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article

Inside the black box: domestic homicide reviews as a source of data

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Domestic Homicide Reviews (DHRs) are a statutory review process to better understand domestic homicide in England and Wales. As a policy intervention, DHRs are intended to build a picture of the circumstances before such deaths and identify gaps in practice, policy and system response. The rationale is that this learning can improve response to domestic violence and abuse and reduce the likelihood of future homicides. However, little is known about how the DHR process operates, including how knowledge is produced or its subsequent use, including any outcomes. In effect, for the most part, DHRs are a 'black box'. Yet, researchers are increasingly using DHR reports as a source of data. By locating ourselves within these processes, this article explores the implications of limited engagement with DHRs as a process of knowledge generation to date. It focuses on the implications for researchers, in particular the epistemological and methodological issues that arise, before considering what this might mean for policy and practice. It identifies recommendations to address key gaps in the understanding and use of DHRs for research purposes.

Key words domestic violence and abuse • domestic homicide review • domestic violence fatality review • methodology

Key messages

- Recognise the potential and challenges of using DHR reports as data.
- Consider the everyday work processes associated with the production of DHR reports.
- Concepts in DHRs must be clearly defined to enable robust data collection.
- Develop a feedback loop between research and practice so each can benefit from and inform the other.

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The most extreme consequence of domestic violence and abuse (DVA) is someone's death. Such deaths are gendered ([Long et al, 2020](#)): they usually involve the killing of women by men in the context of an intimate relationship, although men can also be victims (in both heterosexual and same-sex relationships). Killings also occur in family relationships. In England and Wales, there were 357 DVA-related homicides

in the three years to March 2019 (ONS, 2020: 18). Regardless of the circumstances, these deaths have numerous repercussions. In addition to the loss of life, they have an immediate and long-term effect on family, friends and community; are the subject of both media and public scrutiny; and can reveal weaknesses or failures in practice, policy and system responses to DVA.

Given the scale of these homicides and their repercussions, where DVA-related deaths occur in England and Wales they should be subject to a Domestic Homicide Review (DHR).¹ DHRs are a statutory, multi-agency process whereby deaths caused by a former/current intimate partner, family, or household member and – since 2016 – deaths by suicide are examined. DHRs were introduced in section 9 of the Domestic Violence, Crime and Victims Act 2004 [DVCV] but did not become routine practice until 2011 when statutory guidance was first issued for their conduct (Home Office, 2011). The purposes of DHRs are learning, acting on and applying lessons learnt from domestic homicide; preventing DVA via improving service responses by intervening earlier; better understanding of DVA; and highlighting good practice (Home Office, 2016b). Since their implementation, DHRs have become a regular but tragic aspect of multi-agency practice with some 800 reportedly completed by 2021 (Monckton-Smith, 2021).

Over the first decade of their existence, there has been no repository to hold the findings of DHRs – which are captured in an Overview Report and Executive Summary (hereafter: the ‘DHR report’). Developments will be discussed towards the end of this article. Nor is there a mechanism for the routine aggregate analysis of DHR reports. Nonetheless, DHR reports have increasingly been utilised by researchers. This article considers this use. We reflect that if DHR reports are to be utilised as data then we must consider the implications that arise from the everyday work processes associated with their production.

To contextualise this argument and the potential implications for policy and practice, we introduce the DHR system, locate ourselves as researchers and describe our approach. We then consider how DHR reports have been used as a research tool to date, before exploring the *epistemological* and *methodological* issues that arise. Finally, we explore the implications for practice and the wider DHR system, including the connection to research, before proposing possible ways forward.

An overview of the DHR System in England and Wales

Although established as a national system, the localised delivery of DHRs has potential implications for their efficacy (Payton et al, 2017). Usually, the Community Safety Partnership (CSP)² where the victim was a resident is responsible for commissioning a DHR upon notification of a DVA-related death.³ An independent chair is then appointed to lead a multi-agency review panel including statutory and non-governmental agencies who had contact with the victim, perpetrator and any children, and potentially agencies appointed for their expertise regardless of contact. Family, friends, neighbours or colleagues (hereafter ‘testimonial networks’) may also be involved, although differences in operationalisation stem from how the role and status of testimonial networks are understood (Mullane, 2017; Rowlands and Cook, 2021). Following a deliberative process, findings are identified (including recommendations), and an anonymised DHR report is produced. After sign-off by the commissioning CSP and approval

by the national quality assurance panel,⁴ DHR report(s) are normally published (for an account, see [Rowlands, 2020a](#)).

DHRs have not developed in isolation. They have been and are influenced by other review systems. In the UK, DHRs are one type of statutory review process ([Stanley and Manthorpe, 2004](#); [Payton et al, 2017](#)). Other statutory review processes examine different types of serious injury or death, for example, relating to children, vulnerable adults, and homicides by patients being treated for mental illness (for an illustration of these differences, see [SCIE, 2020](#)). DHRs are a form of Domestic Violence Fatality Review (DVFR), with DVFR first conducted in the United States (US) in the 1990s and since expanding internationally, including to England and Wales ([Bugeja et al, 2017](#); [Websdale, 2020](#)). It is beyond the scope of this article to substantively address these other review systems, however, where appropriate evidence will be utilised to develop the discussion.

Analytical approach

Both authors are researchers with a background in DVA practice and activism who engage extensively with DHRs. JR is undertaking an Economic and Social Research Council (ESRC) funded doctoral study into DHRs and practises as an independent DHR chair. KB is working on a large study to address gaps in existing knowledge of domestic homicide⁵ and sits on a county-level DHR Task and Finish Group. Our respective work brought us into a reflective dialogue about using DHR reports in research. This generated a recognition of shared experiences, including feelings about the importance of this work and our sense of privilege in being involved. However, we identified dilemmas around *how* to engage with and utilise DHR reports. Consequently, following [Cullen et al \(2021\)](#), this article is the outcome of a shared critical reflection, focused on our understanding of, and approach to, DHR reports and the system that produces them. Having introduced DHRs and situated our approach, we now explore several dilemmas that arise.

DHRs as a data source

DHRs are not undertaken specifically for research purposes, nor are DHR reports produced with this goal in mind ([Chantler et al, 2020](#)). Nevertheless, DHR reports are potentially a rich data source, individually and in aggregate. They can illuminate victim and perpetrator characteristics and experiences, circumstances of death events, other contextual factors (including risk, need and agency contact), and learning about practice, policy, and system responses. Ultimately, these data can identify the components of effective practice and organisational arrangements and shape operational and policy development ([Home Office, 2016a](#)).

There has been limited research into the DHR system, however. Issues arise around the preparedness of participants (for example, the motivations, experience and skills required of, or training for, independent chairs or review panel members); the practices and methodology used; decision-making; and the functioning and impact of quality assurance arrangements ([Montique, 2019](#); [Rowlands, 2020a](#)). As a result, drawing on a concept in evaluation design, DHRs are something of a ‘black box’, in that there has been little engagement with the intervention itself ([Harachi et al, 1999](#)).

This lacuna is not unique to DHRs. Internationally, there has been limited research into DVFR as a ‘method of inquiry’ ([Albright et al, 2013](#): 437). Yet, the potential for

DVFR to be a contingent process of knowledge generation is evident. For example, [Bent-Goodley \(2013\)](#) has argued that DVFRs need to be culturally competent to understand and address the needs of minoritised communities (by implication, the absence of cultural competence would impede or distort any findings). Nonetheless, bar exceptions such as [Watt \(2010\)](#), the actual workings of DVFRs remain little examined. Illustrative of this, [Websdale, Ferraro and Barger \(2019\)](#) detail the development of a DVFR clearinghouse in the US. However, their summary of DVFR functioning presents a normative, uncritical account of how knowledge is produced by these processes. Nonetheless, the development of this clearinghouse is an example of how researchers and practitioners can co-produce robust data collection practices. We return to this example, as it provides a case for both conceptual clarity and the standardisation of reporting protocols.

Utilising DHRs for research purposes

Despite the number of DHRs conducted in England and Wales, the extant knowledge base is limited. Indeed, the DHR system presents a triptych of weakness: the difficulty of accessing DHR reports ([Bridger et al, 2017](#)), the absence of a national repository, limiting aggregate reporting ([Sharp-Jeffs and Kelly, 2016](#); [Rowlands, 2020a](#)) and the challenge of evidencing impact ([Payton et al, 2017](#)). Meanwhile, scholarship has largely focused on the secondary analysis of cases and associated recommendations ([Sharp-Jeffs and Kelly, 2016](#); [Home Office, 2016b](#)). In other examples, DHRs have been used to explore the experience of specific cohorts, including older people or children ([Bracewell et al, 2021](#); [Benbow et al, 2019](#); [Stanley et al, 2019](#)); patterns in abusive relationships ([Monckton Smith, 2020](#)); particular forms of abuse ([Todd et al, 2021](#)); and system responses ([Dheensa, 2020](#); [SCIE, 2020](#)).

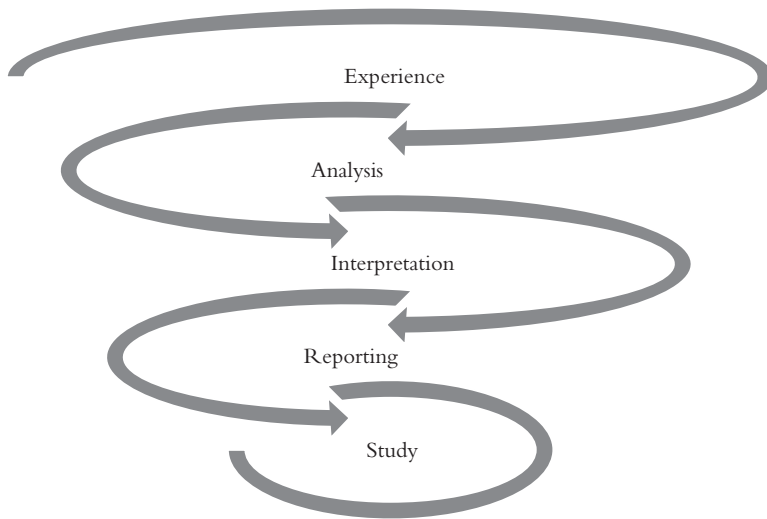
Some broader reflections on the DHR system, in particular its limitations, have been reported. One re-occurring theme, related to the focus of this article, is the quality and content of DHR reports ([Home Office, 2016a](#); [Stanley et al, 2019](#)). Concerns include, for example, the problematic recording of ethnicity data ([Benbow et al, 2019](#); [Chantler et al, 2020](#)). Reflecting this, a systematic review examining 11 DHR/DVFR studies reported a common recommendation for standardised data collection ([Jones et al, 2022](#)). Another concern is the potential tensions around decision-making arising from differing disciplinary perspectives and/or power ([Albright et al, 2013](#); [Dale et al, 2017](#)). Illustratively, in England and Wales [Robinson et al \(2019\)](#) reported hierarchies of voice in review processes and [Mullane \(2017\)](#) has noted how families can be marginalised. These issues highlight the contingency at the heart of DHR/DVFR and speak to our earlier description of these processes as a black box.

Despite such concerns, little consideration has been given to DHR reports *epistemologically* as a data source, the resulting *methodological* implications and, therefore, how reports can be utilised. It is to these points we now turn.

Epistemology and DHRs

Epistemologically, DHR reports have often been treated uncritically as a source of data (for example, see [Bridger et al, 2017](#); [Hope et al, 2021](#)). Others have initially approached DHR reports uncritically, but encountered challenges, including the extent to which specific behaviours are identified and reported ([Todd et al, 2021](#)).

Figure 1: Conceptual model illustrating interpretive layers in a DHR



1. Experience: Interaction with professionals, including if and how this is recorded.
2. Analysis: Agencies retrieve, analyse and report on the information above.
3. Interpretation: Agency and other information (including from testimonial networks) is reviewed, and decisions are made.
4. Reporting: DHR report is produced, capturing findings.
5. Study: Researchers use DHRs; generating data from them.

Initially, limited criticality may have reflected anticipation of the potential of DHRs (as was perhaps the case with [Monckton-Smith, 2012](#)). Regardless, as suggested above, the result is that DHR as a process has largely been treated as a black box. Moreover, there has been limited engagement with DHR reports as documents *per se* ([Bowen, 2009](#)), and more specifically as the products of particular processes of knowledge generation. Yet, DHRs are a contingent process of meaning-making, not least because of their multi-agency nature ([Rowlands, 2020b](#)). Thus, the findings generated from DHRs (and captured in DHR reports) must themselves be more or less contingent. This contingency arises because the findings generated from a DHR, which are then used as data by researchers, are the product of overlapping layers of interpretation which are reified into fact in a DHR report. We conceptualise these interpretive layers as follows (see [Figure 1](#)):

Experience: The first concerns victim experience (or that of others, such as the perpetrator or any children), and then their interaction with professionals/agencies, including if and how this is recorded.

Analysis: The second is the process whereby individual agencies retrieve, analyse, and report this information (usually in the form of individual management reviews (IMR) and/or chronologies).

Interpretation: The third is found within the DHR process itself, as agency and other information (including from testimonial networks) from layer two is reviewed and decisions are made by the review panel individually and collectively, particularly by the independent chair.

Reporting: The fourth occurs when the interpretation in layer three takes documentary form in a DHR report that captures findings, with this subject to both local sign-off and national quality assurance.

Study: The fifth layer becomes relevant when researchers use DHR reports, generating data from them.

Using stalking as an example, a victim may report an abusive partner's behaviour to a professional. They and/or the professional may or may not identify this as stalking. Assuming a report is taken, the victim's account might or might not be explicitly recorded and/or rendered as a description of behaviours that could be recognised retrospectively as stalking (such as a course of conduct). Regardless, if the victim is then killed and a DHR is conducted, their report(s) and/or professional response(s) may be included in an agency's account of contact. This account may/may not define the behaviour as stalking. Meanwhile, the review panel might/might not give credence to, or explore, this behaviour as evidence of stalking. Even if the review panel identifies stalking, it may understand or frame it in a particular way (focused perhaps on the individual, rather than exploring structural barriers). These review panel decisions have implications for any findings generated. Underpinning each stage is the extent to which abusive behaviour is understood and identified (see [Taylor-Dunn et al, 2021](#)). Finally, a researcher using the DHR report must decide whether to record the behaviour as stalking, with this being more or less straightforward depending on the outcome of each preceding stage.

This is not a simple chain of value-free interpretative acts; each layer is born of a complex interplay. Other researchers have identified this complexity. For example, [Todd, Bryce and Franqueira \(2021\)](#) examined 41 DHR reports and noted how the reporting of digitally enabled abuse is dependent on both its identification by practitioners and recognition of the significance of these acts within the DHR process. Indeed, throughout DHRs, there may be conflict about interpretation, although this is little understood. Thus, as noted above, it has been recognised that there may be tensions and conflict around decision-making.

Having considered the epistemological challenges of DHR reports – owing to contingency and interpretation within the DHR process – we concur with [Scourfield et al \(2012: 470\)](#) who undertook sociological autopsies into suicides. They highlighted the interpretative challenge that arose, observing: 'The data cannot simply be assumed to speak for themselves'. Such counsel is apt and we now explore the implications for research.

Methodology and DHRs

Despite the practical and epistemological challenges with DHR reports as a data source, there are few accounts of how data are generated from them. In some examples, the method is not reported ([Monckton-Smith et al, 2017](#); [Dheensa, 2020](#)). Elsewhere, methodological accounts are limited. The most recent government study briefly described using qualitative coding with pre-defined codes ([Home Office, 2016a](#)). Other studies refer to some form of thematic analysis ([Sharp-Jeffs and Kelly, 2016](#); [Benbow et al, 2019](#); [Todd et al, 2021](#)). Such succinctness might be an artefact of what is considered important: if the focus is on findings it is perhaps unsurprising that methodological considerations are not foregrounded. It may be that, certainly reflecting journal word limits, authors have been unable to address this issue substantively. In making this critique, it is important to note that existing studies have made significant contributions to our understanding of domestic homicide. These contributions are particularly important given the UK government's failure

to provide or enable routine aggregate reporting. This failure is in stark contrast to most other DVFR systems (Dawson, 2017), as well as some types of UK statutory reviews, such as reviews into the serious injury or death of children where there is a national repository⁶ and regular analysis (Brandon et al, 2020).

Whatever the extent of their description of methods, researchers commonly appear to use some form of qualitative content analysis (Hsieh and Shannon, 2005) and/or thematic analysis (Braun and Clarke, 2020), depending on the type of quantitative and qualitative data they are seeking to generate, and the analytical method applied. However, this is not a simple task, particularly when examining DHR reports of varying quality, style and complexity. This includes, for example, managing both explicit, more standardised information and content that is implicit and requires interpretation (Schreier, 2012).

Some more in-depth accounts are available. Illustrating this, Stanley et al (2019) described using a data extraction form to collect quantitative data from DHR reports. They reported a close reading of DHRs, using themes developed from the literature. Critically, their account hinted at the interpretative process involved: the close reading is described as providing more in-depth information on the variables against which data was reported. A follow-on article, which described the data extraction process and qualitative analysis of a subset of DHRs, articulated the underlying issue:

Although DHRs are a rich source of information, they are not produced for research purposes. Extracting even basic information such as demographic data is often difficult; understanding the context and dynamics of family relationships is complex. The variable quality of DHRs also impacts on what data can be extracted. (Chantler et al, 2020: 491)

A recent document analysis of DHRs concerning adult family homicide sought to provide a more detailed overview of methods, including quantitative and qualitative data extraction. It summarised the challenges encountered, noting absent information regarding socio-demographics of victims and perpetrators and – perversely given the aspiration that victims should be central to DHRs – that information about the victim is often lacking compared to the perpetrator (Bracewell et al, 2021).

Fundamentally, in analysing a DHR report, researchers must make decisions about complex lives, for which there might be conflicting information or different interpretations. At the heart of this is the fact that researchers using DHRs/DVFRs are analysing information collected for another purpose and by others; they must interpret this information and in doing so, may make errors (Jaffe et al, 2014). Whatever coding method is utilised, these data are situated and often not a simple binary of presence or absence. Returning to the example of stalking, depending on how stalking is recorded in the DHR report, researchers have decision(s) to make. Thus, a conviction for a stalking offence is more easily coded as explicit content than if a course of conduct is evident but not described as stalking.

This creates implications concerning validity and reliability or rigour and trustworthiness. Yet, the limited attention to methodology in the analysis of DHR reports means potential challenges are little explicated. In effect, DHR reports have largely been treated as ‘information containers’ (Flick, 2018: 380) rather than contextually specific, constructed accounts of DVA-related deaths. We suggest that there is a need for more systematic reporting on the design and conduct of DHR

research. Our concern with the use of DHR reports as a source of data, and the methodological and epistemological implications, is not simply a matter of academic obscurantism. Simply put, a concern with *how* we know what we know from DHRs is also relevant to their doing.

Implications for DHR practice

One purpose of DHRs is a better understanding of DVA ([Home Office, 2016b](#)). This section will focus on identifying why DHRs as a process of knowledge production may present challenges for subsequent research.

As detailed, a DHR is a deliberative process of meaning-making. It is reasonable to ask *if* and *how* those involved in the DHR process think that DHR reports can be utilised in research, what their role may be in this effort, and how this might link to and/or affect practice. Yet, it is unclear if and how those involved in DHRs consider the connection between their work (to identify practice, policy and system learning through a biographical account of an individual case) and that of researchers (who usually aggregate DHR reports to understand DVA as a phenomenon).

A further challenge is that numerous concepts relating to DHRs are little defined, affecting understandings of the purpose and the doing of DHRs, including what should or could be considered and recorded ([Rowlands, 2020a](#)). This lack of conceptual clarity spans the DHR process. Three examples are presented here.

- (1) Considering commissioning: DHRs can be undertaken into deaths by suicide. However, these are defined as deaths ‘where the circumstances give rise to concern’, with coercive control given as an example ([Home Office, 2016b](#): 8). This limited definition means that there could be different understandings of such circumstances – including the import of proximity to the death event or an erroneous assumption that such cases should only be reviewed if there was agency contact – so creating variance in CSPs decision-making (see note 3 for a connected discussion). Variable decision-making potentially introduces a postcode lottery in terms of commissioning decisions, with consequent ethical issues if deaths in the same or similar circumstances are treated differently. Variable decision-making may also harm testimonial networks (if, for example, family are forced to campaign for a DHR). This has implications for the capacity of researchers to examine such deaths, given the available DHRs reports will not be representative.
- (2) Considering the doing of specific DHRs, there has been little attention to cases where a DVA perpetrator is killed by their (ex)partner in defensive or retaliatory violence: while any death is a tragedy, in these cases, *who* is properly the subject? One could take a narrow perspective (the homicide victim) or a broader one (both parties, given the significance of the relationship dynamic). This decision has implications for what is considered by the review panel and the findings included in the DHR report. This is in contrast to, for example, New Zealand where a distinction is made between the death event and relationship history ([Family Violence Death Review Committee, 2017](#)).
- (3) Finally, considering what information is recorded within a DHR report: generally, confidentiality concerns apply to all forms of DVFR ([Albright et al, 2013](#); [Dawson, 2017](#)), although the UK has a more permissive information-sharing culture

(Websdale, 2020). Nonetheless, there are tensions for practitioners (and then researchers) when reporting findings. For example, how should a DHR report describe the cause and mechanism of death? Some participants involved in DHRs may feel it is gratuitous to include this information. While there is a need to be sensitive about what is reported and how, a decision not to report has implications: without this information, researchers are unable to identify cases of overkill, defined as ‘excessive, gratuitous violence beyond that necessary to cause the victim’s death’ (Long et al, 2020: 40–1). Here, the issue is that many participants involved in DHRs may be unaware of this concept and/or its significance to a gendered analysis.

In these three examples, an absence of conceptual clarity has an impact on both practice and research. This absence is also evident in how data requirements are understood within the extant, albeit limited, reporting arrangements nationally. In November 2020, the Home Office released a revised reporting form – designed to capture demographic, case and procedural data – which should be completed by the commissioning CSP when DHR report(s) are submitted to the national quality assurance panel.^{7,8} The template itself encapsulates the issues identified throughout this article, with many items undefined or problematic. For example, Table 1 shows the items included under the heading ‘vulnerabilities’.

Items include mental health, drug and alcohol use respectively, pregnancy, physical and learning disabilities. Several mental health issues are then listed. Three immediate questions arise. (1) What is included and excluded: why are only physical and learning disabilities listed? What of sensory impairment or autistic spectrum conditions? (2) What is the definition of these vulnerabilities: only physical and learning disability, and serious or life-limiting illness, are defined. This creates potential differences in understanding(s) of other items. (3) What is the threshold for reporting a vulnerability as present? This is not stated, either evidentially (is this based on reporting by an individual or others, concerns identified by agencies, or a diagnosis?) or temporally (is this over the life course, in a given period, that is, the previous 12 months, or related to the death event itself?). Mental health crosses these issues, given it may be experienced as a short-term episode or be substantial, long-term and constitute a disability.

This short critique highlights challenges in standardising reporting and data captured in DHRs. Here, a lack of conceptual and operational clarity has implications for conduct and research. Moreover, we cannot expect a consistent standard of DHR reports if the infrastructure to elucidate the purpose of good quality reporting and define key concepts is underdeveloped. In contrast, international efforts are significantly more progressed. In Australia Data Collection Protocols exist to enable data collation across DVFR teams (Australian Domestic and Family Violence Death Review Network, 2018). Meanwhile, the aforementioned work to develop a US DVFR clearinghouse will produce reporting templates and protocols (Websdale et al, 2019).

Implications for the DHR system

The issues identified are further illustrated when considering the aggregation and dissemination of DHR findings. DHRs are time- and resource-intensive; therefore it is essential that resultant learning is accessible and subject to regular aggregate analysis (Benbow et al, 2019; Stanley et al, 2019). The absence of both a repository to date

Table 1: Excerpt from the CSP Reporting Form

Vulnerabilities. Please mark (e.g. X) ALL that apply
Mental ill-health
Illicit drug use
Problem alcohol use
Pregnancy
Physical disability ^a
Learning disability ^b
Mental health issue/s identified in the DHR. Please mark (e.g. X) ALL that apply
Depression
Psychosis
Self-harm
Suicidal thoughts
Suicide
Low mood/anxiety (no diagnosis)
Panic attacks
Anxiety
PTSD
Adjustment disorder
Dementia or Alzheimer's disease
Not specified
Any serious or life limiting illness? (Y, N or N/K)^c
If yes please describe

Note. Revised DHR CSP Reporting Form published by the Home Office in November 2020. See: <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>.

^a Defined with reference to the Equality Act 2010 as a 'a long-standing illness, disability or impairment which causes difficulty with day-to-day activities'.

^b Defined as 'affects the way a person understands information, how they learn new skills, how they communicate, and in some cases whether they can cope independently'.

^c Defined as 'an incurable condition that will shorten a person's life'.

and routine analysis of DHRs has been highlighted and is something we return to in the final section of this article.

There is, however, a further concern for both practice and research: specifically, the outcomes associated with DHRs, or indeed what they should be, remain uncertain. As reported earlier, statutory guidance points towards increased understanding of DVA and system improvement. Further outcomes might encompass family experience, including whether DHRs contribute toward memorialisation or societal awareness (Rowlands and Cook, 2021). Whether DHRs lead to, or indeed could be proven to lead to, a reduction in homicide is beyond this article's scope (for a discussion, see Payton et al, 2017). Of relevance is that the recommendations from DHRs have largely been reported (Sharp-Jeffs and Kelly, 2016; Home Office, 2016a). In contrast, there has been no examination surrounding the implementation of recommendations. This is a common challenge across DVFR systems (Storer, Lindhorst and Starr, 2013; Reif and Jaffe, 2019) and other UK statutory reviews (Stanley and Manthorpe,

2004). Indeed, while one outcome might be a reduction in homicide, this is an uncomfortable, crude and likely unrealistic measure of success. Instead, it might be more appropriate to evaluate process or impact, considering for example the extent to which recommendations have affected practice, policy and systems at both a local and national level.

In addition to improving our knowledge of DHRs effectiveness, further investigation regarding implementation might increase recursivity, providing a feedback loop between practice and research while improving DHR report quality. Returning to an earlier example, the reporting of ethnicity data could be remedied in practice, but this is dependent on defined concepts, consistent operationalisation and a shared understanding among DHR participants and researchers about why such data are necessary and how to consistently capture and report them.

Such a dialogue might enhance the quality of recommendations, including our understanding of why recommendations are not always robust or implemented (in this context, see [Fish et al \(2008\)](#) and their critique of serious case reviews). Moreover, if the DHR process is premised on its ability to change practice, policy and systems, when future deaths occur, regular reporting and aggregation of findings could be used to undertake a form of quasi-evaluation. Thus, in undertaking a DHR, review panels might consider whether previous DHR recommendations have been implemented and/or had the desired effect and, if required, identify further action(s) to address outstanding activities or to recommend additional changes.

In summary, research into DHRs is complex, but the extent to which this complexity has been recognised or explicated remains unclear. There may be several reasons for this, and research to date has made significant strides in developing the understanding of domestic homicide (and system responses) in England and Wales. Nonetheless, there is a need to make this complexity explicit, including how it is recognised and managed within the research process.

Moving forward

Thus far, we have presented numerous challenges within the DHR system. This section considers why a more robust engagement with the epistemological and methodological issues in analysing DHR reports has implications for practice, policy and research.

Underpinning DHRs/DVFR is the assumption that they are preventative. That is, the learning from these systems can identify and respond to issues and gaps in practice, policy and systems ([Dawson, 2021](#)). Our ability to examine this is restricted by the aforementioned limitations in reporting and aggregation, particularly the difficulties of accessing published DHRs and the absence of a repository. To address this gap, a repository is being developed in Wales to enable cross-cutting learning,⁹ and there are calls for a UK-wide repository for all reviews ([Robinson et al, 2019](#)). This need has been recognised by the UK government which has committed to creating a ‘public, searchable repository’ ([HM Government, 2019](#): 82). We too advocate for a more centralised, structured approach to facilitate learning. A key issue is functionality. A repository should enable the storage and retrieval of DHRs and, ideally, the capacity to search thematically (for example, by case characteristics). To achieve its full potential, any repository should also enable routine aggregate reporting.

Furthermore, there remain issues around the consistency of data collection which might be less visible but are relevant to practitioners, researchers and any repository. Across the DHR system, to fully assess the quality of DHR reports as a form of reliable research data we need to understand what information is collected and used, how that information is interpreted and by whom, and then what is done with such information. While the aforementioned reporting form is a positive step, it is insufficient and contains key gaps in information and meaning.

Finally, there must be a robust feedback loop between research and practice, so each can benefit from and inform the other. This should include regular reporting of findings and an ongoing dialogue about everyday work processes associated with the knowledge production in and by DHRs. In this context, it is important to address DHRs as an intervention. Further research should investigate the DHR system and its processes, including how review panels navigate ethical issues and decision-making, as well as the quality assurance processes. Critical reflection about the layers of interpretation and complex interplay involved is important. This would increase transparency and further rigorous assessment of the knowledge produced.

Conclusion

While DHR reports are not designed for research purposes they can provide rich learning about individual cases, as well as systems. This knowledge can encourage improvements in policy and practice. In terms of foresight, it is difficult to predict or prevent death(s), for example in the context of intimate partner DVA, given the challenges with both accuracy and the use of risk tools in practice (Graham et al, 2021). However, retrospectively, DHRs can illuminate the circumstances before a DVA-related death. While it is important to investigate these circumstances, and any learning, at an individual case level, a broader understanding of patterns is required to drive meaningful systemic change. To do so means extracting data from DHR reports and using this in aggregate, a process that presents assorted challenges, as illustrated by our conceptual model. Recognising these challenges will help both the practice of, and research into, DHRs. This recognition serves as a reminder that the people at the centre of DHRs lived, like all of us, complex lives: in representing their lives and any learning derived from their deaths, we have a collective responsibility to generate representation(s) that are accurate, respectful and contribute meaningfully to prevention.

Notes

¹ DHRs have recently been implemented in Northern Ireland. No comparable process exists in Scotland.

² CSPs – or ‘Crime and Disorder Reduction Partnerships’ – convene a range of local agencies and have a statutory responsibility for reducing local crime and disorder, substance misuse and re-offending.

³ It is unclear whether all cases are reviewed. Like DVFR elsewhere, DHR is dependent on ‘case finders’ (Fairbairn et al, 2017: 208). That is, DVA-related deaths must be identified and referred, assessed as meeting the threshold, and then a DHR commissioned. Research will only represent deaths where all three stages are met and a DHR report is available. Critically, there is no requirement for CSPs to report on these stages, so the ‘conversion rate’ from deaths to DHRs is unknown. A recent study examining DVA-related death

notifications by the police suggested that there was a high acceptance rate for referrals. However, study limitations meant large amounts of data were missing (Bates et al, 2021).

⁴ Convened by the Home Office with responsibility for quality assuring all DHR reports.

⁵ This three-year study funded by the ESRC (ES/S005471/1) commenced May 2019 under Professor Khatidja Chantler. See: <https://domestichomicide-halt.co.uk/>.

⁶ See: <https://learning.nspcc.org.uk/case-reviews>.

⁷ See: <https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews>.

⁸ In a further example of the limited national aggregation of data, no data has been made available on the earlier version of this form, nor is it clear how data from this revised version will be used and/or reported.

⁹ See: <http://upsi.org.uk/projects-2/wsr>.

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Conflict of interest

The authors declare that there is no conflict of interest.

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