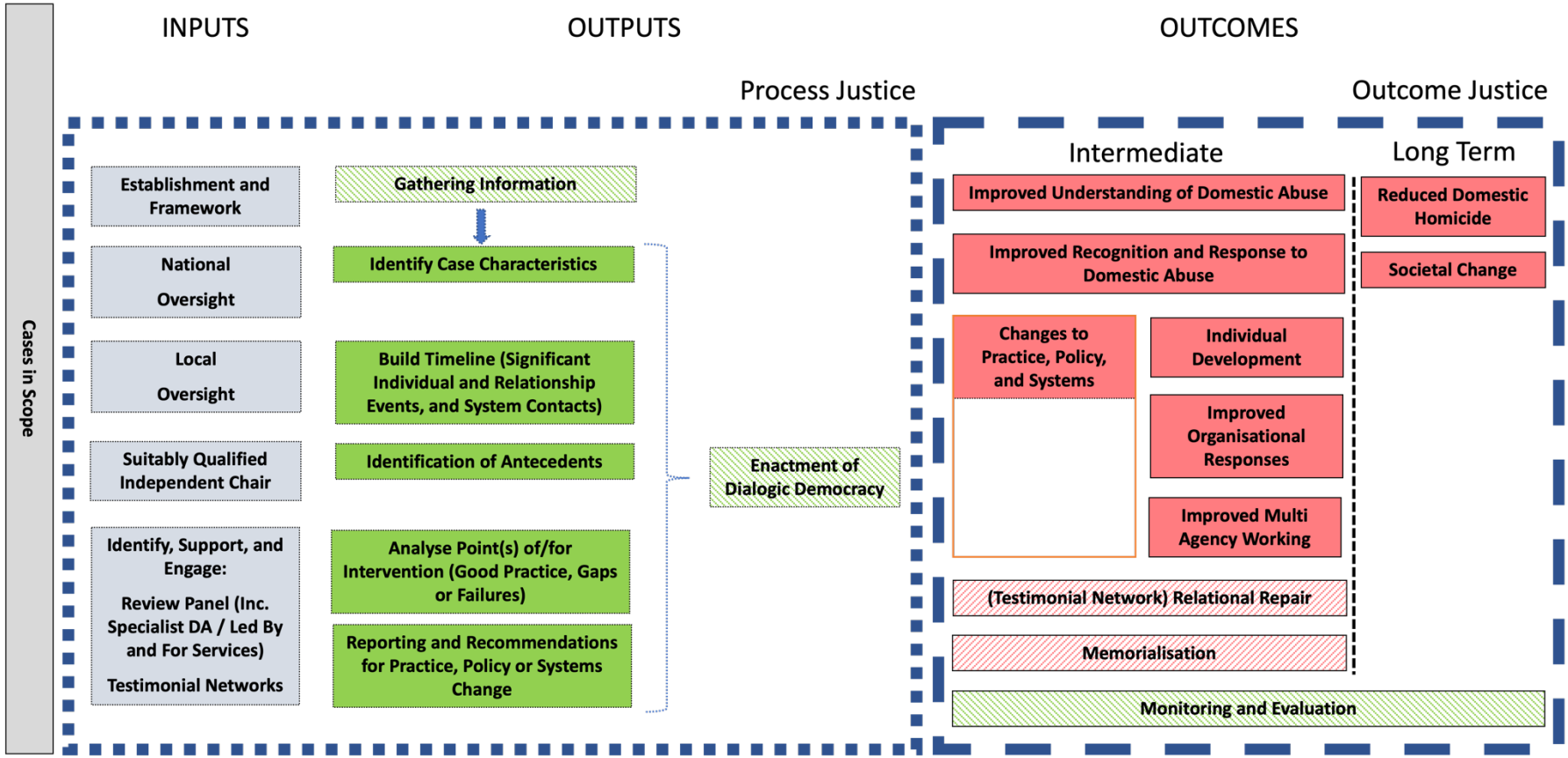
[130] The sense or feeling that justice has been done.

accountability. Meanwhile, other aspects could be readily mapped onto other findings that I have reported, e.g., procedurally, a concern with agency/voice and fairness (process) might speak to the issues about the perceived role and experience of testimonial networks in terms of how they are used. Meanwhile, affective justice could encapsulate family experience as to whether they feel the DHR process has been useful.

By basing this model around justice, I hope to centre victims. First, pragmatically, that is because these aspects of justice are those that have been reported as being of concern to victim-survivors. Second, a focus on justice encourages a questioning of each aspect of DHR – as a process, product, and a system – in terms of what is used, how, and with what effect. In other words, justice might encompass the different ways of thinking about use that I have discussed in this thesis. My final contribution to knowledge then is a logic model, as set out in Figure 23, as a basis for further research.

Figure 23

DHRs as a Mechanism for Justice



9.4 Conclusion

My findings have implications for efforts to learn about and respond to DA-related deaths. In concluding, I return to the beginning. In the *Introduction*, I reflected on the sociological questions of death, and the application of these questions to domestic homicide. I also considered my path to involvement with and concern for DHRs. In response to both these questions and my concerns, I have sought to better explicate DHRs. Ironically, for me, the outcome of that effort is that the passion and concern that have marked my practice experience remain. This is because in this thesis I have articulated both the potential and peril of DHRs. To summarise my findings, the potential of DHRs is their capacity to make sense of DA-related deaths, including a victim's experience and telling their story,[131] and then seeing this used – individually and collectively – to bring about change. Yet, DHRs' peril is that they are a product of a process and a system that is less useable than it should be, and which can misuse those involved and, as a product, be little or ill-used.

This continuity speaks to the contradictions at the heart of any technology, given it might both enable knowledge/power and so objectification but also resistance. Perhaps, in concluding, the lesson is that DHRs will always be – as Emma (an independent chair) suggested – a Sisyphean task. First, and without diluting a perpetrator's accountability, implicit in a DHR is our collective failure to prevent death. Second, in doing DHR to try and address this failure, the very absence of the dead subject, as well as the process of using their death to make the future safer, is indued with risk. Thus, a call to keep the dead subject in mind, and to find a way to think of them as next to us as we go about our work and with a goal of bringing about

[131] And, in doing so, holding a perpetrator to account, although I have not focused in this thesis on the perpetrator or other subjects of DHRs.

meaningful change, is a vital, indeed vitalising, act. It is to this call that I hope this thesis has contributed. Such victim centrality is something all of us – practitioners, policymakers, researchers – have a responsibility to try and honour, in whatever manner of use our encounter with DHRs comes. That means being conscious of the complexity and tensions with and within DHR, both in terms of what it is imagined as being for, what is used in it, and how it is used.

In concluding, I turn to the words of Margaret Atwood, with a poem taken from the final work of an eight-poem cycle. The poems were written for a project called '*Songs for murdered sisters'*, which began as a memorial to Nathalie Warmerdam, who was murdered along with two other women by a common ex-partner in 2015.[132] For me, Atwood's concluding poem – '*Coda*: Song' (2020, p. 39) – captures something of the paradox of death, which encompasses loss but also enduring presence. It is a haunting poem, yet Atwood's words also remind, challenge, and inspire in the context of DHRs. That is because, in a DHR, although their death is a trigger, the dead may also be, if we individually and collectively choose to enable it, an anchor for our efforts:

> If you were a song
> What song would you be?
>
> Would you be the voice that sings,
> Would you be the music?
>
> When I am singing this song for you
> You are not empty air
>
> You are here,
> One breath and then another:
>
> You are here with me…

In short, the dead remain with us should we care to listen.

[132] https://songsformurderedsisters.com.

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Appendices

Appendix A: Published DHRs – Coding Schedule and Manual

Case details	
Case ID	N/A
Police Force area	Pre-defined
Area	HO data
Community Safety Partnership Area (CSP)	Pre-defined
Victim pseudonym	*Description*: The pseudonym used to refer to the victim in the report *Examples:* "The victim is referred to as 'Amy' in this report *Decision rules:* Apply this category when the report identifies a victim pseudonym or there is a consistent way to refer to the victim
Chosen by family?	Pre-defined
Detail	
Date of death	HO data
Year and month of death (from report)	*Examples:* "Date of death: January 2018" *Decision rules:* Apply this category when the report identifies the date of death. If there is an inconsistency, use the date of death as stated on front of the report.

Relationship and typology	
Victim relationship to perpetrator	Pre-defined
Perpetrator relationship to victim	Pre-defined
Relationship	Pre-defined
Typology	Pre-defined
Time frame in scope	*Description*: The timeframe given for the review *Examples:* "To review agency contact from XXX to XXX" *Decision rules:* Apply this category when the report identifies a timeframe for the review. Where there is an explicit timeframe and reference to agencies considering 'any relevant historical contact' out of this note but use the explicit timeframe.

Additional subjects	
No. of additional victims	Pre-defined
No. of additional victims who were children	Pre-defined
Relationship to victim	Pre-defined
No. of additional perpetrators	Pre-defined
Relationship to victim	Pre-defined

(Primary) Victim characteristics			
Age	Pre-defined	Religion	Pre-defined
Disability	Pre-defined	Sex	Pre-defined
Gender reassignment	Pre-defined	Sexual Orientation	Pre-defined
Marriage and civil partnership		Country of Birth	Pre-defined
Race / Ethnicity	Pre-defined	Immigration status	Pre-defined

(Primary) Perpetrator characteristics			
Age	Pre-defined	Religion	Pre-defined
Disability	Pre-defined	Sex	Pre-defined
Gender reassignment	Pre-defined	Sexual Orientation	Pre-defined
Marriage and civil partnership		Country of Birth	Pre-defined
Race / Ethnicity	Pre-defined	Immigration status	Pre-defined

Description: Victim Characteristics / Perpetrator characteristics
Examples: "The victim was age 29-year-old, White British female"
Decision rules: Apply this category when the report includes victim or perpetrator characteristics. This could be explicitly where the information is presented under 'diversity and equality considerations', or where it is referenced in the body of the report.

Children	
No. of children (under 18)	*Description*: Number of children (under 18) *Examples:* "The victim had two children" *Decision rules:* Apply this category when the report identifies the victim had any children
No. of children (over 18)	*Description*: Number of children (over 18) *Examples:* "The victim had two children" *Decision rules:* Apply this category when the report identifies the victim had any children
Living in household?	*Description*: Number of children (under 18) *Examples:* "recorded as living with her child" *Decision rules:* Apply this category when the report identifies any children were living in the family home (where victim and perpetrator reside apart, this should be the victim's home)
Present during homicide	*Description*: Whether the child was exposed directly to the homicide *Examples:* "Child A found the body" *Decision rules:* Apply this category when the report identifies the victim was present. This could be during the homicide and / or where they found the body.

Death event	
Cause of death	Pre-defined
Method of killing	Pre-defined
Perpetrator suicide?	Pre-defined

Criminal justice outcome	
Charged	Pre-defined
Plea	Pre-defined
Outcome	Pre-defined
Sentence (if convicted)	Pre-defined (if more than one offence, most serious)

Notification	
Date CSP notified	*Description*: The date the CSP was notified about a homicide that might meet the criteria for a domestic homicide review *Examples:* "XXX Police made a referral to the CSP on XXX" *Decision rules:* Apply this category when the report identifies a CSP notification date. This should be explicit and include as a minimum the month and year.
CSP decision	*Description*: The data of the decision by the CSP to commission a domestic homicide review *Examples:* "The CSP decided to commission a review on XXX" *Decision rules:* Apply this category when the report identifies a CSP decision date. This should be explicit and include as a minimum the month and year.
Date HO notified	HO data

Chair	
Name of chair	*Description*: The full name of the chair *Examples:* "XXX was appointed as the chair" *Decision rules:* Apply this category when the report identifies the name of the chair. If there was more than one chair, identify the most recent chair using the name under which the report has been published.
Background	*Description*: The professional background of the chair. *Examples:* "XXX was appointed as the chair. They are a former police officer. *Decision rules:* Apply this category when the report identifies the professional background. This is the substantive career of the chair. E.g., retired police officer would be coded as "police officer".
Report writer	*Description*: The full name of the report writer *Examples:* "XXX was appointed as the writer" *Decision rules:* Apply this category when the report identifies a report writer. If this is also stated as being the chair, do not apply this category.

Panel	
Date of first panel	*Description*: The date the first review panel meeting *Examples:* "The review panel met on XXX and then XXX, XXX and XXX. *Decision rules:* Apply this category when the report identifies a first review panel meeting date. This should be explicit and include as a minimum the month and year.
No. of panels	*Description*: The number of review panel meetings *Examples:* "The review panel met on XXX and then XXX, XXX and XXX. *Decision rules:* Apply this category when the report includes information on the number of review panels. This could be explicitly stated or the sum of reported review panel meetings.
Size of Panel (no. named individuals excluding chair/report writer)	*Description*: The size of the review panel by person *Examples:* "The review panel was made up of…." *Decision rules:* Apply this category when the report identifies the substantive members of the review panel. Exclude the chair, report writer and any administrative support (e.g., "minute taker").
Size of panel (no. agencies excluding chair/report writer)	*Description*: The size of the review panel by agency *Examples:* "The review panel was made up of…." *Decision rules:* Apply this category when the report identifies number of agencies represented on the review panel. Where there is more than one individual from the same agency, these should be categorised as a single agency. The exception is health (by trust) and local authority (by department). Exclude the chair, report writer and any administrative support (e.g., "minute taker").
Inclusion of domestic abuse services	*Description*: Representation of specialist domestic abuse services on the review panel *Examples:* "The local IDVA service" *Decision rules:* Apply this category when the report identifies an agency which is a specialist domestic abuse provider. This could be identified directly or indirectly.

Family involvement	
Victim family approached	*Description*: Which family members involved *Examples:* "X's father and mother were invited to comment on the Terms of Reference and the draft overview report" *Decision rules:* Apply this category when the report identifies victim's family were involved, regardless of outcome.
Detail	*Description*: Consideration of victim family involvement *Examples:* "The family were invited to comment on the Terms of Reference and the draft overview report" *Decision rules:* Apply this category when the report identifies if the victim's family were involved, regardless of outcome.
Specialist support offered	*Description*: If specialist support offered *Examples:* "The family were provided with information on case work support by…" *Decision rules:* Apply this category when the report identifies if the victim's family were offered support
Detail	*Description*: Support offered to victim family *Examples:* "The family were provided with information on case work support by…" *Decision rules:* Apply this category when the report identifies how the victim's family were offered support
Specialist support taken up	*Description*: If support taken up by victim family *Examples:* "AAFDA provided a case worker who acted as the link with the family" *Decision rules:* Apply this category when the report identifies if specialist support was taken up
Detail	*Description*: Support taken up by victim family *Examples:* "AAFDA provided a case worker who acted as the link with the family" *Decision rules:* Apply this category when the report identifies how specialist support was taken up (i.e., delivery)
Perpetrator family involved	*Description*: Perpetrator family involvement *Examples:* "X's father and mother were invited to comment on the Terms of Reference and the draft overview report" *Decision rules:* Apply this category when the report identifies perpetrator's family were involved, regardless of outcome.
Other informal network involved	*Description*: Consideration of other informal network (e.g., friends, colleagues or neighbours) involvement *Examples:* "friends identified by the family were approached" *Decision rules:* Apply this category when the report identifies friends, colleagues or neighbours were involved, regardless of outcome.
Detail	*Description*: Consideration of perpetrator family or other informal network involvement *Examples:* "The perpetrators family were interviewed" *Decision rules:* Apply this category when the report identifies if the perpetrator family or other informal network were involved, regardless of outcome

Perpetrator involvement	
Perpetrator approached?	Pre-defined
Perpetrator involved?	Pre-defined

Recommendations	
No.	*Description*: Number of recommendations *Examples:* "The following recommendations were made…" *Decision rules:* Apply this category when the report identifies recommendations arising from the domestic homicide review. Include the sum of single and multi-agency recommendations in this category.
No. single agency	*Description*: Number of single agency recommendations *Examples:* "The following recommendations were made…" *Decision rules:* Apply this category when the report identifies single agency recommendations arising from the domestic homicide review. Exclude multi-agency recommendations in this category. Do not use this category if recommendations are not clearly described as 'single agency'.
No. DHR	*Description*: Number of multi-agency recommendations *Examples:* "The following recommendations were made…" *Decision rules:* Apply this category when the report identifies multi agency recommendations arising from the domestic homicide review. Exclude single-agency recommendations in this category. Do not use this category if recommendations are not clearly described as 'multi agency'.

Sign off and handover	
Date of handover to CSP	*Description*: The date the completed domestic homicide review was handed to the CSP *Examples:* "a completed overview report was handed to the CSP on XXX" *Decision rules:* Apply this category when the report identifies a handover date. This should be explicit and include as a minimum the month and year.
Date of submission of HO Quality Assurance (QA) panel	*Description*: The date the completed domestic homicide review was submitted to the HO *Examples:* "the overview report was submitted to the HO on XXX" *Decision rules:* Apply this category when the report identifies a handover date. This should be explicit and include as a minimum the month and year.
Date of HO QA Panel	HO data
HO QA Panel outcome	HO data

Publication	
Date of first search	*Research record*
Date of second search	*Research record*
Available	*Research record*
Website	*Research record*

Documents	
Overview report	Pre-defined
Length	*Description*: The number of pages *Decision rules:* Apply this category based on total length of report. This should be based on the total number of pages, regardless of whether page numbers are given
Executive summary	Pre-defined
Home Office letter	Pre-defined

Appendix B: Published DHRs – Case Details and Independent Chair Background

Published DHRs – Case Details

Demographic Data and Death Event	Victim		Perpetrator	
	n	%	*n*	%
Gender[a]				
Woman	46	76.7	49	83.1
Man	14	23.3	10	16.9
Age				
Range	6 to 93[b]	-	19 to 86	-
Mean	49	-	48	-
Missing	5	8.3	13	21.7
Other	2[C]	3.3	3[d]	5.0
Disability				
No	8	13.3	5	8.3
Yes – Autistic Spectrum	0	0.0	1	1.7
Yes – Learning Disability / Difficulty	3	5.0	2	3.3
Yes – Long-standing illness	5	8.3	3	5.0
Yes – Mental Health condition	10	16.7	9	15.0
Yes – Other	1	1.7	1	1.7
Yes – Physical Impairment	5	8.3	2	3.3
Missing – Possible Mental Health	3	5.0	1	1.7
Missing	25	41.7	36	60.0
Gender Reassignment				
Cis female	1	1.7	0	0.0
Cis male	0	0.0	1	1.7
Missing	58	96.7	59	98.3
Other	1[e]	1.7	0	0.0
Ethnicity				
Asian or Asian British – Bangladeshi	1	1.7	1	1.7
Asian or Asian British – Chinese	1	1.7	0	0.0
Asian or Asian British – Indian	1	1.7	1	1.7
Black or Black British – African	1	1.7	1	1.7
Black or Black British – Caribbean	0	0.0	2	3.3
Mixed – Any other Mixed background	2	3.3	0	0.0
Mixed – Black Caribbean & White	1	1.7	1	1.7
Other	1	1.7	1	1.7
White – Any other White background	2	3.3	2	3.3
White - English/Welsh/Scottish/ Northern Irish/British	23	38.3	23	38.3
White – Gypsy or Irish Traveller	1	1.7	1	1.7
White – Irish	1	1.7	1	1.7

Missing	25	41.7	26	43.3
Faith/Religion				
Christian	3	5.0	0	0.0
Hindu	1	1.7	0	0.0
Muslim	2	3.3	2	3.3
Other	0	0.0	1[f]	1.7
Not known	4	6.7	5	8.3
Missing	50	83.3	52	86.7
Sexual Orientation				
Bisexual	1	1.7	0	0.0
Gay man	1	1.7	1	1.7
Heterosexual / Straight	53	88.3	50	83.3
Missing	4	6.7	9	15.0
Other	1[g]	1.7	0	0.0
Country of Origin				
England	2	3.3	1	1.7
Bangladesh	1	1.7	0	0.0
France	1	1.7	0	0.0
Ireland	1	1.7	0	0.0
Jamaica	0	0.0	2	3.3
Latvia	1	1.7	0	0.0
Lithuania	2	3.3	3	5.0
Nigeria	1	1.7	0	0.0
Pakistan	1	1.7	0	0.0
Poland	0	0.0	1	1.7
United Kingdom	1	1.7	0	0.0
Uruguay	0	0.0	1	1.7
Zimbabwe	1	1.7	0	0.0
Other	0	0.0	1	1.7
Missing	48	80.0	51	85.0
Citizenship/Migration Status				
British	2	3.3	1	1.7
EU national	2	3.3	2	3.3
Leave to remain	1	1.7	1	1.7
Missing	55	91.7	56	93.3
Method of Killing				
Blunt instrument	9	15.0	-	-
Burning	2	3.3	-	-
Drowning	1	1.7	-	-
Explosion	1	1.7	-	-
Hitting, kicking, etc.	6	10.0	-	-
Other	2	3.3	-	-

Poison or drugs	1	1.7	-	-
Sharp instrument	20	33.3	-	-
Shooting	4	6.7	-	-
Strangulation, asphyxiation	9	15.0	-	-
Missing	5	8.3	-	-
Cause of Death				
Drowning & blunt force to head	1	1.7	-	-
Assisted Suicide	1	1.7	-	-
Cardiac arrest	2	3.3	-	-
Combined effects of blunt force head injury and compression of the neck	1	1.7	-	-
Compression of the neck	2	3.3	-	-
Extensive bleeding due to a single laceration to the neck	1	1.7	-	-
Gunshot	1	1.7	-	-
Haemorrhage and lacerations to liver	1	1.7	-	-
Head Injury	7	11.7	-	-
Immolation	1	1.7	-	-
Inhalation of fire fumes	1	1.7	-	-
Inhalation of fire fumes / exposure to fire	1	1.7	-	-
One wound to his chest was more serious	1	1.7	-	-
Raised intercranial pressure / Sub-Dural haematoma	1	1.7	-	-
Severe beating	1	1.7	-	-
Severe trauma	1	1.7	-	-
Stabbing	2	3.3	-	-
Strangulation	1	1.7	-	-
Suffocation	1	1.7	-	-
Suicide	1	1.7	-	-
Wounds to neck, jugular vein	1	1.7	-	-
Missing	30	50.0	-	-

Note. Total sample of 60 published DHRs.

[a] Excludes 1 case where the identity of the perpetrator was unknown.

[b] Includes 1 case where a child was a victim and both parents died (perpetrator unknown).

[c] Data was given as an age range.

[d] Multiple perpetrators in three cases.

[e, g] In one case the victim was a child.

[f] In one case coding was unclear.

Published DHRs – Independent Chair Background

Background	*n*	%
Health	2	3.3
Housing	1	1.7
Legal	1	1.7
Local Authority	5	8.3
Other – 'Government'	2	3.3
Other – 'Public Service'	1	1.7
Other – ‘Academic’	2	3.3
Police	30	50.0
Probation	2	3.3
Social Work	6	10.0
Specialist DA Sector	4	6.7
Missing	4	6.7
Total	60	100.0

Appendix C: Published DHRs – Engagement of Other Testimonial Networks

Friends, Colleagues or Neighbours

Involvement	*n*	%
Approached – Declined	7	11.7
Approached – Involved	25	41.7
Approached – No response	2	3.3
Decided not to approach	2	3.3
Not able to approach - Other	2	3.3
Missing	21	35.0
N/A	1	1.7
Total	60	100.0

Perpetrator's Family

Involvement	*n*	%
AFV – Same family	9	15.0
IPV – Same family	2	3.3
Approached – Declined	4	6.7
Approached – Involved	11	18.3
Approached – Involvement Missing	2	3.3
Approached – No response	3	5.0
Not able to approach – Other	1	1.7
Missing	28	46.7
Total	60	100.0

The Perpetrator

Involvement	*n*	%
Approached – Declined	13	21.7
Approached – Involved	5	8.3
Approached – No response	11	18.3
Approached – Other[a]	2	3.3
Decided not to approach	8	13.3
Not able to approach – Suicide	7	11.7
Missing	14	23.4
Total	60	100.00

Note. Total sample of 60 published DHRs.

[a] Shared report but no response received.

Appendix D: Web-based Survey – Template

Start of Block: Default Question Block

QA1
"Illuminating the past to make the future safer?"
Exploring Domestic Homicide Reviews as a mechanism for change

Thank you for your interest in this study, which is part of a PhD project being conducted at Sussex University looking at how Domestic Homicide Reviews (DHRs) operate. It is exploring a range of issues around DHRs including how: decisions are made; institutional or social change is understood; learnings and recommendations are produced. *This study explores the experience of people who have participated in a DHR. To take part in the study, you need to be aged 18 or over and to have participated in at least one DHR in England and Wales. You can have participated in a variety of ways, including as an:*

- Advocate or case worker (for family or friends of someone who was a subject of a DHR)
- Family member or a friend (of someone who was a subject of a DHR)
- Independent chair (of a DHR)
- Local Authority officer (who commissioned a DHR)
- Report writer (who wrote a DHR)
- Panel member (who represented an agency on a DHR)
- Reader for, or member of, the national Quality Assurance Panel
- Other (you participated in a DHR in some other way)

Ethical approval: This research has been approved by the Social Sciences & Arts Cross-Schools Research Ethics Committee (C-REC). This ethical review application number is ER/JR514/1.

Contact for further information: For further information you can contact the researcher, James Rowlands directly by email (J.Rowlands@sussex.ac.uk). If have any concerns about the way in which the study has been conducted, you can contact the researcher's supervisors: Professor Alison Phipps (A.E.Phipps@sussex.ac.uk) or Dr Tanya Palmer (T.Palmer@sussex.ac.uk). Alternatively, you could contact the chair of the Social Sciences & Arts C-REC: Dr Liz McDonnell (E.J.Mcdonnell@sussex.ac.uk).

Insurance: The University of Sussex has insurance in place to cover its legal liabilities in respect of this study.

For more information, or to start the questionnaire, please click on the button below:

Page Break

QA2 This page provides answers to some of the questions you may have about the study:

What will happen to me if I take part? You will be asked to complete an online questionnaire about your experiences of participating in Domestic Homicide Reviews (DHRs). The questionnaire will take around 20 minutes to complete. Your participation is voluntary. You can stop at any point and can do this by simply closing the questionnaire window. However, once you reach the end of the questionnaire and have submitted your responses, it is not possible to withdraw your answers.
The questionnaire is anonymous, but towards the end of the questionnaire you will be asked if you would like to take part in a follow up interview to discuss your experiences further. If you are willing to do this, you will be asked to provide your name and contact details.

What are the possible disadvantages and risks of taking part? There is no direct risk to you taking part, but there may be an emotional impact as you will be thinking about your experiences of DHRs.

What are the possible benefits of taking part? The findings from the questionnaire will influence practice in the future, leading to improvements in how DHRs are conducted.

Will my information be kept confidential? Everything you share will remain confidential in accordance with The General Data Protection Regulation (GDPR) 2018. Information will be kept electronically, and password protected. Any paper-based files will be kept in a lockable cabinet.

What will happen to the results of the study? Questionnaire data will be retained for 10 years, with anonymously data being archived if possible. Any data you provide will be retained for 10 years and, having been anonymised, will be deposited in the UK Data Archive. Data will be used in the write up of research to produce my thesis and may also be used in other publications.

If you would like to take part, and to start the questionnaire, please read and answer yes or no to the following questions:

	Yes (1)	No (2)
I am aged 18 or over (1)	○	○
I have read and understood the information about this questionnaire (2)	○	○
I consent to take part in this questionnaire (3)	○	○

Skip To: Q45 If This page provides answers to some of the questions you may have about the study: What will happe... = No

Page Break

Q1 Have you taken part in a DHR? *Please select one option. If more than one option could apply, please answer thinking about how you were most recently involved:*

- ○ I have taken part as a family member or a friend (of someone who was a subject of a DHR) (1)
- ○ I have taken part in a professional capacity (as an advocate for family or friends, an independent chair, someone who commissioned a DHR, as a panel member, report writer, review panel member, or in some other way) (2)
- ○ I am a reader for, or member of, the national Quality Assurance Panel (3)
- ○ I have not been involved (4)

Skip To: Q9 If Have you taken part in a DHR? Please select one option. If more than one option could apply, plea... = I have taken part as a family member or a friend (of someone who was a subject of a DHR)

Skip To: Q2 If Have you taken part in a DHR? Please select one option. If more than one option could apply, plea... = I have taken part in a professional capacity (as an advocate for family or friends, an independent chair, someone who commissioned a DHR, as a panel member, report writer, review panel member, or in some other way)

Skip To: Q20 If Have you taken part in a DHR? Please select one option. If more than one option could apply, plea... = I am a reader for, or member of, the national Quality Assurance Panel

Skip To: Q45 If Have you taken part in a DHR? Please select one option. If more than one option could apply, plea... = I have not been involved

Page Break

Q2
What was your role in the DHR? Please select one option:

- ○ Advocate or case worker (for family or friends of someone who was a subject of a DHR) (1)
- ○ Independent chair (of a DHR) (2)
- ○ Local Authority officer (who commissioned a DHR) (3)
- ○ Report writer (who wrote a DHR) (4)
- ○ Panel member (who represented an agency on a DHR) (5)
- ○ Other - please specify: (6) _____

Q3 When you were involved in the DHR, which of the following best describes your employer at the time? *Please select one option:*

▼ Criminal Justice – National Probation Service / Community Rehabilitation Company (1) ... Other (30)

Page Break

Q4 Was this the first DHR you have been involved in? *Please select one option:*

○ Yes (1)

○ No (2)

Display This Question:

If Was this the first DHR you have been involved in? Please select one option: = No

Q4a How many other DHRs have you previously participated in? *Please enter the number:*

_____

*

Q5 Prior to becoming involved in the DHR, had you participated in any other statutory review process(es) concerning serious incidents or deaths? *This response is multiple choice, please select as many options as apply:*

☐ Mental Health Homicide Review (now Independent Investigation Report) (1)

☐ Safeguarding Adult Review / Adult Practice Review (2)

☐ Serious Case Review (now Child Safeguarding Practice Review / Child Practice Review) (3)

☐ Other - please specify: (4) _____

☐ None (5)

Page Break

Q6 Prior to being involved in the DHR, did you receive any training to support your participation? (e.g. e-learning, in house training, external training course). *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Prior to being involved in the DHR, did you receive any training to support your participation? (... = Yes

Q6a *Please describe the training:*

_____

_____

_____

_____

_____

Q7 During your involvement in the DHR, was there any support available to you? *This response is multiple choice, please select as many options as apply:*

- ☐ Clinical Supervision (1)
- ☐ Employee support / assistance programme (2)
- ☐ Informal support from colleagues (3)
- ☐ Supervision with a manager (4)
- ☐ Support from a trade union or professional body (5)
- ☐ Other - please specify: (6) _____
- ☐ None (7)

Display This Question:

If During your involvement in the DHR, was there any support available to you? This response is mult... = Clinical Supervision

Or During your involvement in the DHR, was there any support available to you? This response is mult... = Employee support / assistance programme

Or During your involvement in the DHR, was there any support available to you? This response is mult... = Informal support from colleagues

Or During your involvement in the DHR, was there any support available to you? This response is mult... = Supervision with a manager

Or During your involvement in the DHR, was there any support available to you? This response is mult... = Support from a trade union or professional body

Or Or During your involvement in the DHR, was there any support available to you? This response is multiple choice, please select as many options as apply: Other - please specify: Is Not Empty

Q7a Did you take up any of the support that was available to you? *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Did you take up any of the support that was available to you? Please select one option: = Yes

Q7b
Please describe why and what happened (e.g. what did you ask for support with? What was the outcome?)

_____

_____

_____

_____

_____

Page Break

Q8 In addition to the DHR you were involved in, were any other statutory review process(es) undertaken into the case being reviewed? *This response is multiple choice, please select as many options as apply:*

- ☐ Mental Health Homicide Review (now Independent Investigation Report) (1)
- ☐ Safeguarding Adult Review / Adult Practice Review (2)
- ☐ Serious Case Review (now Child Safeguarding Practice Review / Child Practice Review) (3)
- ☐ Other - please specify: (4) _____
- ☐ No other statutory reviews were undertaken (5)

Skip To: Q12 If In addition to the DHR you were involved in, were any other statutory review process(es) undertak... = No other statutory reviews were undertaken

Display This Question:

If In addition to the DHR you were involved in, were any other statutory review process(es) undertak... = Mental Health Homicide Review (now Independent Investigation Report)

Or In addition to the DHR you were involved in, were any other statutory review process(es) undertak... = Safeguarding Adult Review / Adult Practice Review

Or In addition to the DHR you were involved in, were any other statutory review process(es) undertak... = Serious Case Review (now Child Safeguarding Practice Review / Child Practice Review)

Or In addition to the DHR you were involved in, were any other statutory review process(es) undertak... = Other - please specify:

Q8a *How did the DHR and the other statutory review processes(s) interact? Please describe what was the same and what was different?*

_____

_____

_____

_____

_____

Skip To: Q12 If Condition: How did the DHR and the oth... Is Displayed. Skip To: In your own words, how would you desc....

Skip To: Q12 If Condition: How did the DHR and the oth... Is Not Displayed. Skip To: In your own words, how would you desc....

Page Break

Q9 Before you start the rest of the questionnaire, is there anything you would like to say about your family member or friend? (you do not have to answer this question. It is optional and it is a chance, if you wish, to share anything you would like to say). *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Before you start the rest of the questionnaire, is there anything you would like to say about you... = Yes

Q9a *What would you like to say?*

_____

_____

_____

_____

_____

Page Break

Q10 At the start of the DHR, were you given any information about what the DHR process would involve? *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If At the start of the DHR, were you given any information about what the DHR process would involve?... = Yes

Q10a *What were you told and by whom?*

_____

_____

_____

_____

_____

Q11 Did you receive any formal support to help you participate in the DHR (e.g. support from a police Family Liaison Officer, or from a charity like Advocacy After Fatal Domestic Abuse (AAFDA) or Victim Support)? *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Did you receive any formal support to help you participate in the DHR (e.g. support from a police... = Yes

Q11a *Which organisation(s) provided you with formal support? What support did you receive?*

_____

_____

_____

_____

_____

Display This Question:

If Did you receive any formal support to help you participate in the DHR (e.g. support from a police... = No

Q11b *Why didn't you receive any formal support?*

_____

_____

_____

_____

_____

Page Break

Q12 In your own words, how would you describe the purpose(s) of a DHR?

_____

_____

_____

_____

_____

Page Break

Q13 **Thinking about the DHR you were involved in, how satisfied were you with the following areas?** ***Please provide a response to each statement:***

	Extremely satisfied (23)	Somewhat satisfied (24)	Neither satisfied nor dissatisfied (25)	Somewhat dissatisfied (26)	Extremely dissatisfied (27)	Not applicable (28)
Your opportunity to contribute (e.g. whether you felt able to speak and be heard) (1)	○	○	○	○	○	○
The contribution of others (e.g. whether you felt other people were able to speak and be heard) (2)	○	○	○	○	○	○
The information available (e.g. whether you felt the DHR had all the information it needed to build a picture of what happened) (3)	○	○	○	○	○	○
The quality of the discussion (e.g. whether you felt the DHR was an open process and everyone's contribution was considered) (4)	○	○	○	○	○	○
The quality of the learning (e.g. whether you felt the DHR identified the learning from the case circumstances, such as barriers to help seeking or the effectiveness of agency responses) (5)	○	○	○	○	○	○
The quality of the recommendations (e.g. whether you felt the recommendations made by the DHR addressed the learning) (6)	○	○	○	○	○	○

The quality of the Overview Report (e.g. whether it was of a good standard) (7)	○	○	○	○	○	○
The conduct of the chair (e.g. whether you felt the chair led the DHR in a way that helped everyone contribute, identify learning and make recommendations) (8)	○	○	○	○	○	○

Page Break

Q14 **Thinking about the DHR you were involved in:**

What do you think worked well?

_____

_____

_____

_____

_____

Q15 What do you think could be improved or done differently, and how?

_____

_____

_____

_____

_____

Page Break

Q16 How satisfied were you with the way the DHR 'articulated the life through the eyes' of the victim, any children and the perpetrator? (e.g. did the DHR accurately represent the subjects of the review (or your relative or friend) as a person, as well as their risks, needs and experiences prior to the homicide?). *Please provide a response to each statement:*

	Extremely satisfied (1)	Somewhat satisfied (2)	Neither satisfied nor dissatisfied (3)	Somewhat dissatisfied (4)	Extremely dissatisfied (5)	Not applicable (6)
The victim (1)	○	○	○	○	○	○
Any children (2)	○	○	○	○	○	○
The perpetrator (3)	○	○	○	○	○	○

Q16a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q17 **Thinking about your experience of the DHR process as a whole, to what extent do you agree with the following statement:**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think that the understanding of domestic abuse will improve as a result of the DHR" (1)	○	○	○	○	○

Q17a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q18 **Thinking about your experience of the DHR process as a whole, to what extent do you agree with the following statement:**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think the help and support available to people affected by domestic abuse will improve as a result of the DHR" (1)	○	○	○	○	○

Q18a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q19 **Thinking about your experience of the DHR process as a whole, to what extent do you agree with the following statement:**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think the learning and recommendations from the DHR will help prevent future homicides" (1)	○	○	○	○	○

Q19a *Please explain your answer:*

_____

_____

_____

_____

_____

Skip To: Q33 If Condition: Please explain your answer: Is Displayed. Skip To: Equality monitoring The following q....

Page Break

Q20 How are you involved with the Quality Assurance Panel? *Please select one option:*

- ○ I am a reader (1)
- ○ I am a panel member (2)
- ○ I am involved in some other way - please specify: (3) _____

Q21 When you are involved with national Quality Assurance Panel, which of the following best describes your professional background? *Please select one option:*

▼ Civil Servant – Home Office (1) ... Other (32)

Page Break

Q22 Prior to becoming involved with the national Quality Assurance Panel, did you receive any training to support your participation? (e.g. e-learning, in house training, external training course). *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Prior to becoming involved with the national Quality Assurance Panel, did you receive any trainin... = Yes

Q22a *Please describe the training:*

_____

_____

_____

_____

_____

Q23 During your involvement with the national Quality Assurance Panel, is there any support available to you? This response is multiple choice, please select as many options as apply:

- ☐ Clinical Supervision (1)
- ☐ Employee support / assistance programme (2)
- ☐ Informal support from colleagues (3)
- ☐ Supervision with a manager (4)
- ☐ Support from a trade union or professional body (5)
- ☐ Other - please specify: (6) _____
- ☐ None (7)

Display This Question:

If During your involvement with the national Quality Assurance Panel, is there any support available... = Clinical Supervision

Or During your involvement with the national Quality Assurance Panel, is there any support available... = Employee support / assistance programme

Or During your involvement with the national Quality Assurance Panel, is there any support available... = Informal support from colleagues

Or During your involvement with the national Quality Assurance Panel, is there any support available... = Supervision with a manager

Or During your involvement with the national Quality Assurance Panel, is there any support available... = Support from a trade union or professional body

Or Or During your involvement with the national Quality Assurance Panel, is there any support available to you? This response is multiple choice, please select as many options as apply: Other - please specify: Is Not Empty

Q23a Have you taken up any of the support that is available to you? *Please select one option:*

- ○ Yes (1)
- ○ No (2)

Display This Question:

If Have you taken up any of the support that is available to you? Please select one option: = Yes

Q23b *Please describe why and what happened (e.g. what have you asked for support with? What was the outcome?)*

_____

_____

_____

_____

_____

Page Break

Q24 In your own words, how would you describe the purpose(s) of a DHR?

_____

_____

_____

_____

_____

Page Break

Q25 **The responsibilities for the National Quality Assurance Panel are set out in the 2016 statutory guidance.** Thinking about completed DHRs that are submitted to the National Quality Assurance Panel, how satisfied are you with panel's performance in relation to the following? Please provide a response to each statement:

	Extremely satisfied (1)	Somewhat satisfied (2)	Neither satisfied nor dissatisfied (3)	Somewhat dissatisfied (4)	Extremely dissatisfied (5)
Assessing overview reports against the statutory guidance (1)	○	○	○	○	○
Ensuring that areas have spoken with the appropriate agencies, voluntary and community sector organisations, and family members and friends, to establish a full a picture as possible (2)	○	○	○	○	○
Ensuring that the overview report demonstrates sufficient probing and analysis and the narrative is balanced (3)	○	○	○	○	○
Ensuring that lessons will be learnt and that areas have plans in place for ensuring this is the case (4)	○	○	○	○	○
The likelihood of a repeat homicide is minimised (5)	○	○	○	○	○

Page Break

Q26 Thinking more generally about the DHR process as a whole, how satisfied are you with the performance of the National Quality Assurance Panel in relation to the following? Please provide a response to each statement:

	Extremely satisfied (1)	Somewhat satisfied (2)	Neither satisfied nor dissatisfied (3)	Somewhat dissatisfied (4)	Extremely dissatisfied (5)
Disseminating lessons learned at a national level and effective practice (1)	○	○	○	○	○
Assessing progress identified at a national level (2)	○	○	○	○	○
Identifying serious failings and common themes (3)	○	○	○	○	○
Communicating with the media to raise awareness of the positive work of statutory and voluntary sector agencies with domestic violence and abuse victims and perpetrators so that attention is not focused disproportionately on tragedies (4)	○	○	○	○	○
Communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies (5)	○	○	○	○	○
Providing central storage for DHRs to allow for clear auditing of review documentation and quick retrieval if required (6)	○	○	○	○	○
Reviewing decisions by CSPs not to undertake a DHR (7)	○	○	○	○	○
Recommending national training needs and working across government to ensure existing training is highlighted (8)	○	○	○	○	○
Recommending service needs to commissioners (9)	○	○	○	○	○

Page Break

Q27 Thinking about your experience of the national Quality Assurance Panel:

What do you think works well?

_____

_____

_____

_____

_____

Q28 What do you think could be improved or done differently, and how?

_____

_____

_____

_____

_____

Page Break

Q29 Thinking about your experience of the DHRs process as a whole, how satisfied are you about the way DHRs 'articulate the life through the eyes' of those involved? (e.g. do DHRs accurately represent the subjects of the review as a person and their risks, needs and experiences prior to the homicide?) *Please provide a response to each statement:*

	Extremely satisfied (1)	Somewhat satisfied (2)	Neither satisfied nor dissatisfied (3)	Somewhat dissatisfied (4)	Extremely dissatisfied (5)	Not applicable (6)
The victim (8)	○	○	○	○	○	○
Any children (9)	○	○	○	○	○	○
The perpetrator (10)	○	○	○	○	○	○

Page Break

Q30 **Thinking about your experience of the DHR process as a whole, to what extent do you agree with the following statements:**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think that the understanding of domestic abuse will improve as a result of the DHR process" (1)	○	○	○	○	○

Q30a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q31 Click to write the question text

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think the help and support available to people affected by domestic abuse will improve as a result of the DHR process" (1)	○	○	○	○	○

Q31a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q32 Click to write the question text

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
"I think the learning and recommendations from the DHR process will help prevent future homicides" (1)	○	○	○	○	○

Q32a *Please explain your answer:*

_____

_____

_____

_____

_____

Page Break

Q33 **Equality monitoring** The following questions are about you as a person. Collecting, analysing and using equality information will help show whether families and professionals from various sections of our communities experience DHRs differently. **If you do not want to answer a question, there is a 'prefer not to say' option.** What is your age?

▼ 18 - 24 (1) ... 75 or over (7)

Q34 **What gender are you?**

▼ Man (1) ... Prefer not to say (4)

Q35 **Do you identify as the sex you were assigned at birth?**

▼ Yes (1) ... Prefer not to say (3)

Q36 **How would you describe your ethnic origin?**

▼ White - English/Welsh/Scottish/Northern Irish/British (1) ... Prefer not to say (19)

Q37 **Which of the following best describes your sexual orientation?**

▼ Bisexual (1) ... Prefer not to say (6)

Q38 **What is your religion or belief?**

▼ Agnostic (1) ... Prefer not to say (12)

Q39 **Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?**

- ○ Yes a lot (1)
- ○ Yes a little (2)
- ○ No (3)
- ○ Prefer not to say (4)

Display This Question:

If Are your day-to-day activities limited because of a health problem or disability which has lasted... = Yes a lot

Or Are your day-to-day activities limited because of a health problem or disability which has lasted... = Yes a little

Q40 **If you answered 'yes', please state the type of impairment. If you have more than one, please tick all that apply:**

- ☐ Physical Impairment (1)
- ☐ Sensory Impairment (2)
- ☐ Learning Disability/Difficulty (3)
- ☐ Long-standing illness (4)
- ☐ Mental Health condition (5)
- ☐ Autistic Spectrum (6)
- ☐ Other Developmental Condition (7)
- ☐ Other (please state) ..... (8) _____
- ☐ Prefer not to say (9)

Page Break

Q41 **You have reached the end of the questionnaire - thank you for taking part.**

To complete the questionnaire you will need to select “YES” below.

Please note, by selecting "YES" you are confirming that you understand that you will not be able to withdraw your questionnaire responses.

I consent to submitting my questionnaire responses:

- ○ Yes (1)
- ○ No (2)

Skip To: Q46 If You have reached the end of the questionnaire - thank you for taking part. To complete the questio... = No

Q42 **Would you be interested in talking about your experience of DHRs?**

I am recruiting participants to take part in a semi-structured interview. The interviews will explore some of the issues covered in this questionnaire and are an opportunity for people to discuss their experience of DHRs in more detail.

Would you be interested in taking part? Please click 'Yes' if you would like to receive further information.

- ○ Yes (1)
- ○ No (2)

Skip To: Q43 If Would you be interested in talking about your experience of DHRs? I am recruiting participants to... = Yes

Skip To: End of Survey If Would you be interested in talking about your experience of DHRs? I am recruiting participants to... = No

Q43 **Please provide your name and contact details:**

- ○ Name (1) _____
- ○ Contact telephone number (2) _____
- ○ Contact email address (3) _____

Skip To: End of Survey If Condition: Name Is Not Empty. Skip To: End of Survey.

Page Break

Q45 Thank you for your interest in this research.

You have been routed out of the questionnaire because your answer to the previous question means you are not eligible to take part in the study.

If you have made a mistake, or would like to review your last answer, please click the button below on the left ('the back button'). This will return you to the questionnaire. Otherwise please click the button on the right.

Skip To: End of Survey If Thank you for your interest in this research. You have been routed out of the questionnaire becau... Is Displayed

Q46 Thank you for your interest in this research.

You have been routed out of the questionnaire because you ticked "*no*" in response to the last question.

As you have not given consent to submit your questionnaire responses, this means your data will not be saved or used.

If you have made a mistake, or would like to review your response, please click the button below on the left ('the back button'). This will return you to the questionnaire. Otherwise please click the button on the right.

Skip To: End of Survey If Thank you for your interest in this research. You have been routed out of the questionnaire becaus... Is Displayed

End of Block: Default Question Block

Appendix E: Web-based Survey – Professional Respondent Role, Demographic Data, and Access to Training

Professional Respondent Role

Organisation	*n*	%
Criminal Justice – National Probation Service / Community Rehabilitation Company	1	1.0
Criminal Justice – Police	9	8.7
Education Provider – Secondary School	1	1.0
Fire service	1	1.0
Health – Ambulance Trust	1	1.0
Health – Clinical Commissioning Group	8	7.8
Health – Community Health Trust	1	1.0
Health – Hospital Trust	5	4.9
Health – Mental Health Trust	5	4.9
Health – National Health Service (NHS) England	1	1.0
Health – Primary Care	2	1.9
Local authority – Adult Social Care	3	2.9
Local authority – Children Social Care	5	4.9
Local authority – Community Safety	20	19.4
Local authority – Education Welfare	1	1.0
Local authority – Housing	3	2.9
Other	6	5.8
Perpetrator's Employer	1	1.0
Self-employed	7	6.8
Social Landlord (i.e., not-for-profit housing provider)	2	1.9
Victim's Employer	1	1.0
Voluntary Sector - Criminal Justice	2	1.9
Voluntary Sector - DA	17	16.5
Total	103	100.0

Note. Total sample of 103 professional respondents.

Professional Demographic Data

Demographic Data	*n*	%
Age		
25 - 34	3	2.9
35 - 44	33	32.0
45 - 54	37	35.9
55 - 64	27	26.2
65 - 74	3	2.9
Gender		
Man	17	16.5
Woman	84	81.6
No response	2	1.9
Identify as sex assigned at birth		
Yes	102	99.0
No response	1	1.0
Ethnicity		
Asian or Asian British – Bangladeshi	1	1.0
Asian or Asian British – Indian	3	2.9
Black or Black British – Caribbean	1	1.0
Mixed – Asian & White	1	1.0
White – Any other White background	6	5.8
White – English/Welsh/Scottish/Northern Irish/British	89	86.4
White – Irish	1	1.0
Prefer not to say	1	1.0
Sexual Orientation		
Bisexual	3	2.9
Gay man	3	2.9
Heterosexual/Straight	90	87.4
Lesbian/Gay woman	3	2.9
Prefer not to say	3	2.9
No response	1	1.0
Religion or belief		
Agnostic	11	10.7
Atheist	21	20.4
Buddhist	1	1.0
Christian	45	43.7
Hindu	2	1.9
Muslim	1	1.0
Other	8	7.8
Pagan	3	2.9
Prefer not to say	8	7.8
No response	3	2.9

Disability		
No	86	83.5
Yes a little	12	11.7
Yes a lot	3	2.9
Prefer not to say	2	1.9

Note. Total sample of 103 professional respondents.

Professional Access to Training – Occurrence of Themes and Sub-Themes in Free Text Responses

Themes and Sub-Themes	References
Conference	2
Family[133]	2
Experiential Learning	5
Other Statutory Review Training	3
Reviewer Training	4
Police Review Officer Training	1
Training on DHRs	51
Externally Delivered Training[134]	24
AAFDA	7
Home Office Chair Training	3
Local or Regional Training	4
Clinical Commissioning Group (CCG)	1
CSP	1
County Wide	1
DA Forum	1
Standing Together	2
Unspecified	8
Internally Delivered Training	11
In-House Training	7
Informal Training from Colleagues	3
Online Training	16
Home Office Online Training	11

[133] This may be a reference to annual conferences organised by AAFDA.
[134] Participant responses indicated that the training was delivered outside of their agencies, it was not always possible to determine the type or its format. In some instances, a provider was named.

Appendix F: Interviews – Interview Guide

PARTICIPANT INFORMATION SHEET – INTERVIEW SCHEDULE (PROFESSIONALS)

Background information

1. Please tell me about your involvement in DHRs.

The DHR process

2. In your own words, how would you describe the purpose(s) of a DHR?
3. How did you become involved in DHRs?
4. What is / was the impact on you of being involved in DHRs?

Thinking about the most recent DHR you were involved with

5. How did you prepare for the start of the DHR?
6. What was it like taking part in the DHR?
7. How did the Review Panel gather information during the DHR?
8. How were decisions made during the DHR?
9. Were there any tension(s), disagreement(s) or conflict(s) during the DHR?
10. The statutory guidance says that 'the narrative of each review should articulate the life through the eyes of the victim (and their children)', as well as the perpetrator. What does 'articulating the life' mean to you?
11. Thinking about the DHR as a whole, what was it like overall?
12. What can you tell me about the learning and recommendations that were produced?
13. Thinking about the DHR, what do you think it has / will achieve?

Debrief

- Is there anything you would like to talk about that we have not yet discussed?
- Is there anything that you would like to ask me?
- How did you find the survey?
- Do you need any support following this discussion? If yes, would you like to be referred back to worker or provider or have other support/signposting?
- Thank you

PARTICIPANT INFORMATION SHEET – INTERVIEW SCHEDULE (FAMILY)

Background information

1. I want to acknowledge that your involvement in a DHR came about because of the tragic death of a family member or friend - Is there anything you would like me to know about your family member or friend?

The DHR process

2. In your own words, how would you describe the purpose(s) of a DHR?

3. How did you become aware that a DHR was going to be conducted?

4. What is / was the impact on you of being involved in the DHR?

Thinking about the DHR

5. How did you prepare for the start of the DHR?

6. What was it like taking part in the DHR?

7. What are your reflections on the information gathered during the DHR?

8. What are your reflections on any decisions made by the Chair and Review Panel?

9. In your involvement with the DHR, were there any tension(s), disagreement(s) or conflict(s)?

10. The statutory guidance says that 'the narrative of each review should articulate the life through the eyes of the victim (and their children)', as well as the perpetrator. What does 'articulating the life' mean to you?

11. Thinking about the DHR as a whole, what was it like overall?

12. What can you tell me about the learning and recommendations that were produced?

13. Thinking about the DHR, what do you think it has / will achieve?

Debrief

- Is there anything you would like to talk about that we have not yet discussed?
- Is there anything that you would like to ask me?
- How did you find the survey?
- Do you need any support following this discussion? If yes, would you like to be referred back to worker or provider or have other support/signposting?
- Thank you

Appendix G: Interviews – Demographic Question

Participant ID number:

EQUALITIES MONITORING FORM

Title of Project: '*Illuminating the past to make the future safer?' – Exploring Domestic Homicide Reviews as a mechanism for change*

Name of Researcher and School: James Rowlands, School of Law, Politics and Sociology

C-REC Ref no: ER/JR514/1

The following questions are about you as a person. Collecting, analysing and using equality information will help show whether families and professionals from various sections of our communities experience DHRs differently

What is your age?	.....years ☐ Prefer not to say
What gender are you?[135]	☐ Male ☐ Female ☐ Other - please state ..... ☐ Prefer not to say
Do you identify as the sex you were assigned at birth?	☐ Yes ☐ No ☐ Prefer not to say

How would you describe your ethnic origin?

White ☐ English/Welsh/Scottish/ Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Any other White background (please give details) ..... Asian or Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Chinese ☐ Any other Asian background (please give details)	Black or Black British ☐ African ☐ Caribbean ☐ Any other Black background (please give details) ..... Mixed ☐ Asian & White ☐ Black African & White ☐ Black Caribbean & White ☐ Any other mixed background (please give details)	Other Ethnic Group ☐ Arab ☐ Any other ethnic group (please give details) ..... ☐ Prefer not to say

Which of the following best describes your sexual orientation?

[135] I adapted this form from an existing monitoring form, and note in hindsight its conflation of gender and sex (Guyan, 2022).

☐ Heterosexual/Straight ☐ Lesbian/Gay woman ☐ Gay man
☐ Bisexual ☐ Other (please state) ..... ☐ Prefer not to say

What is your religion or belief?

☐ I have no particular religion ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jain ☐ Jewish ☐ Muslim	☐ Pagan ☐ Sikh ☐ Agnostic ☐ Atheist ☐ Other (please state)	☐ Other philosophical belief (please state) ..... ☐ Prefer not to say

Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?	☐ Yes a little ☐ Yes a lot ☐ No (do not answer the next question) ☐ Prefer not to say (do not answer the next question)

If you answered ‘yes’, please state the type of impairment. If you have more than one please tick all that apply. If none apply, please mark ’other’ and write an answer in (examples are given in the guidance).

☐ Physical Impairment
☐ Sensory Impairment
☐ Learning Disability/Difficulty
☐ Long-standing illness
☐ Mental Health condition
☐ Autistic Spectrum
☐ Other Developmental Condition
☐ Other (please state .....

Appendix H: Interviews – Information Sheet

PARTICIPANT INFORMATION SHEET – INTERVIEWS

TITLE OF PROJECT: *'Illuminating the past to make the future safer?' – Exploring Domestic Homicide Reviews as a mechanism for change.*

INVITATION: *Thank you for your interest in this study, which is part of a PhD project looking at how Domestic Homicide Reviews (DHRs) operate. This Information Sheet contains information about the research and what taking part will involve. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.*

WHAT IS THE PURPOSE OF THE STUDY? *Domestic Homicide Reviews (DHRs) were introduced in England and Wales in 2011. DHRs are conducted when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by someone with whom they were in an intimate relationship, a family member or a member of the same household. The purpose of this study is to investigate how DHRs operate in practice, including how: decisions are made; institutional or social change is understood; learnings and recommendations are produced.*

WHY HAVE I BEEN INVITED TO PARTICIPATE? *This study explores the experience of a range of participants in DHRs. I would like to hear from people who have taken part in DHRs, which could include:*

- Advocates for family or friends of someone who died and for whom a DHR was conducted
- Independent Chairs
- Local Authority Officers who commission or are involved in supporting DHRs
- Review Panel Members
- The family / friends of someone who died and for whom a DHR was conducted.

DO I HAVE TO TAKE PART? *It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a Consent Form. Even if you decide to take part you can change your mind. You can withdraw from the study anytime until April 2021 and you do not have to explain why. If you withdraw, that means any data you provided will not be used.*

WHAT WILL HAPPEN TO ME IF I TAKE PART? *If you decide to take part you will be invited take part in a semi-structured interview. You will [be] provided with an interview schedule in advance of the interview. This will set out the topic areas that I would like to cover. However, there is no 'right' answer. During the interview you may want to raise other issues relating to your experience of DHRs and you are encouraged to talk about the things that are important and relevant to you. The interview is likely to last 60-90 minutes. With your consent, the interview will be audio-recorded to* assist in the production of a transcript. *You will be asked for your consent to be recorded before the interview begins. After the interview you will be provided with a draft transcript for review. This is so you can check that the transcript is an accurate representation. You can amend, elaborate on or remove anything you said at the interview by providing feedback within two weeks of receiving the transcript. If you choose not to provide any feedback, the researcher will assume you agree with the transcript.*

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART? There is no direct risk to you taking part, but there may be an emotional impact. Before taking part, it is

important to think about how talking about your experiences of DHRs may affect you. If you do decide to participate, at the end of the interview there will be time to debrief if want to do so. This could include discussing you experience of the interview and asking any questions you may have. Information on support services will also be provided. The researcher will not record this debrief session but may include their reflections on the discussion in their case notes.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART? As someone who has participated in a DHR, taking part in the study is an opportunity to reflect on your previous experiences. By taking part, you will have an opportunity to share these reflections and your opinions.

Your contribution will help build a picture of how DHRs are working in England and Wales. This will help the researcher identify what is and is not working in DHRs. The research findings may influence practice in the future, leading to improvements in how DHRs are conducted. That may include helping ensure that lessons are identified more effectively, which should enable services and local partnership to improve their ability to safeguard victims of domestic abuse and prevent future homicides.

WILL MY INFORMATION IN THIS STUDY BE KEPT CONFIDENTIAL? If you decide to take part you will be asked to sign a Consent Form, outlining the terms of your consent. Everything you share will remain confidential in accordance with The General Data Protection Regulation (GDPR) 2018. The information collected about you (like your name, job role etc., which is 'personal data') and demographic data (like your race, ethnic origins etc., which is 'special category personal data') will be kept strictly confidential (subject to legal limitations). Information will be kept electronically, and password protected. Any paper-based files will be kept in a lockable cabinet. Information collected about you will be stored separately from the research data (i.e. your interview transcript). Information that could be used to identify you or another participant (e.g. your role in relation to a DHR; the DHR(s) with which you are involved; your agency if you are a professional; and the area you are based) will be changed and / or generalised. This is [to] protect your identity.

You will have the opportunity to suggest a pseudonym, how best to describe your role in relation to DHRs (e.g. "chair", "panel member" or "family member") as well as your agency if you are a professional (e.g. "domestic abuse worker" or "police officer"). The pseudonym, and if appropriate your role and agency description, will be used to refer to you in the write up of the research and any other publications. The researcher will normally agree to suggestions you make, unless there is a good reason not to. In these circumstances, the researcher will discuss this with you and agree a mutually acceptable alternative.

WHAT SHOULD I DO IF I WANT TO TAKE PART? Once you have read this Information Sheet, and if you decide to take part, you should complete and return the Consent Form.

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY? Any data you provide will be retained for 10 years and, having been anonymised, will be deposited in the UK Data Archive. Your data will be used in the write up of my research to produce the researcher's thesis. It may also be used in other publications such as Journal Articles, Blogs or other research products. You can request to be notified when the thesis is published.

WHO IS ORGANISING AND FUNDING THE RESEARCH? The researcher is undertaking a PhD in Gender Studies (Social Sciences). They are a student in the School of Law, Politics and Sociology at Sussex University (http://www.sussex.ac.uk/lps/index).

WHO HAS APPROVED THIS STUDY? This research has been approved by the Social Sciences & Arts Cross-Schools Research Ethics Committee (C-REC). This ethical review application number is ER/JR514/1.

CONTACT FOR FURTHER INFORMATION: For further information you can contact the researcher directly - James Rowlands (J.Rowlands@sussex.ac.uk or 07810 55 32 68). If have any concerns about the way in which the study has been conducted, you can contact the researcher's supervisors: Professor Alison Phipps (A.E.Phipps@sussex.ac.uk / 01273 877689) or Dr Tanya Palmer (T.Palmer@sussex.ac.uk / 01273 877665). Alternatively, you could contact the chair of the Social Sciences & Arts C-REC: Dr Liz McDonnell (E.J.Mcdonnell@sussex.ac.uk)

INSURANCE: The University of Sussex has insurance in place to cover its legal liabilities in respect of this study.

Thank you for taking the time to read this information. [April 2020]

Appendix I: Interviews – Consent Form

Participant ID number:

CONSENT FORM FOR PROJECT PARTICIPANTS DOING INDIVIDUAL INTERVIEWS (PILOT)

Title of Project: '*Illuminating the past to make the future safer?' – Exploring Domestic Homicide Reviews as a mechanism for change*

Name of Researcher and School: James Rowlands, School of Law, Politics and Sociology

C-REC Ref no: ER/JR514/1

	Please tick box
• I have read the Information Sheet, had the opportunity to ask questions and I understand the principles, procedures and possible risks involved.	☐
• I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw anytime until April 2021, without being penalised or disadvantaged in any way nor do I have to give reasons for this.	☐
• I consent to being interviewed by the researcher for a single interview, which is likely to last 60-90 minutes.	☐
• I consent to allowing the interview to be audio-recorded to assist in the production of a transcript (*Please note: your participation is not reliant on you ticking this box. If you do not want to be audio-recorded but still want to participate, only paper notes will be taken during your interview*).	☐
• I consent to the use of anonymised quotes in publications from the research.	☐
• I understand that I will be given a draft interview transcript for review and that I can amend, elaborate on or remove anything I said at the interview within two weeks of receipt. If I choose not to provide any feedback, the researcher will assume I agree with the transcript.	☐
• I understand that I can suggest a pseudonym, as well as how best to describe my role in relation to DHRs, as well as my agency if I am a professional. Where possible, these will be used to refer to me in the write up of the research and any further publications.	☐
• I understand that any personal information I provide is confidential and that identifying details about me will be changed.	☐
• I consent to the processing of my personal information and data for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the General Data Protection Regulation (GDPR) 2016.	☐

- I consent to my data being deposited in the UK Data Archive for re-use in future research and analysis. I understand that it will be fully anonymised before deposit. ☐

- I agree to take part in the above University of Sussex research project. ☐

Name:

Signature:

Date:

Appendix J: Interview – Participant Demographic Data

Demographic Data	*n*	%
Age		
25 - 34	3	7.5
35 - 44	10	25.0
45 - 54	8	20.0
55 - 64	11	27.5
65 - 74	1	2.5
Prefer not to say	3	7.5
No response	4	10.0
Gender		
Female	26	65.0
Male	9	22.5
No response	5	12.5
Identify as sex assigned at birth		
Yes	35	87.5
No response	5	12.5
Ethnicity		
Asian or Asian British – Bangladeshi	0	0.0
Asian or Asian British – Indian	1	2.5
Black or Black British – Caribbean	0	0.0
Mixed – Asian & White	0	0.0
White – Any other White background	3	7.5
White – English/Welsh/Scottish/Northern Irish/British	30	75.0
White – Irish	1	2.5
No response	5	12.5
Sexual Orientation		
Bisexual	4	10.0
Gay man	0	0.0
Heterosexual/Straight	29	72.5
Lesbian/Gay woman	1	2.5
Other	1	2.5
No response	5	12.5
Religion or belief		
Agnostic		
Atheist	5	12.5
Buddhist	0	0.0
Christian	14	35.0
Hindu	1	2.5
Muslim	0	0.0

No particular religion	14	35.0
Pagan	0	0.0
Prefer not to say	1	2.5
No response	5	12.5
Disability		
No	28	70.0
Yes a little	6	15.0
Yes a lot	1	2.5
No response	5	12.5

Note. Total sample of 40 participants.