SCHOOL OF NATURAL & SOCIAL SCIENCES

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Preventing Domestic Abuse Related Homicides and Suicides

Learning Lessons from 'near-miss' cases

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Summary

The aim of this study was to engage with professionals involved in managing responses to domestic abuse in England and Wales to understand the steps that they took to prevent homicide and/or suicide in so-called 'near-miss' cases. Thirty professionals from police forces and domestic violence charities were interviewed, and each of them related the detail of approximately four near-miss cases (on average), which produced a total number of around one hundred and twenty cases for the study. It was found, through a thematic analysis, that there are key activities and approaches that are believed to promote a positive outcome and potentially prevent domestic abuse related homicide and/or suicide. Advocacy was the single most dominant theme, being cited in all interviews irrespective of the job role or agency. Advocacy is a specific activity that differs in critical ways from support, advisory, or investigative activities. Advocates may speak for someone, may fight for their rights or position, and may give an informed opinion. Advocacy was directly linked by interviewees to effective offender management, victim engagement, risk management, and positive outcomes. It was suggested that advocacy could help circumvent any problems with interpreting organisational policy, and promoted innovation. It was also linked to job satisfaction and learning. It was however, universally felt, that effective advocacy could only be achieved with support from line managers and supervisors who would encourage any challenges, and support any decisions to make a challenge. It was argued that without advocacy, victim engagement was more difficult, and without victim engagement, offender management was more difficult. The importance of advocacy is previously acknowledged and led to the use of IDVAs. However, all our interviewees felt that advocacy was not defined by job role, and that any professional could be involved in advocating for victims to achieve positive outcomes.

The advocacy wheel represents the key themes that were described as part of advocacy, and were simultaneously linked to positive outcomes.

Advocacy was linked to victim engagement, and this was believed to link to effective offender interventions and management, including prosecutions and convictions. The activities of advocacy included coordinating responses, making challenges to policy and decisions, innovation and offender management, and not simply victim support.

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Contents

Introduction

The aim of this study was to engage with professionals involved in managing responses to domestic abuse in England and Wales to understand the steps that they took to prevent homicide and/or suicide in so-called 'near-miss' cases. For this study, we define a 'near-miss' as a case where a homicide or suicide may have been prevented due to agency interventions and subject knowledge. The exploration of 'near-miss' case reviews in this report is intended to complement and add to the growing body of knowledge that is being developed from post-death reviews.

Post-death reviews, like Domestic Homicide Reviews (DHRs), are statutory processes that happen with some consistency across England and Wales to learn lessons and gather data to prevent future domestic abuse related homicide and suicide. As with any process, however, there are limitations and challenges when performing post-death reviews. There is a paucity of information and research available on the efficacy and impact of post-death reviews such as DHRs, as they are a relatively new process with the first formal reviews in the UK commissioned in 2011 (Bugeja et al, 2017).[1] Reports have focused on themes for learning, raised in published reviews (Boughton 2022; Jones *et al* 2021;Chantler et al 2020), and on challenges identified by Community Safety Partnerships and homicide review panels in conducting the reviews (Boughton 2022; Montique 2019).

What are known as 'near-miss reviews' occur when it appears that a death has been prevented through a successful agency or professional intervention, and data is gathered to learn lessons from interventions used. 'Near-miss' reviews in contrast to post-death reviews, are not statutory or mandatory processes, and it is very difficult to identify with any certainty when a homicide has been prevented. 'Near-miss' death reviews have a stronger presence in a health context but are more informal and locally-driven in a criminal justice context. In a health context, the maternal near-miss case review (NMCR) is a widely used model promoted by the World Health Organisation (WHO) as an approach that improves the quality of care. Research into lessons learned in this review model found that there was a statistically significant reduction in maternal deaths (Lazzerini *et al* 2018) and improvements in quality of care, and more rapid filtering of recommendations into the system than in post-death reviews (Knight *et al* 2014). There are ostensible differences in the health and criminal justice contexts, but there are also some similarities. The government response to a select committee report on NHS post-death reviews stated "Complainants…too often feel their issue is managed or avoided, to minimise reputational damage to individuals and organisations, or to avoid financial liability…with an unresolved tension between the desire for an open "no blame" culture and the demand for the clear accountability the public is entitled to expect from a public service" (p74), (Department of Health 2015). Research into the process of maternal death reviews in a 'no blame, no shame' culture, also found that organisations will claim that events were out of their control to avoid accountability (Melberg *et al* 2019).

[1] No large-scale studies of DHRs have been carried out to determine how effective they have been in achieving their objectives (Dawson, 2017).

In a post-death review, there may be concerns around blame and accountability, even though, in a criminal justice context, there is a stipulation in DHR and other statutory post-death review guidance that a 'no blame' approach should be taken. Research has found, however, that an appreciation by agencies of the 'no-blame' approach in the DHR process is not easy to understand (Boughton, 2021). There are concerns that organisations involved may still take a defensive position, and that, because of this, there may be a reluctance to be open about what has happened, thereby reducing the effectiveness of the process (SCIE 2015). Boughton (2021) posits that if it is difficult to conceptualise what a 'no-blame' approach is, then the whole DHR process will suffer. The parallel reviews that may be taking place alongside the DHR, such as an Independent Office for Police Conduct (IOPC) investigation, for example, may add to a reduction in trust that there is a 'no blame' process.

In a 'near-miss' review there may be less focus on blame and accountability because death was avoided, potentially through good practice. In this study, we found less reluctance to participate in talking about positive outcomes through discussion of 'near-miss' cases. We aim to focus more intently on those examples of good practice, to add to the knowledge and learning produced in post-death reviews. We hypothesise that with a 'near-miss' model, we may be able to identify and gather information that will be, in some respects, qualitatively different to that gathered in a post-death review, and that any learning may be disseminated more quickly. We believe that this data will also add to, and develop, the information gathered in post-death reviews.

As noted, it is very difficult to identify, with any certainty, when a homicide has been prevented. We relied on professionals identifying cases *they defined* as such within the parameters that we set for inclusion. We do not focus on cases where someone's life was saved because of medical intervention after a homicide or suicide attempt.

Post-death and 'near-miss' reviews

There is an abundance of international research studies on near-miss reviews in a health context, especially in midwifery. There is significantly less literature available focusing on near-miss reviews in a criminal justice context. The WHO Near Miss Case Review (NMCR) model reviews maternal near-miss cases (Say et al., 2009). It is argued that the use of a uniformed assessment model provides a means to review the quality of obstetric care that allows comparisons between institutions and countries, also accounting for changes over time (Say et al., 2009). Several studies have identified the model's effectiveness, including findings leading to reduced mortality and improvement of care (Gebrehiwot & Tewolde, 2014; Lazzerini et al., 2018). Identifying the cause of a maternal near-miss helps to identify key areas of failure in the response system, particularly by identifying delays in recognising danger signs, reaching sources of care, and obtaining appropriate treatment (Kiruja et al., 2017; El-Kak et al., 2020; Akpan et al., 2020; Carvalho et al., 2020; Zhali et al., 2020; Agarwal et al., 2021; Magalhães et al., 2021; Visi & Akoijam, 2021). In this sense, both medical and socio-cultural variables related to accessing help are identified (Mohammadi et al., 2017; Magalhães et al., 2021). This may have links to identified problems for victims of domestic abuse, and lessons from the use of a standard near-miss review model in healthcare can be potentially useful in a criminal justice context. For example, the finding that delaying response in key areas can have a negative effect, using what is called the 'three-delays model' – that is, delays in (i) identifying danger signs (ii) reaching sources of care (iii) obtaining appropriate treatment, resonate with findings from DHRs where risk assessment, multi-agency interventions and appropriate responses are recurring themes. The near-miss reviews in the NMCR have found that focusing on these three key areas, where delay can have an impact, can help address systemic issues that hinder access to services (Liyew et al., 2018; Mersha et al., 2019; Morrison et al., 2021; de Araújo et al., 2021) and this is relevant in domestic abuse responding. It is also suggested that understanding which organisational factors may impact outcomes, such as staff commitment and time, managerial support and involvement in the process, financial issues, quality of data recording, consistent staff training, and good local communication and coordination – may be crucial for the model's effectiveness (Alwy Al-beity, 2019; Lilungulu et al., 2020; Bacci et al., 2018; Filippi et al., 2004; Shaw et al., 2005; Lazzerini et al., 2018) and there may be similar learning in a criminal justice context to prevent domestic abuse related deaths.

It has been found that surviving a near-miss in a medical context impacts women significantly at a physical, psychological, and socioeconomic level (Hinton et al., 2015; Knight et al., 2016; Wachira, 2020; Herklots et al., 2020; von Rosen et al., 2021; Abdollahpour et al., 2019). Good practice would suggest that supporting women with experience of severe pregnancy complications, for example, includes ongoing assistance around levels or providers of care and longer-term support, particularly for mental health (Hinton et al 2014). Social support is also argued to be a robust protective factor (Alemu et al., 2020). In criminal justice research on near-miss cases, there is a focus on preventing suicide in prison, and preventing errors in the criminal justice system. For the former, research has

evidenced how patterns can be identified, and risk factors related to substance abuse and mental health can be addressed to avoid death and severe self-harm in custody or prison (Borrill et al., 2005; Best et al., 2006; Mackenzie et al., 2013). It is recommended that staff are trained, and specialist help is available for individuals with a history of trauma, abuse, and mental illness (Borrill et al., 2005). 'Sentinel events' are events that could have caused death or serious harm, and in a criminal justice context include those events where there has been a wrongful conviction or the release of a dangerous individual into the community. In the United States, 'sentinel event reviews' were introduced in 2011 by the National Institute of Justice (Doyle, 2015; Ritter, 2015).

In the United Kingdom, near-miss reviews have been introduced as good practice to disseminate learning within mental health services, policing, and safeguarding children boards on a localised basis (Ofsted, 2011; National Police Foundation, 2018; Niche Health & Social Care Consulting, 2020). In Rotherham, South Yorkshire, more than twenty cases of domestic abuse near-misses have been analysed since 2015 (Raven & Barstow, 2021). Rowlands (2014) details learning from a near-miss case in Brighton and Hove and presents implications for practice, including moving from an 'event-based' approach to domestic abuse to constructing robust, coordinated, and pro-active multi-agency action plans. SafeLives (2015) reported on an exchange undertaken with a Local Authority that conducted a near-miss review of attempted suicide and expressed recommendations for the local Multi-Agency Risk Assessment Conference (MARAC), this led to introducing new staff training, setting out more explicit expectations for engaging with survivors with complex needs, and creating a new city-wide action plan to ensure wrap-around support for every survivor. In a review of the literature on Domestic Homicide Reviews (DHRs) and their counterparts in other countries, such as Australia, Canada, the United States, and New Zealand, Bugeja and colleagues (2015) studied 71 jurisdictions across these five countries and reported that no reduction in deaths was registered as a consequence of the review process. However, evidence from the United States shows that the Milwaukee Homicide Review Commission (MHRC), a multi-agency homicide review process, helped improve communication, cooperation, and strategy across agencies (O'Brien et al., 2007).

It is reported that DHRs help to define priorities when improving a multi-agency response to domestic abuse. It is suggested that frontline agencies such as healthcare and policing should increase contact with survivors, enhance early intervention plans, and be more proactive in taking responsibility for ensuring survivors' safety (Cullen et al., 2019; Bracewell et al., 2022; Potter, 2021; Saxton et al., 2022). It is also found that the cultural, social, and gendered barriers to accessing services should be acknowledged (Mohammadi et al., 2017; Musielak et al., 2020; Hope et al., 2021). Knowledge of domestic abuse is found to be crucial and an ability to recognise the impact that the perpetrators' manipulation may have on survivors' contact with services, as well as awareness of perpetrators' deceptive techniques to promote challenge and avoid reliance on domestic abuse myths (Hail-Jares et al., 2018; Robinson et al., 2019; Musielak et al., 2020; Potter, 2021). The literature suggests that actions should be taken at a

local and national level to improve the implementation of recommendations found in DHRs and that agencies should have a domestic abuse policy (Potter, 2021; Haines-Delmont et al., 2022). It is even suggested that agencies should take organisational responsibility to learn from death reviews, even if it could be interpreted as blame (Haines-Delmont et al., 2022). Rowlands (2020) suggests that the current DHR oversight system should be evaluated independently, there should be a national programme to support best practices established, and a national repository of DHRs should be built to share information effectively. Some of this may happen organically as the oversight of DHRs is soon to be carried out by the office of the Domestic Abuse Commissioner, but Boughton (2022) goes further than Rowlands (2020) and suggests that the whole DHR system is flawed in many ways and needs to 'undergo a series of changes as soon as possible so that it can truly cement its importance within both criminal justice and society more generally' (Broughton, 2021, p.6). Common themes across the analysis of death and near-miss reviews in different countries evidence how factors such as coercive control, substance misuse, mental illness, and history of previous offending and attempted suicide are vital in assessing the risk of lethality in families affected by domestic abuse (UK Home Office, 2016; Cullen et al., 2019; Bridger et al., 2017; Benbow et al., 2019; Monckton-Smith, 2020; Chantler et al., 2020; Bracewell et al., 2022; David & Jaffe, 2021; Oliver & Jaffe, 2021; Potter, 2021). Multi-agency collaborations that include involving the families of the victims, should be trauma and mental health informed, and good information sharing should ensure that patterns that lead to an increased risk of harm and mortality are identified and addressed consistently. Risk and threat assessment tools, such as DASH, DARA, and the Homicide Timeline 8 Stages should consider these evidence-based risk factors to prevent homicide in intimate relationships.

Methods

For this research, thirty professionals from police forces and domestic violence charities were interviewed and each of them related the detail of approximately four near-miss cases (on average), which produced a total number of around one hundred and twenty cases for the study. All the participants worked routinely with high-risk victims of domestic abuse and their children. Semi-structured interviews were carried out and recorded through contemporaneous note-taking using a pre-structured matrix focusing on the background to the case and the chronology of responses and interventions.

The interviews were all carried out via Microsoft Teams or Zoom, rather than face to face or telephone, and lasted between one and two hours each. The researchers were able to establish a good rapport with each participant and gathered valuable data. Given the sensitivity of the subject, it was acknowledged that the face-to-face aspect of the online interviews would be both more effective and ethical, allowing interviewees to have visual contact. Rapport building is advocated in all research interview processes (Lavrakas 2008), as well as the PEACE model for investigative interviewing used by police. Participants were asked to select cases that were domestic abuse related according to the Home Office definition of domestic abuse, which occurred after coercive control was criminalised under the Serious Crimes Act (2015). Each case involved circumstances where a homicide or suicide was thought to have been prevented due to the interventions that were made. In many of the cases identified by participants, there were extreme or serious circumstances and complexities linked to cultural background or 'complex needs', and in a large majority of cases, and the level of violence and stalking was severe. It was expected that in asking for cases that were 'near miss', those cases would involve violence as it is a visible and consistent predictor of serious harm or homicide. However, it was not always at the beginning of a case that extreme characteristics were identified. In some cases, the initial disclosure was from third parties expressing concern, for example, family members or members of the public. It was on follow up, that the characteristics of the case became more obvious. So even though all had serious and high-risk aspects, it was the response to the initial disclosure that identified these factors. In some cases, the identification of high-risk markers by the victim or third party were unclear. It was interesting however, that most of the cases chosen did have complexities around immigration status, cultural issues, or evidence of extreme violence. Over half the cases identified involved victims from ethnic minority groups, including the traveller community, Eastern European, African, Asian, Muslim and Black communities. There may be many reasons to explain why these groups were so prominent within the sample, but awareness-raising around cultural complexities and marginalised victims has been high profile in recent years and is found in research to be crucial (Mohammadi et al. 2017; Musielak et al. 2020; Hope et al. 2021).

A thematic analysis was performed to categorise the interventions under broad themes. The discussion is organised around those broad themes which are: Perpetrator management; advocacy; supervision; policy; engagement with the victim; specialist services; innovation; knowledge of domestic abuse and coercive control; status of domestic abuse and coercive control.

Discussion

The following discussion is structured around the broad themes that dominated the interviews and were aspects of domestic abuse responding that were perceived to improve outcomes. Broadly, the importance of good knowledge of coercive control was argued to be crucial. Some participants expressed that it was not always easy to convince others of the risks of coercive control, especially where there was no obvious injurious violence identified at an early stage. It was also suggested that training around the responses to domestic abuse may be more effective where so-called 'soft skills' are in evidence. It is argued that less attention is given to developing 'soft skills' such as emotional intelligence that would prepare an individual to deal with the complexity of domestic abuse and that, for police officers, responding to domestic abuse is perceived as different to other forms of traditional police work (Millar *et al* 2019). There are training programmes that are developing content to focus on these skills, especially their importance in advocacy and effective evidence gathering (Better Lives Training[2]). There is also a developing interest in the behavioural patterns of perpetrators, and the importance of gaining skills to recognise perpetrators' manipulation and its impact on victims' contact with services, as well as awareness of perpetrators' deceptive techniques to promote challenge and avoid reliance on domestic abuse myths (Hail-Jares et al., 2018; Robinson et al., 2019; Musielak et al., 2020; Potter, 2021). The idea of advocacy dominated the interviews in this study, irrespective of the agency being interviewed, and there was a distinction drawn between those professionals who would advocate and those who would not. It is argued by Hales and Higgins (2016) that the role of the police is changing towards a more victim-oriented system (cited in Millar *et al* 2019) and there may be tensions between those who may have a more traditional view of policing that is less victim-focused.

Some participants talked about misunderstandings around coercive control and gathering evidence, and conflicts between Crown Prosecution Service (CPS) lawyers and police officers. It was suggested that there is a tendency to try and prove a pattern, for coercive control legislation, by documenting and linking 'incidents', rather than identifying and evidencing control tactics, that prove a pattern of coercive control. This is an important distinction and suggests that good knowledge of coercive control and its patterns, and the legislation is not necessarily widespread. Training to raise awareness of domestic abuse and coercive control is widely delivered across agencies, but the content of the courses differs depending on the course, and those delivering it. Most police services in England and Wales receive focused training around coercive control and risk assessment and have been doing so since 2009. Her Majesty's Inspectorate of Constabulary (HMIC) has also stated that training in coercive control is important so that police do not rely on outdated ideas about what domestic abuse looks like and how to assess the risks involved (HMIC 2014). It is also important to have

[2] Better Lives Training have developed DA training with advocacy content for multi-agency professionals betterlivestraining.co.uk

knowledge of the complexities of domestic abuse and that the cultural, social, and gendered barriers to accessing services should be acknowledged (Mohammadi et al. 2017; Musielak et al. 2020; Hope et al. 2021).

Many of the participants talked about the difficulties in securing the victim's engagement with their service and then maintaining engagement. Some accepted that engagement was often difficult and needed to be nurtured, whilst some expressed dissatisfaction with agencies that interpreted victim disengagement as a reason for services to then disengage. Those participants who were able to engage with victims, especially immediately following an incident, felt that this was advantageous for them and enabled them to establish trust. Sometimes this facilitated immediate safeguarding practices, like for example, arresting the perpetrator or finding safe accommodation for the victim. Many of the participants highlighted how receiving information from the victims immediately following an assault was crucial for establishing trust and long-term engagement although this was not always possible for many of the participants because their contact with victims was determined by a referral from another agency. The concept of the 'golden hour' was highly regarded by many professionals and considered crucial in establishing engagement and achieving positive outcomes. Victim engagement was largely thought to be determined by a victim's level of fear of the perpetrator, trust that the agency would take safeguarding seriously, and fears about whether the criminal justice system could manage the perpetrator effectively.

The following themes, identified from the interviews, sit in the context of good knowledge of coercive control and its patterns and dynamics, and focus on perpetrator mangement.

Perpetrator Management

There are firm plans in the UK to deal with domestic abuse offenders more robustly. The Home Office Tackling Domestic Abuse Plan (May 2022) ambitiously sets out the framework for a system that will aim to not only attempt to prevent domestic abuse from happening, but will deal with perpetrator offending in an unrelenting way and will be 'unequivocal in insisting that it is they (the perpetrators) who need to change their behaviour'. Although at the time of writing this plan is not yet in place, this research suggests that when agencies work together to safeguard women and children who are suffering domestic abuse by dealing robustly and efficiently with the perpetrators, it is possible that there will be better outcomes for the victims. The Violence Against Women and Girls national strategy published jointly by the National Police Chief's Council (NPCC) and the College of Policing in 2021 states that there will be 'relentless perpetrator pursuit' (NPCC 2021) including multi-agency interventions and the use of electronic tagging, so there is support for developing this area of domestic abuse responding (p21).

The importance of perpetrator management was clear throughout the interviews, with most of the perpetrator interventions focused on the safety of the victim. The concept of advocacy was a strong theme but in the context of perpetrator management. It was suggested however, that perpetrator management was difficult for many reasons. Specifically, issues around bail, remand, prosecution, restraining orders, and breaches of orders. The safety of the victim was often more dominant than the management of the perpetrator. Victim safety was a priority, but perpetrator management was a subtheme within that activity rather than taking primacy. There were conversations around 'hiding' victims from perpetrators - moving them out of the area, changing their names, and so on. Persistent perpetrators created the most difficulty for the police, and there was a suggestion from participants that this was the most difficult task due to the restraints of regulations and legislation. The perceived unpredictability of the courts and the Crown Prosecution Service were considered a barrier both to victim engagement and professional interventions. Positive outcomes were perceived to be achieved, in many cases, when the courts and the CPS took threats to the victim seriously and remanded perpetrators or acted on breaches of orders robustly, and this was argued to link to the importance of knowledge about risk and threats presented by perpetrators. In the discussion, perpetrator management underpinned all the themes and was clearly a key frustration perceived to create barriers to achieving a positive outcome.

Domestic abuse responses are dominated by risk and threat assessment (Monckton Smith 2020) and those processes focus on perpetrator behaviours, histories and patterns. However, the data gathered in risk assessments does not necessarily drive safety planning. The data is used to measure the scale or imminence of the risk of serious harm or homicide, and it is that measure that will determine the response and resources applied to any particular case. Research has shown that Domestic Homicides (DH), and specifically Intimate Partner Homicides (IPH) are predictable and potentially preventable (Monckton Smith 2020; Juodis *et al* 2014) and do not occur 'out of the blue'. Juodis *et al* (2014) found in an American study that 82.9% of cases had elements of planning, and 86.5% had been assessed for risk and showed levels of risk before the fatal violence occurred. They also suggest that little of what is known about DH has come from studies of male perpetrators. Campbell *et al* (2007) report that in a review of 35 major IPH studies conducted over nearly 50 years, that only two of those studies included interviews with perpetrators (cited in Juodis *et al* 2014). It is a criticism that perpetrators are relatively invisible in domestic abuse responses, with less focus on the management of their offending, than attempts to move victims beyond their reach. Juodis *et al* (2014) argue that offender management is crucial and that, ideally, responses should be quick with careful monitoring, ongoing risk and safety planning for victims, and ongoing risk management of perpetrators (with consequences for failure to complete programmes), but that this would require a co-ordinated community response (Juodis *et al* 2014).

Arguably, offender management has had the least development in domestic abuse responses. There have been legislative changes, and there have been various instruments and tools to manage perpetrators introduced, like for example Stalking Protection Orders (SPOs) and Domestic Violence Protection Orders (DVPOs), but in a Home Office review, it was found that SPOs are not widely or consistently used (Home Office 2022) and prosecutions for domestic abuse offending are reported to be falling, though reports are increasing (HMICFRS 2019).

High-risk and persistent offenders are considered difficult to manage, and In one case example, a perpetrator was so persistent he stated to professionals that he would continue to try and harm the victim even if he was remanded. In other cases, perpetrators would continue to contact and threaten the victim from prison, with few, if any, checks on those communications being undertaken even where restraining orders were in place. The persistence of the perpetrators in 'getting around' restrictions were considered to be almost impossible to manage, even if communications and correspondence were monitored. This raises a crucial issue in perpetrator management and reveals weaknesses in the system. There was a lot of activity between agencies to promote safety, but ultimately the courts, CPS, and prison systems were not always part of that collaborative effort. Where they were, or where an individual judge or lawyer was considered to understand domestic abuse and coercive control risk, these cases were considered to have better outcomes.

It was suggested that in some cases the legislation or regulations were not a barrier to a positive outcome, but the interpretation of policy or legislation was not consistent, and it was this that could create barriers. HMICFRS (2019) suggested that changes to the use of police bail were putting victims at risk and leaving them vulnerable to further offending when 'released under investigation' (RUI) was used as an interim case outcome. Offender management within prisons was not considered by interviewees to be a priority, and often, incarceration alone was considered by some agencies to create safety. In cases of stalking and coercive control where fixation and obsession often characterise the offending, incarceration alone does not always stop the perpetrator's abuse or harassment or block them from harming the victim. However, incarceration can close cases within processes like MARAC for example, and automatically reduce the risk prediction to a lower level. Persistent offenders can continue their abuse if they are not monitored and managed, and there is not a robust system of re-visiting risk and threat assessment when perpetrators are released from custody. The focus on incarceration by interviewees, as providing safety, may reflect the perceived inadequacies of perpetrator management, and the inconsistent responses to breaches of orders, which are the most common form of community perpetrator management. In one case, for example, a perpetrator had an electronic tag fitted, but when he failed to charge the tag this was not pursued by the courts as a breach, but as a

misunderstanding in the process of charging the device. The outcome was that the perpetrator was unmonitored for at least 24 hours, and follow-up on the alleged breach was not until days later. In terms of the risk, it was considered that the perpetrator have knowledge of the potential window of opportunity for re-offending.

Overall, there were interventions considered and used by agencies in managing perpetrators both in the community and in prison, but the barriers were often perceived as insurmountable, creating a focus on victim safety planning, rather than perpetrator management. However, broadly, it was considered that perpetrator management brings the most positive outcomes and is effective in homicide prevention.

The Drive[3] project was specifically mentioned in a positive outcome, and risk intelligence was gathered through the professionals delivering the programme, and this was considered to have potentially saved the victim's life.

> *"We worked with DRIVE to move him out of the area but if services don't respond the disruption created by DRIVE will fail. Quick action is needed" (R24)*

Advocacy

In all interviews, the importance of effective advocacy was identified by participants as being important for achieving a positive outcome, irrespective of the professional role of the interviewee. Advocacy is a specific activity that differs in critical ways from support, advisory, or investigative activities. Advocates may speak for someone, may fight for their rights or position, may give an informed opinion, and those with a formal advocacy role are often involved in criminal justice, legal, or other similar processes. A victim's ongoing participation in any process was argued by participants to be crucial, and that this may be supported and encouraged through advocacy. It has been found that frontline agencies such as healthcare and policing should increase contact with survivors, enhance early intervention plans, and be more proactive in taking responsibility for ensuring survivors' safety (Cullen et al., 2019; Bracewell et al., 2022; Potter, 2021; Saxton et al., 2022) and this links to the process of advocacy. The role of advocacy with abused women was looked at in-depth in a study carried out by Sullivan and Bybee (1999) who formulated a detailed advocacy intervention of five stages that covered getting to know the victim and building trust, accessing relevant community

[3] **The DRIVE Project** is a perpetrator programme that works with high harm, high risk and serial domestic abuse perpetrators to change their behaviour and reduce their offending against women and children.
http://driveproject.org.uk/

resources, examining the effectiveness of those resources, continuing to provide support based on need and ending the support relationship in a timely and appropriate way. Sullivan and Bybee found overall that advocacy intervention increased social support for the victim, and this led to improvements in quality of life and escape from abuse (Bybee & Sullivan, 2002). In a more recent study on the role of specialist advocacy for families bereaved through domestic homicide (Monckton Smith and Haile forthcoming), the participant families were overwhelmingly supportive of a service that provides someone to speak for the families' rights, knows what those rights might be, and can have difficult conversations with professionals. The most pressing matter for families was not to have emotional support, although good communication skills and empathy were seen as extremely important, it was about having someone who 'knew the ropes', and could argue their case, and speak with professionals for them. It was also said to be important that any advocate should have certain specialist knowledge, and that general advocacy would not be as useful.

Two areas of specialist knowledge were highlighted by nearly all families in this study: knowledge of the formal processes, and the dynamics of domestic abuse. The families suggested that having someone on their side who was aware of their rights and would be willing to speak up for them, encouraged their participation in formal processes. In cases of domestic homicide, it was recommended by then victim's commissioner Louise Casey that bereaved families should have the services of a specialist and expert advocate (Casey 2011; Home Office 2016). Casey stated that bereaved families need support, help and advocacy and that those taking on such a role should have the necessary skills and knowledge (2011:64). The ostensible differences between preventing homicide and the aftermath of it aside, it must be acknowledged that the knowledge of domestic abuse response processes, and the dynamics and risks of domestic abuse, are crucial in both contexts. When considering interventions that were linked to positive outcomes, interviewees in this research talked about becoming an advocate for the victim with a similar specialist knowledge base – that is knowledge of domestic abuse and coercive control and the risks to safety for the victim, and knowledge of the processes, roles and policies of the organisations involved. These are both areas that victims may have little knowledge of. There are many statutory and specialist organisations that may be involved, and victims may have little ability to advocate for themselves and may not even be allowed to do so. Victims don't necessarily have access to all the organisations, or even awareness of their existence, they may not know the policies and processes of the many organisations that are involved or that may offer assistance. It was also suggested that victims advocating for themselves could be labelled as troublesome if they attempted to challenge police or housing decisions for example, and that this could become a barrier to access to services:

"she's the problem because she's a complainer, but her complaints are valid. MH services started advocating for her because when she challenged the services, they were not helpful to her. We helped her to construct her complaints, and in that way, we got a result for her" (R08)

It was also said by participants that sometimes they found the process of challenging decisions and policy difficult, involving tense conversations and professional challenges:

"Challenging (someone) can create problems, if you say 'I need an urgent update' for example, someone said to me 'you don't get to make demands of me' the services need to be receptive, we can advocate all we like but services need to respond" (R04)

"you can't have an advocate who's going to back down" (R01)

"we always go over our hours in the course of a day, it's about going the extra mile, these things are time-consuming" (R10)

"seems like you have to be willing to have the fight and put your head above the parapet for the victims and patients" (RO3)

"you have to be a risk-taker in this work if you're risk-averse you'll never achieve anything" (R09)

Arguably, Independent Domestic Violence Advisors or Advocates (IDVAs) are professional advocates for victims of domestic abuse and may be expected to have those difficult conversations and coordinate the responses for victims. However, it was suggested in interviews that not all professionals had the confidence or support from supervisors, to make difficult challenges. The importance of advocacy was not only articulated by IDVAs - police officers, housing officers, and mental health nurses who participated in this study also considered that the best results came when they were able to advocate for the victim.

"The Mental Health services acted as advocate because the process was being misused"(R02)

"(Police) we don't just accept that victims won't engage. Persist and if all the cogs work together there can be a positive outcome" (R12)

"an advocate is somebody who stands up for you when everything else has been taken from you" (R20)

Advocacy in the cases discussed revolved around safety management. Both the professionals and the victim were concerned primarily with the safety of the victim. Issues around housing, for example, would be primarily in the context of making the victim safe from the activities of the perpetrator. There were conflicts sometimes between victims and professionals around safety, and a lack of trust from both in the systems that are available to attempt to create safety. Victims would sometimes not engage with criminal justice processes as they felt their safety would be compromised. Professionals were sometimes frustrated with the lack of predictability of other professionals across agencies. As noted, safety management is not necessarily dominated by activities to manage the activities of the perpetrator, but rather to remove the victim from their reach. There is an important distinction here, and this appears to create many of the issues with victim engagement. Professionals expressed the idea across the interviews that perpetrator management was the most effective intervention, but that it was the most difficult to achieve. Conversations around encouraging victim engagement despite the risks to themselves, were more visible than addressing the perpetrator's activities through positive action. This was, as noted, due to mistrust of the criminal justice system to deliver effective perpetrator management, which was in many cases linked to a lack of knowledge around domestic abuse threats and risk across agencies.

What was clear from the interviews was that the risks inherent in domestic abuse are not consistently recognised and that it was knowledge of individuals within agencies, rather than agencies, that would create a positive outcome. This included all agencies, and knowledgeable professionals were considered at all levels to create positive outcomes, rather than those who were less knowledgeable about risk. This cannot be separated from individual perceptions of domestic abuse, which are not necessarily solely about a lack of knowledge. Cultural and political differences impact perceptions of domestic abuse and belief in the domestic abuse myths, and whilst training for all professionals has been standard since at least 2009, the raising of the status of the offences and the victims has not been widespread.

Part of the method for this research was that participants self-defined the cases to be discussed, and then further defined what a successful intervention was, so it was interesting that advocacy was raised in every interview, though the term 'advocacy' was sometimes described through language that reflected standing up for the victim and fighting for the victim.

Supervision

It was almost universally felt, that effective advocacy could only be achieved with support from line managers and supervisors who would encourage any challenges and support any decisions to make a challenge. There were differences between the way those supervisors who would support advocacy and those who would not, were described. Supervisors who backed professionals attempting to challenge decisions were described in the most positive terms and named as crucial to the positive outcome. Supervisors who did not support advocacy were given as examples as those blocking a positive outcome. It was argued that advocacy was not driven by policy, but by the individual professional and their supervisor. Those who followed policy, but did not advocate, were perceived by the participants to be less effective in achieving a positive outcome. Whether advocacy was used was seen to be a personal trait, rather than a job role, suggesting that the way policy and organisational agenda were interpreted was largely down to an individual's perception,

> *"it's the individuals, not the organisations that are good" (R07)*

> *"we need supportive managers. I'm lucky my manager has an open door policy" (R15).*

Even within processes, it was individuals who pushed for ways in which the process could be manipulated to work:

> *"There should never be a no-action MARAC, you should always have an action, not give up because the victim won't engage" (R11)*

Policy

What was a positive outcome was also self-defined and there were tensions around whether an organisational policy should be rigidly applied, whether it should be subverted to achieve an aim, or where it was perceived policy had been, or could be, misapplied. There were also tensions around what a positive outcome was. Knowing the desired outcome was suggested to be important, and that was not necessarily specifically aligned with an organisational agenda

> *"Policy is a guide, not a rule, it should be part of the normal conversations around responding to domestic abuse" (R05)*

"I have to be happy I've laid the foundations, sometimes I have to move my ideas and recalibrate what success is" (R21)

"Success looks different in different cases" (R013)

"success might be the victim recognising the abuse and IDVA success might be different to police success" (R14)

Many of the conversations around advocacy were directly linked to policy and process. All professionals must work with policies, and this was raised by many as a critical framework for advocacy and challenge. It became clear that positive outcomes were linked to subverting the rigid application of policies, or the challenging of what were perceived as misinterpretations of policies by partner agencies. For example, it was raised that the interpretation of the Bail Act by some CPS professionals was not always correct, and the ability to challenge or seek a second opinion could be the basis for changing the outcome of a case; in another example, it was stated that there was a misinterpretation of housing policy by a professional, and it was only challenge of that interpretation that changed the direction of the case and created the positive outcome; it was also suggested that there is a wide misinterpretation of General Data Protection Regulation (GDPR) rules leading to blocking of information sharing. In these cases, it was not the policy itself suggested to be blocking positive outcomes, it was about the specific individual understanding the policy and using it effectively:

"If they get offered a property and turn it down, they aren't offered another one" (R29)

There were concerns in this case that the policy was too rigidly applied and the reasons for the victim turning down a property were not taken into consideration – being rehoused in the same area as the perpetrator for example. There was a challenge to the policy in an individual case rather than more broadly, and the decision was eventually changed.

"MH services turn people away with alcohol issues – we must deal with that first." (R18)

In this case, the difficulties that may come with complex needs were complicating when and if victims could access necessary services. This was also raised around some accommodation policies that included barriers to helping victims with suicidal ideation. Suicidal ideation was said to be common in cases of high-risk domestic abuse, but some refuges would not accept that complexity and refused space. The case worker would then

need to search for a refuge placement with a different policy. This was said to be easier where there was local knowledge and the time to complete such a task.

> *"Then there's the tri-contact policy – if there's no answer on the third try, they close the case, but are they even knowing what time to call?" (R06)*

Some domestic abuse services have a policy that they will make three attempts to call a victim, if there's no response by the third call then the case is closed. It was considered that this policy was about resource management rather than safeguarding, and that understanding when a victim would be free or safe to take a call was not necessarily informing the call policy.

> *"Extensive waiting lists are a problem. Some waiting lists are six months long– how do we keep a victim engaged for six months? We need an all-at-once service to get as much done as you can within 24 hours" (R22)*

In this case, the waiting list for mental health services was perceived to be a barrier to victim engagement, and this was exacerbated by waiting lists for other services. Victims were disengaging with the services they perceived as not providing the help needed at the time it was needed.

> *" the DASH score was only four but we still referred to MARAC" (R19)*

In this case, the risk score was required to be fourteen for referral to MARAC (Multi-Agency Risk Assessment Conference). Even though the risk score was low the case worker challenged the policy and was successful in referral into the process.

> *"Safeguarding trumps GDPR, they don't seem to realise that" (R26)*

This example is about the problems with information sharing, and how GDPR rules can be misunderstood and misapplied. Information sharing or lack of it is a recurring theme in the findings of Domestic Homicide Reviews (Rowlands, 2020) but this example refers to misinterpretation of the regulations, rather than the regulations themselves being a barrier to information sharing. It was not only barriers for victims receiving service that were mentioned in this context, but in offender management. Offender management was seen to be crucial in all cases discussed and was also a problem in all cases.

"argue with the CPS, be empowered to argue. Prosecutors are nervous around DA" (R30)

"Aim high should be the mindset, some lawyers are only interested in a sure thing, they aim low" (R23)

"the CPS wouldn't go for remand, they misinterpreted the Bail Act by over-focusing on pre-cons and not risk, this was high-risk stalking. He got bail and she withdrew. The CPS complained the victim wasn't scared enough, but police evidenced her fear. Then we found a more open-minded prosecutor. The new lawyer was horrified at the original decision. They got the remand – it was needed for safety. Since he's been remanded, she's engaging again" (R16)

"CPS used to be in police stations now they are on the phone and no relationships are built" (R25)

"the assault was horrific but we took it to the CPS and had to argue with them for a charge." (R28)

Engagement with the Victim

In many of the case examples, determination and active engagement with the victim were seen to be successful:

"There was a quick response …he was arrested and remanded immediately for GBH. The Police liaised with housing and social services to build trust with her and got her an emergency move. We didn't use uniforms – she would only engage with certain people – by the end even the kids knew the officer's name" (R24)

"Calls were blocked from the prison he was phoning her and the children. We got funding to have texts and everything transcribed – police did a lot of that themselves. This victim was from a traveller background and very distrustful. But in the end, she said 'my faith in the police has been restored. She said she would always call the police in the future" (R27)

"If you can get them to engage the perps move on" (R30)

Victim support of a prosecution was perceived as crucial and keeping victims onside could be difficult. There was a suggestion that all evidence gathering for a potential prosecution should follow the principles of so-called evidence-led prosecution (ELP,) (an evidence-led prosecution does not rely on the support of the

primary victim) irrespective of the current status of the victim's participation. Participants talking about victim disengagement talked about the potential reasons for that disengagement:

" (she said) please don't arrest him, the chronic fear was really evident" (R03)

"She had no memory. Police checked CCTV and everything they could and his story …didn't hold up. She believed his story, so we did an ELP and an enhanced cognitive interview to help with the memory loss, a Tier 5 interviewer got enough evidence for charge. He was remanded" (R09)

Case Example One

A male victim arrived at a hospital with serious wounds to his back. He broke down when being treated by the nurse and disclosed that his wife had caused his injuries and that physical abuse had been going on for some years. With the victim's permission and trust, the nurse reported the abuse to the police who in turn referred the victim to an IDVA and both advocated for him.

The victim was not from the UK, but his wife had not wanted him to apply for indefinite leave to remain. There was a long history of coercive control and quite severe physical abuse involving the wife and other family members, but the police were never called, and the victim had never previously sought help from any agency or confided in anyone about the abuse. The nurse, through routine enquiry and rapport building gained the trust of the victim. The IDVA worked with partners around the victim's immigration status, child custody issues, welfare benefits and accommodation. The police worked with the IDVA and the victim to prosecute the offender. There was a conviction in this case and the offender was sentenced to four years custody. The IDVA supported the victim, with the police throughout the trial. This was also a case where the ONE CHANCE RULE was important.

Specialist Services

There was also discussion of the use of specialist services. The use of a service may rely on knowledge of its existence, what it can provide, and how to access the service. Local knowledge in this respect was important, and it was suggested that personal relationships with some of those specialist services were helpful. Victims cannot be expected to know about all the services available, so again the role of advocacy and good supervisor support is argued to be vital.

> *"We got a Forced Marriage Protection Order[4], but we also applied it to her sisters- there were six in the family, and they were all unprotected. Karma Nirvana were really helpful." (R15)*

> *"We worked with DRIVE to move him out of the area but if services don't respond the disruption created by DRIVE will fail. Quick action is needed" (R24)*

> *"Police recognised high risk DA via a third-party referral. Police listened to her – very important. Got the victim to her mother's house and intervention by specialist service. This service offers counselling for mums too. Victim had no idea the IDVA would be there, but it worked" (R12)*

> *"We got a referral phoned from abroad, the family were worried – the police referred to the IDVA service and they made contact. When she was spoken to, the victim said she wanted to go home and leave the country. Police paid for hotel with IDVA service, paid for flights, hotel staff helped with donations of clothes and things like that. Everyone worked together. She left the country and went back to her family. The IDVA service has a pot of money from donations – no money from govt for this. IDVA also contacted the embassy in her country" (R23)*

> *"The victim was a Muslim gay man, and he was able to speak to a gay male advocate. The police and mental health services went out to see him together as they were concerned about suicide. He wanted*

[4] **Forced Marriage Protection Orders (FMPO)** in the UK are orders legally sanctioned by the court and are designed to protect a person facing forced marriage or who has been forced into a marriage. Someone who disobeys a court order can be sent to prison for up to two years for contempt of court – but breaching a FMPO is a criminal offence with a maximum sentence of five years imprisonment. https://www.gov.uk/government/publications/forced-marriage-protection-orders-fl701/forced-marriage-protection-orders

to stay with the abuser – but not after the meeting. He was relocated, and supported a prosecution, The perp was convicted of serious offences with a substantial sentence. We also got the Freedom programme[5] for victim" (R14)

Case Example Two

A young woman in her 20s had been forced to marry a much older man – he was more than twice her age. He had travelled to the country where she was living for the marriage and then brought her to the UK. They had a young child together. He had been married previously and had a daughter who also abused the victim and her child. The victim was not allowed to work more than 16 hours a week, she was not allowed to see her family, and he repeatedly threatened to kill her. She had learned to speak a little English by working in a fast-food outlet. She was regularly beaten and sought the support of other domestic violence organisations, but she felt unable to engage with them as she did not feel that they understood what she was going through and repeatedly let her down. After one particularly violent assault she ended up in the hospital where the IDVA was based, and she disclosed the abuse.

The hospital wanted to discharge her back to the abuser, but the IDVA advocated for her and managed to get a mental health assessment, as a result of this challenge of hospital policy and building rapport with the victim, she was placed in a home for patients with mental health issues for two weeks. The IDVA used this time to to ensure that she was given indefinite leave to remain in the UK by pursuing a DV Concession for no recourse to public funds. She also helped her and her child to escape and gain alternative accommodation and welfare benefits.

This is another case where the ONE CHSNCE RULE and advocacy secured a positive outcome

[5] **The Freedom Programme** is a domestic violence programme, that examines the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors. The aim is to help victims make sense of and understand what has happened to them and to move forward with their lives in a positive and productive way.
https://www.freedomprogramme.co.uk/

"we used Karma Nirvana and the Home Office helpline, we gave her Tecsos[6] and even had her NHS numbers changed, and new names for children in school. It was so worrying we also got her a panic room" (R02)

"We have a crisis assessment suite attached to the hospital. This high-risk victim slept in the crisis centre, it was so good we had that as an option whilst her accommodation needs were addressed, rather than her return to her abuser. She was frightened of being trafficked for marriage" (R20)

"The IDVA had the language skills - we have a wide range of bi-lingual advocates" (R06)

"The IDVA challenged a counter allegation of abuse with the police and provided them with information about counter-allegations, the victim did not speak English" (R10)

There are numerous examples here of the use of specialist services, and of individuals and organisations working to achieve the best outcome for the victim. The importance of partnership working is clear, and this has been reported in the assessment of findings from DHRs.

Innovation

Innovative individuals were described as those who had imaginatively applied tactics that they said created a positive outcome. In one example, in a case of intimate partner rape where several victims from previous relationships had been identified, it was decided to use Family Liaison Officers[7] (FLOs) for each victim. This was described as creating ongoing participation and engagement from the victims through to a successful trial.

In another example, covert tactics were used to disrupt an offender's ongoing abuse leading to their arrest and conviction, as well as safeguarding the victim.

[6] **TecSOS** is a mobile phone that provides immediate connection to the police at the touch of a button 24/7

[7] **Family Liaison Officers** are police officers trained to provided liaison between the police and families who have been victims of crime

"We managed to hold open a refuge place, normally they won't do this. The victim had to get her child by pretending to them (the abuser) that everything was okay, so we needed that refuge place for when she achieved that" (R22)

"He said he'd kill her even if he was kept in custody, he said he'd pay for someone to do it. She was urgently moved out of area" (R05)

"We knew her complex needs and I would call her before she was high later in the day just to keep contact." (R11)

"DRIVE were informing the IDVA service – they found out he knew where she was." (R08)

"She hated police, there was no trust, and she wouldn't call even if the violence was serious. She could be abusive to professionals so they would just leave. We set boundaries on her – when you are using, we won't contact you. She was worried about being a grass but would speak to the IDVA. He was finally arrested and prosecuted – it took time and persistence." (R17)

"We used the PPiT tool[8] and targeting the top ten DA offenders and proactively interviewing and challenging to let them know they're on the radar" (R07)

"The Homicide Timeline[9] is being used daily in all aspects of our DA policing, it's used in ELPs and risk assessment" (R25).

"Multiple victims with the same perp reported to the IDVA service. Police were able to use multiple victims in one prosecution. Police made sure it was evidenced that there was no conspiracy between the victims. He said it was a conspiracy. Police followed up on all his ex-girlfriends – and a number was provided for victims. He was charged with serious offences" (R19)

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[8] **The Priority Perpetrator Identification Tool (PPiT)** is envisioned as an instrument to be used to trigger an intervention rather than an intervention itself, and aims to support the identification of a commonly recognised priority cohort of individuals, which will be the focus of the collective effort of recognised priority cohort of individuals which will be the focus of the collective efforts of all partners. https://orca.cardiff.ac.uk/id/eprint/75006/

[9] **The Homicide Timeline** is an evidence-based model for understanding the way risk and threat can progress in a controlling relationship and potentially end in homicide. See appendix Two (Monckton Smith 2020)

"There's an IDVA in the control room to advise" (R01)

"We used surveillance tactics and put in a bid for surveillance on a stalking case. We have weekly triage meetings with a specialist DA stalking advocate. There's also specialist training in stalking for certain officers who are able to advise. There's a purple badge scheme so all staff know they can be approached about stalking cases" (R13)

Case Example Three

An Asian couple who had lived in the UK for several years were known to the police for the domestic abuse that the husband perpetrated against the wife. She had married him before arriving in the UK as she wanted to escape her abusive family. When they arrived, he refused to learn English whilst she attended college to learn the language and to integrate with the community. They ran a small business – a local shop - although he controlled the finances.

He was often violent towards her and the level of violence he used had increased over the years; there were several occasions when he was arrested but as she always felt unable to support a prosecution, every incident was NFA'd. In the final violent incident, he stabbed her several times and tried to gouge out her eyes – the police believed that he had intended to kill her but she fought back and survived.

He was arrested and remanded – the police then referred the victim to an IDVA. Originally because of her faith, she did not wish to prosecute him but just wanted to forgive him and leave. The IDVA worked hard with her to convince her that it was necessary for her safety and the safety of her children that she support the prosecution. The IDVA also liaised with other agencies on the victim's behalf to safeguard her and her children. He was convicted of attempted murder and received a life sentence.

"We used FLOs for three victims in one case. There was horrific violence, we used expert interviewers and there was an emergency charging decision because of the high risk of homicide – he was convicted and got 20 years" (R28)

"The victim supported at first then retracted, it wasn't personal it was self-preservation for the victim. The perpetrator is always the most powerful person to the victim and at the end she said, 'You saved my life'" (R21)

Knowledge of Domestic Abuse and Coercive Control

Knowledge of domestic abuse and its dynamics and risks was argued to underpin all advocacy and innovation. Participants felt they were, in some cases, having to educate others as they went along, or 'via the back door' as one participant put it. One participant talked about using the MARAC process to educate the panel on domestic abuse and coercive control dynamics and risks. The myths of domestic abuse were cited as creating many barriers to positive outcomes, but a good understanding that these were myths was allowing the right innovations to be used.

"we find that first responders who have knowledge about the risks around non-mols[10] are the most helpful" (R30)

"We used ELP from the start. So you get everything, body-worn evidence crucial; 999 transcripts; neighbours and children as witnesses; it's not victim led, it's victim-focused" (R16)

"we have to say why we didn't arrest on the report" (R27)

"When the CPS understand the risk, when they understand domestic abuse, it's so much better" (R18)

"we are using CC legislation a lot. It's about a pattern of control, not a pattern of incidents" (R26)

"be aware of red flags. Things like locks on the outside of doors and holes in the wall." (R04)

[10] A Non-Molestation Order (non-mol) is an order protecting a victim or any children from abuse or harassment from a named person

"Perps are resource-intensive, it's difficult to manage them" (R10)

Some participants felt that success in a DA case unless it was extreme, was not acknowledged or recognised. But where there was some form of celebration and acknowledgement, this was talked about in the most positive terms.

"We should report on successes more" (R05)

"We should have best practice conferences" (R21)

"People should be thanked for good work" (R03)

"if managing the safety of a domestic abuse case was a management priority things might change" (R16)

Case Example Four

This case involved multiple victims of a serial perpetrator who regularly raped them, used strangulation against them, as well as extreme violence and control. They were all terrified of him but as they also felt threatened by their community, which was described as an area where you don't talk to the police, so the victims initially refused to cooperate with the police.

The Police took an approach of advocacy and used Family Liaison Officers (FLOs) – a different one for each victim - to work with the victims to build their trust and confidence – this strategy worked and a substantial case was built around the perpetrator who was convicted of multiple counts of rape and coercive control and received a twenty-year sentence.

Status of Domestic Abuse and Coercive Control

All of the participants were specialists in the area of coercive control, their knowledge of domestic abuse, however, was not gained solely through training, but also through experience. The importance of supervisors

having that knowledge was also cited as crucial. There were comments around leadership and the relative importance given to domestic abuse as an organisational priority.

"you don't get brownie points for dealing with DA, it needs more status, you have to be pushing all the time" (R29)

Case Example Five

A third party reported a woman with serious injuries. The injured woman said that she had been beaten but she had no memory of the attacker. She was disorientated and had strangulation injuries. Evidence at the crime scene suggested her partner was the assailant. The victim had no memory and it was probable she had been unconscious for some time. She did not believe it was her partner who had attacked her, and he said it was a stranger and denied any involvement.

The police worked with the victim to encourage her support of the investigation and advocated for her to receive support from partner agencies. Eventually, with a thorough investigation with her engagement and support, the partner was prosecuted, convicted and jailed.

Conclusions

There were many consistencies in the interviews and the importance of awareness and knowledge of domestic abuse and coercive control (its patterns, dynamics and tactics) were universally recognised. This has been mentioned across many studies and in the findings of DHRs and other post-death reviews. Training has been a priority for many organisations, but what may not be as routine, is the way that training may be organised and structured in practice. Risk assessment dominates agency responses to domestic abuse, and effective risk management must include effective offender management. The findings from this study suggest that it is employing advocacy that leads to effective offender management and victim engagement, with the assertion that with those two themes in place, positive outcomes are more likely.

The Advocacy Wheel (Appendix One) is a visual depiction of the activity themes associated with advocacy that are agued to continually strengthen each other in a cycle, and lead to more positive outcomes. Advocacy is a victim centred approach, but in this context, is driven by offender management. It was argued that without advocacy, victim engagement was more difficult, and without victim engagement, offender management was more difficult. Advocacy was linked by interviewees to the personal characteristics of individual professionals, but the activities of advocates could be encouraged more broadly, and supported, with supervisor and agency support. Interviewees defined advocacy through building rapport with victims, co-ordinating agency responses for victims, challenging policy interpretation and decisions, innovation, with all this activity leading to fewer barriers to offender management. The case examples throughout the report show this cycle in action. It also appeared through the interviews that leadership is as important as training. Strong organisational priority and leadership was argued to link to support for advocacy. Even though the role of IDVAs as advocates was acknowledged, it was argued that any professional could, or should, support or practice advocacy.

In summary, the findings suggest that there are many interventions and services available to respond to domestic abuse and create positive outcomes, there are also many useful policies to facilitate positive outcomes, but those policies can be misinterpreted, and decisions may be made through lack of knowledge of domestic abuse and its risks, and lack of knowledge of policies. It was also argued that policy could be used to close cases, rather than pursue victim engagement and offender management. It is almost impossible to know if a homicide has been prevented in any of the cases reported, and this is one of the issues raised. Participants suggested that celebration of positive outcomes and dissemination of good practice may be even more important than dissemination of findings from post-death reviews.

Advocacy Wheel

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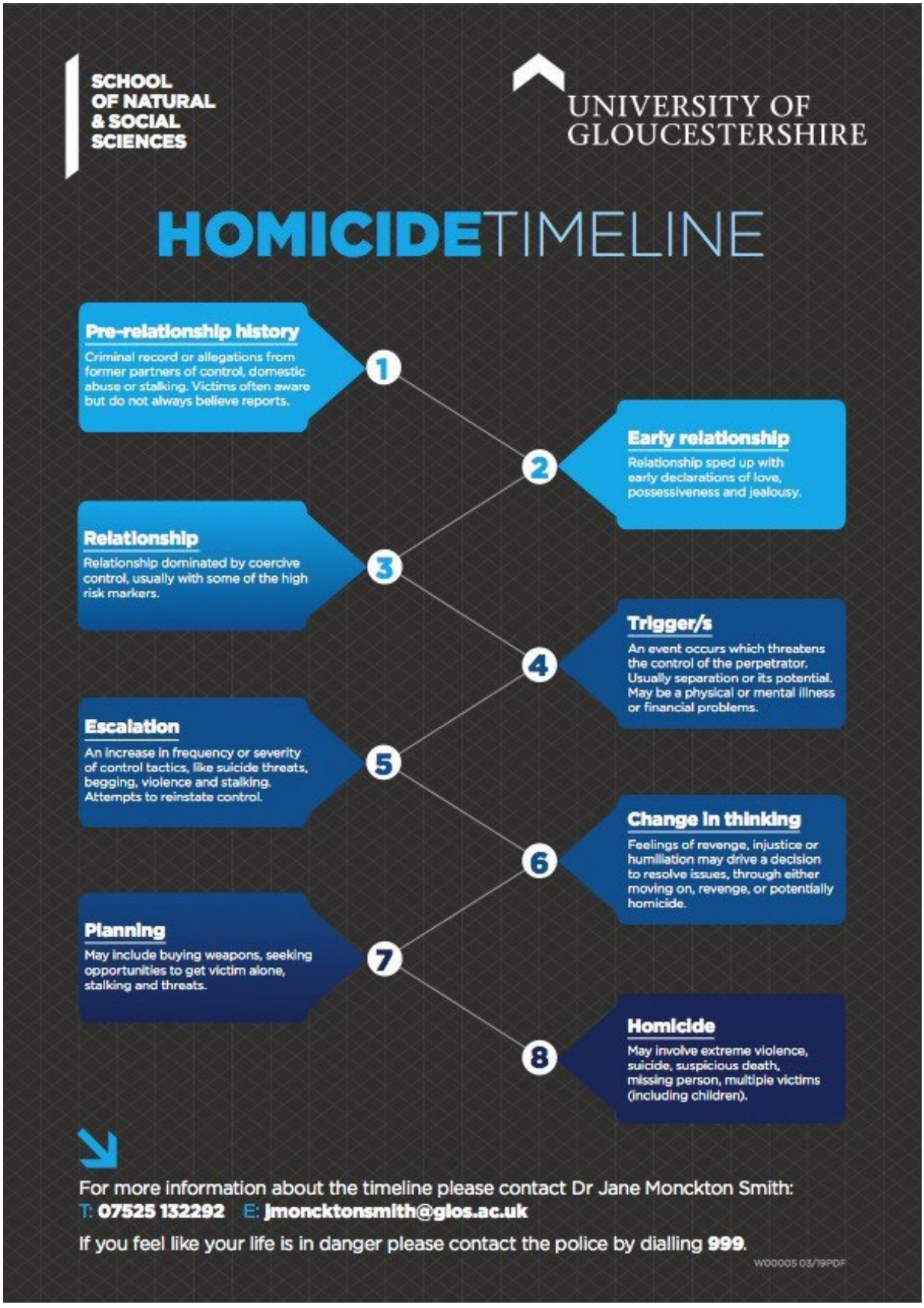
Appendices

Appendix One

Advocacy Wheel

Appendix 2: The ‘Homicide timeline’ (Monckton-Smith 2019).



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