Domestic Homicide Reviews West Yorkshire: Thematic Analysis

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Violence Reduction
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You find strength and the ability to carry on for your loved one. They have to have a voice as no-one else can speak for them; only the ones left behind; we are the ones that can speak for them. They must not be forgotten, and all the services must learn from all the mistakes made and admit to the mistakes no matter how small; the answers mean so much to the loved one's left behind. This is not to apportion blame or point the finger at any one department or service. Just give the answers to the questions that we ask as life is precious and we need as much information as we can get. As the curriculum states; every young person should learn English and Maths. But we should be teaching the latter to respect and to honour each other. Relationships should be taught from a young age both at home and in school. Let's make a difference. Now, and in the future.

An excerpt from the family statement in DHR-14

Domestic Homicide Reviews – Thematic Analysis

The content of this document contains graphic references and details sensitive, potentially triggering and upsetting themes from the outset including but not limited to violence, self-harm, abuse, and suicide. We appreciate this may lead to emotional responses and readers are advised to prioritise their emotional wellbeing when reading this document.

Contents

Background

The West Yorkshire Violence Reduction Partnership undertook this project to identify key risk factors and common patterns in incidents of domestic homicide to help inform and make recommendations for our partners.

This paper reports the findings from a thematic analysis of Domestic Homicide Reviews (DHR) in West Yorkshire, looking at:

- Patterns and characteristics of the incidents and escalation towards it
- Trends in victim, offender, and family characteristics, including
    - Who the victims are
    - Age of victims and offender
    - Ethnicity of victims and offender
    - The relationship between victim and offender
- Intelligence and information held by services
- The response of services
- Lessons to be learned and recommendations

The purpose of this analysis is to understand more about domestic homicide, draw out key themes and trends, and to promote key learning for future DHRs conducted in West Yorkshire.

Homicide & Domestic Homicide Reviews

The term 'homicide' covers the offences of murder, manslaughter, and infanticide. Domestic homicide involves victims killed by their partner/ex-partner or a relative or by someone else living with the victim at the time of the killing.

In the year ending March 2023, there were 100 domestic homicides and 70% of victims were women[1]. Of the 100 domestic homicides, 68 victims were killed by a partner or ex-partner, 18 were killed by a parent, son or daughter, and 14 were killed by another family member.

For the three-year period, between April 2018 and March 2021, there were 373 domestic homicides recorded by the police in England and Wales. This represents approximately 1 in 5 of all homicides, where the victim was aged 16 years and over during this period. 72.1% of victims of domestic homicide were female, which contrasts greatly to non-

[1] Homicide in England and Wales - Office for National Statistics (ons.gov.uk)

domestic homicides. In the majority of female domestic homicides (77%) the suspect was a male partner or ex-partner, whereas in the majority (62.5%) of male domestic homicides, the suspect was a male family member[2].

Domestic Homicide Reviews (due to be renamed Domestic Abuse Related Deaths Reviews upon the passing of the Victims and Prisoners Bill) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. The Home Office guidance states that Domestic Homicide Reviews "*should illuminate the past to make the future safer*". Since 2011, there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.

Domestic Homicide Reviews are conducted after the death of a person aged 16 or over from violence, abuse, or neglect by someone to whom they are related, in an intimate relationship, or in the same household. The key purposes for undertaking DHRs are to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working

The threshold for conducting a DHR is lower than the criminal threshold. For example, a DHR may be conducted on a suspected suicide, where it appears the suicide was caused by abuse, but this would not be homicide under law.

[2] Domestic abuse prevalence and trends, England and Wales - Office for National Statistics (ons.gov.uk)

Methodology

The approach to this analysis is qualitative, involving thematic analysis of domestic homicide reviews to understand the characteristics and contexts of each incident, how services worked with those involved, and identify any patterns or themes across the cases.

Sample

The Domestic Homicide Reviews included in this report are either publicly available on the Government website or are summaries published on the local authority website.
13 DHRs[3] were available from the Home Office and a further 4 were available directly from Bradford, Wakefield, and Calderdale local authority websites.

The number of Domestic Homicide Reviews by district is:

Bradford	4
Calderdale	2
Kirklees	4
Leeds	5
Wakefield	2

The DHRs included were published between 2013 and 2022 detailing deaths that occurred between 2012 and 2019[4].

Coding framework

The Domestic Homicide Reviews have been analysed through the lens of two existing frameworks – the Domestic Homicide Timeline[5] developed by Professor Jane Monckton-Smith and the influential factors explored by the West Yorkshire Violence Reduction Partnership. The Domestic Homicide Timeline is a framework for tracking homicide risk in cases of coercive control and stalking which identifies a common behavioural pattern for intimate partner homicide. The Influential Factors report[6] explores the risk and

[3] There are a total of 15 DHRs available on the Home Office website, however two of these are summaries of the lessons learned as opposed to the full Domestic Homicide Review and therefore have not been included
[4] Full details of the sample is included at Appendix A.
[5] Domestic Homicide Timeline
[6] Influential Factors report

protective factors associated with becoming involved in serious violence across the four levels of the socio-ecological model.

The Domestic Homicide Reviews were read and coded against the different elements of each coding framework, where relevant[7]. From this, themes were identified to understand the commonalities and differences in the incidents, escalations to them, characteristics of those involved and engagement with services.

In addition, service involvement was explored as a standalone section, acknowledging that engagement with services will overlap with understanding the risks identified through the Domestic Homicide Timeline and Influential Factors frameworks.

The recommendations made in each Domestic Homicide Review were analysed separately from the personal content of the Review to understand where similar recommendations had been made repeatedly across the districts and over the years.

[7] An overview of how the coding frameworks map on to the reviews is included at Appendix B

Analysis

Demographics

14 of the 17 victims were female, aged between 23 and 62 years old. 59% of victims were of a white ethnic background, 12% were from an Ethnic Minority background and ethnicity was unknown in 29% of cases.

Across the DHRs there were 18 perpetrators, of which 89% were male. The age of perpetrators ranged from 27 to 62 years old. 39% of perpetrators were of a white ethnic background, 22% were from an Ethnic Minority background and ethnicity was unknown in 39% of cases.

The age and ethnicity of both victims and perpetrators is not recorded in every DHR, meaning an accurate picture of the demographics cannot be ascertained.

Intimate partner homicide (where the perpetrator was a current or former partner) accounted for 82% of the 17 DHR cases. In the three remaining DHRs the perpetrators were an acquaintance, son, and brother. All of the 17 victims had children (of varying ages), and in three of the review's children are noted as being present when the homicide occurred.

The most common method of murder recorded was being stabbed (n=8), followed by death by assault (n=4). Less common methods were head trauma (n=2), asphyxiation (n=1), strangulation (n=1) and not included (n=1).

Domestic Homicide Timeline

The Domestic Homicide Timeline developed by Professor Jane Monckton-Smith details eight stages that denote a common pattern of behaviour in intimate partner homicides. As such, this timeline was relevant to all but three[8] of the domestic homicide reviews analysed for this paper.

A limitation of Domestic Homicide Reviews is that they are focused on agencies' responses rather than the individuals involved, therefore the details of pre-relationship, early relationship, and in some cases, relationship, are not explicitly explored. As a result, the risk factors evident within these stages cannot be discussed.

[8] Those committed by a brother and a son against their family members and jointly by a friend and acquaintance of the victim

In addition, as the perpetrators declined to or were unable to take part in the Domestic Homicide Reviews insights into their change in thinking, planning, and the homicide characteristics were not always ascertainable.

The number of Domestic Homicide Reviews which include themes relating to the Domestic Homicide Timeline stages is included below.

Stage	Number
Pre relationship	5
Early relationship	7
Relationship	14
Trigger	11
Escalation	6
Change in thinking	3
Planning	3
Homicide characteristics	9

Pre-relationship

The relationship history of the perpetrator refers to coercive and controlling behaviours, stalking, or domestic abuse exhibited by the perpetrator against other victims. These incidents do not have to be reported to the police but could be allegations made by former partners to family and friends or other agencies.

Insight into the pre-relationship stage was evident in five of the Domestic Homicide Reviews analysed. The key themes that emerged were:

- Previous stalking and harassing behaviour
- Previous domestic abuse
- Prior convictions

Previous stalking and harassing behaviour

Examples of previous stalking and harassing behaviour included a perpetrator reported by their ex-partner for sending *'abusive texts and emails from him after they broke up from a five-month relationship'*. Another perpetrator made *'multiple threatening telephone calls to [their ex-wife] demanding money and property'.* Harassment Warnings were issued to at least two of the perpetrators due to their actions towards former partners.

Previous domestic abuse

There was evidence of previous domestic abuse perpetrated upon former partners. The abuse present was verbal, manipulation, and physical. For one perpetrator there were three domestic related violence incidents recorded regarding previous partners. One of the female perpetrators included in the analysis had previously injured a former male partner, *'hitting them over the head with bottles and glasses or punching them in the face'* and *'pouring boiling water onto their chest and stomach'.* In some cases, this abuse had been reported to the police both West Yorkshire Police (WYP) and other forces.

Prior convictions

Prior convictions were present in the pre-relationship history of two perpetrators. One perpetrator is described as having *'the potential for violent and unpredictable behaviour'* with previous convictions for threatening behaviour, criminal damage, and racially aggravated threatening behaviour. Another was a registered sex offender following an earlier sexual assault. This individual also had an offending history including Actual Bodily Harm, theft, burglary, and possession of heroin.

In addition, whilst not included in the Domestic Homicide Timeline, a commonality between the pre-relationship history of some of the victims was having previously experienced or witnessed domestic abuse. This is not to place blame upon the victims, rather to highlight how witnessing and experiencing domestic abuse increases an individual's vulnerability.

Early relationship

Early relationships, as defined by the timeline, are normally not determinant of what the relationship would evolve into. Within these cases the early typical steps of forming a relationship are 'sped up'. For example, this could be moving in together quickly or early declarations of love.

Indicators relating to the victim and perpetrator's early relationship were present in seven of the DHRs analysed. The key themes that emerged were:

- Having children early
- Co-habiting quickly
- Changes in behaviour
- Warnings from others

Having children early

Having children early into the relationship was evident in two of the reviews. One victim and perpetrator had their child shortly after beginning their relationship whilst another had two children in short period of time, this was also soon after the perpetrator had left prison for an assault.

Co-habiting quickly

Co-habiting quickly was also present, with one perpetrator moving into the victim's property after only two months and another within three months. In both cases, the perpetrator moved into a property owned or rented by the victim.

Changes in behaviour

Changes in behaviour were noted in the behaviour of both the perpetrator, in that they started to become controlling, and within victims, for example becoming withdrawn which could be an indicator of coercive behaviour and/or domestic abuse. A victim who was murdered by their husband after 25 years of marriage, had experienced *'an occasion early in the marriage where [the perpetrator] had locked her in the house and hidden the key'.*

Similarly, another victim experienced domestic abuse for the first time in their relationship after three months with the perpetrator being verbally abusive. This relationship was also described as characterised by *'incidents of coercive and controlling behaviour'* with the perpetrator beginning to monitor her phone and limit her contact with friends from the start of the relationship.

In one case, friends noted during the review that shortly after the relationship commenced, the victim's behaviour changed with her *'usual cheerful disposition becoming more withdrawn',* noting that she acted differently when the perpetrator was present even early in the relationship.

Warnings from others

Warnings from others was a key aspect of one of the Domestic Homicide Reviews which had a male victim and female perpetrator. Friends of the victim had repeatedly warned him early in their relationship that the perpetrator had previously *'stabbed another friend in the neck and been a reason behind another friend trying to take their own life'.*

These themes reflect how the early relationship is conceptualised in the domestic homicide timeline as a stage where perpetrators attempt to seek early and firm commitment, before progressing to possessiveness and controlling behaviour.

Relationship

When the relationship is established, these become dominated by coercive control, stalking, and domestic abuse. Control can be established through preventing the victim from having autonomy over their own life, for example when they go out or how they dress. This stage is the most varied in terms of the length of time for which it lasts.

Evidence of the behaviours included in the relationship stage of the domestic homicide timeline were present in all of the intimate partner domestic homicide reviews analysed.

The key themes that emerged were:

- Fear
- Controlling behaviour
- Police involvement
- Drugs & alcohol use
- Life stressors
- Familial perceptions
- Evidence of violence

Fear

Fear was present for a number of the victims, but this was not always reported to agencies during the relationships. One perpetrator was suspected of causing injury to the victim's child, and her family believed the fear that this would result in her child being removed prevented her from disclosing any incidents of domestic abuse.

The relationship of a victim who had been with the perpetrator for 30 years was *'characterised by fear and physical* assault', with the victim disclosing to services that she had lived in fear of him for many years.

Controlling behaviour

Analysis of these Domestic Homicide Reviews have highlighted how hidden controlling and coercive behaviour can be within relationships and often this is not viewed as domestic abuse. The children of one victim, who was murdered by their husband of almost

40 years, commented that there had been no previous history of domestic abuse. However, there was evidence that the perpetrator was controlling, taking charge of all financial matters for the family leaving the victim *'unable to complete simple personal tasks like paying bills such had been the control [he] had had over their relationship.'* Similarly, another victim who was murdered by her husband of 25 years, disclosed to agencies shortly before her murder that her husband was controlling and emotionally abusive.

A common element of coercive and controlling behaviour is alienation. One perpetrator slowly isolated the victim from friends and family, other than her mother, who disapproved of him, leaving her with no potential sources of support. His control was exerted over multiple elements of her life, for example he *'phoned the office at 9am every day, which was usually shortly after [the victim] arrived'* indicating a monitoring of her whereabouts.

This element of control was seen in another review, where the perpetrator made the victim delete contacts from her Facebook account, monitored her phone, and attempted to limit or block her contact with friends. Furthermore, this perpetrator restricted the victim's access to her money, in one incident taking her handbag and contents away from her.

Indications of controlling behaviour were also observed in a case where the victim asked her family not to share details of her socialising for her birthday on Facebook as the perpetrator would not have been pleased she went out.

In some cases, controlling behaviour was accompanied by physical violence. This physical violence could have lasted for a number of years, with one victim detailing to the Crown Prosecution Service a history of physical abuse over a period of 24 years, with some incidents resulting in the perpetrator being arrested.

Police involvement

In one review it is noted that within three months '*there were 27 callouts, nineteen were explicitly related to incidents of domestic abuse*' and that West Yorkshire Police '*arrested the [perpetrator] on a number of these occasions but he was always released without charge'.*

The ex-partner of one victim, who was not the perpetrator, voiced concerns about the perpetrator during their relationship and reported these to the police. As a result, a Prohibited Step Order was obtained to stop the perpetrator having contact with the victim's child. Concerns were raised to West Yorkshire Police several times regarding his child's safety with the perpetrator.

Drugs & alcohol use

There are links between alcohol and drug use and domestic abuse, sometimes substance use and domestic abuse occur at the same time or the former can increase the severity of the abuse[9]. In addition, victims of domestic abuse can use alcohol or substances to help them cope. A victim and perpetrator who both had a history of drug use prior to their relationship experienced an escalation of this once they were together.

One of the DHRs with a female perpetrator noted alcohol as a significant factor relating to their violent behaviour. This perpetrator had been barred from two public-houses and whilst intoxicated she would '*hit and verbally abuse [the victim]'*.

Life stressors

Life stressors can have an impact on any relationship but for those where controlling behaviour is also present there can be more severe consequences. There were financial inequalities between the victim and perpetrator in one relationship, where the perpetrator was financially dependent on the victim (female) which created tension between the couple.

Stressful life events were recorded in another DHR, again relating to financial difficulties. The perpetrator had recently become bankrupt which had severely impacted their mental health and the relationship.

Perceptions

Domestic Homicide Reviews try to capture the voice of the victim, usually through contributions from their family and this can shed light on how the relationship was perceived from the outside. The mother of one victim felt that *'the control in the relationship was with the perpetrator'.* Similarly, the behaviour of one perpetrator was observed by the victim's children who described him as *'so angry'*

One review received contributions from neighbours of the victim and perpetrator, who described the relationship as '*volatile',* and they were fearful the perpetrator may *'explode at her'.* A similar situation was described in another review with neighbours telling the police when they were called to a domestic incident, *'they do this a lot but tonight it is really loud and the screaming hasn't stopped'.*

[9] Alcohol and domestic abuse | Alcohol Change UK

These themes reflect the description of this stage in the domestic homicide timeline, especially the diversity in length of time this stage lasts for. Furthermore, the dominance of controlling and coercive behaviour within these relationships is obvious, whether disclosed at the time or not.

Trigger

At this stage, risk begins to rise for the victim, usually prompted by something occurring that threatens the amount of control the perpetrator has over the relationship. A common trigger identified by Professor Monkton-Smith was separation.

The (potential) trigger for the homicide was included in 11 of the DHRs analysed. The key themes that emerged were:

- Injury
- New relationship
- Separation/end of relationship
- Removal of child
- Pregnancy
- Life stressors

Injury

The trigger within one relationship was the perpetrator being suspected of injuring the victim's child. This suspicion caused the end of the relationship as the victim did not want to risk losing her child and so ceased contact with the perpetrator which was not well received.

New relationship

The withdrawal of commitment is highlighted in the domestic homicide timeline as a reason for murder. In one case, the victim began a new relationship shortly after splitting with the perpetrator and was enquiring about moving her children to a new school when she moved in with her new partner.

Separation/end of relationship

Similarly, separation or the ending of a relationship was a commonly given reason for murder given by perpetrators analysed in the domestic homicide timeline. One victim left her husband of many years a few weeks prior to her murder, instigating conversations

about selling their joint financial assets. The ending of the relationship was a catalyst for the perpetrator's behaviour to escalate, changing from being physically violent to stalking, and causing theft and damage at the victim's address. Another perpetrator who attempted to take his own life, reported that his problems stemmed from "*his wife reportedly telling him she didn't love him anymore".*

One victim had disclosed to a relative, the day before her murder, that *'she was leaving [the perpetrator] as he was violent and disrespectful to her including in the presence of the baby'.* Another victim shared her intention to divorce her husband in an application for housing in which she stated, *'my situation is now so poor, I'm getting divorce with my husband, and I have 3 kids, now I live at my friend's house'.* The victim's threat of divorce had escalated arguments and tensions between the couple.

Turbulent relationships were present across the reviews and one couple had separated a number of times, the latest being a few weeks before the homicide whilst she was pregnant, meaning the victim was at higher risk of repeating and escalating incidents.

Removal of a child

A key trigger for one murder was the removal of a child into care. This incident caused the victim to become estranged from her family and escalated the violence and substance misuse of both the victim and the perpetrator.

Pregnancy

In one case, the trigger led immediately to the victim's murder. The victim disclosed to the perpetrator that she was pregnant; he did not believe that he could be the father and accused the victim of having a relationship with another man. The victim denied this, and the perpetrator commenced a sustained attack that caused her death.

Life stressors

Examples of life stressors that may have acted as a trigger that threatened the amount of control the perpetrator held include being made redundant, debt, bankruptcy, and excessive drinking.

As is described in the domestic homicide timeline, these themes relate to a perceived loss of control and/or status.

Escalation

Escalation is an increase in frequency, severity or variety of the abuse, control or stalking behaviours. This is viewed as an attempt to re-establish control or status. A number of tactics can be employed, including begging, threats of violence, or suicide threats.

The escalation of abuse and control prior to the homicide was discussed in six of the DHRs analysed. The key themes that emerged were:

- Stalking & harassment
- Increasing police involvement
- Escalating domestic abuse/control
- Attempted suicide or threats of

Stalking & harassment

Stalking and harassment was commonly seen as an attempt to re-establish control or status by the perpetrator.

Receiving regular unprompted visits from her husband from whom she'd separated was the experience of one victim, and it was on one of these visits that he murdered her. Similarly, another perpetrator began stalking and harassing his wife, from who he was separated, by following her and their sons when out on walks and changing the Wi-Fi code to prevent the victim's internet access. Other victims had suspected their perpetrator of breaking into their house, leaving them feeling unsafe in their own home.

The stalking and harassment of one perpetrator was so impactful on the victim she became scared to leave the house and often felt suicidal. In addition, this victim began carrying a knife to protect herself from the perpetrator. The stalking tactics of this perpetrator were described as *'using information to invade parts of [the victims] private life, to punish, to torment, and humiliate her'* causing her to feel as though she had no control over her daily life.

Increasing agency involvement

For one victim, in the two months prior to their death, Yorkshire Ambulance Service received fourteen call outs to the victim and perpetrator, many of these were alcohol related but there was also an incident where the victim had self-harmed and another when she had been assaulted by the perpetrator. Also, within this period, there were seventeen police call outs relating to multiple assaults.

Escalating domestic abuse/control

To assert their power over the victim following a trigger some perpetrators increased the severity or frequency of their domestic abuse and controlling behaviour. Even following their separation, one perpetrator continued to send the victim a barrage of texts wanting to know her whereabouts and declaring his love for her.

For another victim the physical abuse they experienced increased, with their family reporting to the review that in the weeks leading to the homicide the victim was often bruised.

Attempted suicide or threats of

Multiple perpetrators attempted suicide or threatened to take their own life in response to the victim leaving them or planning to. On more than one occasion, during repeated separations, one perpetrator *'threatened to kill himself if [the victim] did not take him back'.* The victim had disclosed to health professionals that the perpetrator held this over her whenever they argued.

Another perpetrator did attempt to take their own life upon learning that his wife planned to divorce him due to his controlling and abusive behaviour, and the perpetrator cited marital problems as his reasons for attempting suicide.

As explained in the domestic homicide timeline these escalating behaviours appear to attempt to re-establish the control or status previously lost.

Change in thinking

This stage tends to occur towards the end of the period of escalation and is when a perpetrator makes a decision to deal with the loss of control. This could be starting a new relationship or reuniting with the victim and resuming control, but it could also be when they make the decision to murder.

The perpetrator's change in thinking was harder to ascertain but was discussed in three of the Domestic Homicide Reviews. The key themes that emerged were:

- New relationship
- Beginning a new life
- Fear of perpetrator

Many of the themes identified under the change in thinking stage are similar to the trigger stage. These may have occurred after the couple have separated and rather than being a direct threat to the control of the perpetrator, they led the perpetrator to respond.

One victim entered into a **new relationship** four months after the relationship with the perpetrator ended. The victim planned to move in with her new partner shortly before her death. Her ex-partner, the perpetrator, was evidently unhappy with this new relationship texting the victim with a variety of demands and often declaring his love for her which was not reciprocated.

Whilst not entering a new relationship, one victim who left their perpetrator after a long marriage was focused on **beginning a new life.** She had moved into a new home in the weeks prior to her death and had sought a financial settlement with her husband to establish her new life. The perpetrator attempted to continue to exert control over the victim by continually contacting her.

One victim had separated from the perpetrator but before her death her **fear of the perpetrator** appeared to increase. The perpetrator had texted the victim saying *'Slag, watch what I do to you, if I can't have you no one can'*, followed by '*I'm not the monster I used to be, what do you think I am going to do to you?* The victim replied to this last text saying, *'I know what you are going to do, you're going to kill me'.*

These behaviours occurred at the end of a period of escalation, as detailed in the domestic homicide timeline, and were a response to perceived irretrievable loss of control.

Planning

Once the decision to commit a homicide has been made, perpetrators begin planning the murder and this can include searching methods for killing people or purchasing weapons. Indications of how the homicide was planned were included in three of the DHRs analysed.

The key themes that emerged were:

- Purchasing equipment
- Removing children
- Leaving evidence

Purchasing equipment

There was evidence of one perpetrator preparing to commit murder as they were found to have purchased duct tape the morning of the homicide, which was then found to be used in the murder.

Removing children

A common behaviour seen amongst the perpetrator was ensuring the children they shared with the victim were not present at the time of the murder. One collected their baby from the house they shared and took the baby to stay with relatives, before returning to murder his partner. Another arranged for his father to look after their children before meeting the victim and preceding to murder her.

Leaving evidence

One perpetrator who took his own life after murdering his wife, contacted the police to inform them he had committed a murder, providing them with their home address. He explained he had left a holdall containing keys to their house and the alarm code prior to taking his own life.

As the domestic homicide timeline discusses these indicators are often discovered following the homicide either through investigations or police interviews.

Homicide characteristics

The final stage is the completion of homicide, which may involve extreme levels of violence. The homicides may also include a clear confession, the suicide of the perpetrator, children witnessing the murder, or victim blaming.

The characteristics of the homicide, after it had occurred, was referenced in nine of the DHRs analysed. The key themes that emerged were:

- Denial of intent
- Victim blaming
- Admission of guilt
- Suicide following murder
- Deemed accidental

Denial of intent

Multiple perpetrators admitted their involvement in the death of the victim but denied intending to kill them. One perpetrator said that whilst they accepted their actions led to the victim's death, they did not intend this and lost their self-control. Another perpetrator admitted to stabbing his wife but maintained *'he felt threatened by [the victim]'.*

A perpetrator who plead guilty, denied murder, claiming they had been intoxicated with alcohol and drugs. Whilst another said the victim had *'given her a hug and a kiss'* and she had accidentally stabbed him.

Victim blaming

Often a denial of intent was coupled with victim blaming, for example one perpetrator claimed they attacked the victim in response to the victim threatening to report them for a serious offence. Similarly, another perpetrator claimed they picked up the knife used to murder his wife in order to prevent her picking it up and being violent to him.

Another perpetrator stated in police interviews that the victim had been seeing other people and used this as an explanation for his actions.

Admission of guilt

Some of the perpetrators admitted their guilt either directly to the police or by pleading guilty to murder.

Suicide following murder

In three of the domestic homicide reviews analysed, the perpetrator took their own life following the murder. One took their own life in the property they murdered their partner in, another stabbed his partner and then set their house on fire, and the third was located elsewhere.

Deemed accidental

In one case, the perpetrator was found not guilty of all charges as it had been argued that the head injury that proved fatal could have been accidental or self-inflicted.

The themes identified within the characteristics of the homicides were varied and did not always reflect the level violence experienced within the relationship.

Influential Factors

Influential factors are also referred to as risk and protective factors. Risk factors are associated with a higher likelihood of engaging with or experiencing violence or exploitation. Protective factors are the inverse, whereby they can reduce the likelihood of engaging with or experiencing violence and exploitation. Neither risk nor protective factors directly cause or prevent violence, and it is not a predisposition. Influential factors traverse the four levels of the socio-ecological model – individual, relationship, community and societal.

The role of key influential factors in the lives of the victims, but also the perpetrators, were explored to understand how these may have affected vulnerability and risk.

The focus of Domestic Homicide Reviews meant the victim and perpetrators lived experiences, prior to the relationship involved in the homicide, were not always explored. As such, a number of influential factors including inequalities, deprivation, neurodiversity, care experience, and education were not evident in the reviews.

The influential factors found to be prevalent within these Domestic Homicide Reviews were:

- Trauma and resilience (n=10)
- Race & ethnicity (n=5)
- Gender (n=15)
- Disability (n=3)
- Mental health (n=14)
- Housing (n=8)
- Employment (n=13)
- Substance use (n=12)
- Bereavement (n=1)

Trauma and resilience

Trauma can be defined as a lasting emotional response that often results from living through a distressing event. Ten adverse childhood experiences have been identified including multiple forms of abuse, mental illness, parental separation, and neglect.
The examples of traumatic events experienced by the victims and perpetrators in the DHRs analysed were incredibly varied.

Some events which could be considered traumatic had occurred, or started, during childhood, for example both the victim and the perpetrator in the fratricide (brother killing brother) had been raised by other family members due to their mother being unwell.

The most common traumatic experience evident within these Domestic Homicide Reviews, for both victims and perpetrators, was witnessing domestic abuse. Victims and perpetrators had witnessed domestic abuse in their household whilst growing up or within their family as an adult. In addition, it was reported that two victims had also previously been a victim of domestic abuse in relationships prior to the one with the perpetrator.

Other examples of traumatic experiences reported in the DHRs included experiences within the armed forces, bereavement (as discussed later), removal of children into care, having parents with significant mental health issues, suffering a serious assault, and experiences as a sex worker.

Whilst the impacts of trauma on the victims and perpetrators were not explored in detail across the DHRs, when highlighted these included self-medicating behaviours, excessive drinking, and multiple overdoses. This evidences the links between trauma and other influential factors that further affect an individual's vulnerability for becoming a victim or perpetrator.

Race & ethnicity

Racism and bias are evident across social systems, including housing, education, employment and health, all of which are factors that can increase a person's vulnerability to victimisation or perpetrator of violence. In addition, some services, including mental health services, are less accessible to those from ethnic minority backgrounds.

As noted earlier, not all Domestic Homicide Reviews detail the ethnicity of the victim and perpetrator involved. Within the sample analysed, two victims and four perpetrators were identified as being from an Ethnic Minority background. Domestic Homicide Reviews usually examine the relevance of the protective characteristics under the Equality Act 2010 to each homicide. Three of the four Domestic Homicide Review's involving an individual from an Ethnic Minority background reported there were no obvious barriers to services relating to ethnicity.

However, one DHR did highlight that little consideration had been given to the ethnicity of the victim and perpetrator (both Black British), how this may have impacted their help seeking behaviours or how services may have needed to adapt their responses to supporting the victim and perpetrator. In addition, ethnicity was missed from referral

information between services limiting these agency's ability to effectively respond to the victims and perpetrator's needs.

Whilst not specifically relevant to race and ethnicity, barriers to support were present for one victim whose first language was not English. When engaging with the victim, West Yorkshire Police used the victim's daughter as an interpreter to collect a quick account of the incident. Whilst this is appropriate here, the language barrier prevented a full discussion of the victim's experience and any discussion about a safety plan or consideration of whether this exposes the daughter to harm of risk.

Gender

Women experience higher rates of domestic and sexual violence victimisation and are much more likely to be coerced and experience fear, then men.

Women are twice as likely to experience domestic abuse and men are far more likely to be perpetrators. The majority of domestic homicide victims are women, killed by men, and on average two women are killed each week by their current or former partner[10]. The social inequality still experienced by women limits their ability to leave abusive relationships, thus increasing their likelihood of experiencing sexual violence. This is reflected in these Domestic Homicide Reviews as 82% of victims were women and 89% of perpetrators were men. Furthermore, when parents are murdered it is typically sons as perpetrators and women as victims as seen in the matricide case analysed.

Gender in and of itself is not a risk or protective factor for violence but rather is interlinked with other societal factors. The connection to other influential factors was clear across the Domestic Homicide Reviews analysed. For example, one victim struggled with addiction and when she had the opportunity to enter a detox programme, whilst excited she was concerned about being with men on the programme. This highlights a limitation, at the time, within Leeds, as there was no women only residential detox provision available, even though this is preferred by many women[11].

Furthermore, gender can also be just one of many identities individual hold that can compound the inequality and discrimination they face.

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[10] Office for National Statistics 'Crime Statistics, Focus on Violent Crime and Sexual Offences, Year ending March
2016, Chapter 2: Homicide'. 2016

[11] Listening to the voices of women experiencing problematic substance use and gender-based violence http://www.avaproject.org.uk/media/43594/listening%20to%20the%20voices%20of%20women%20experiencing%20sm%20and%20gbv.pdf

Women from ethnic minorities may experience increased risk due a combination of individual circumstance, socio-cultural norms, and systemic socio-economic disadvantages including poverty and racism. One victim from a Black British background was unable to access specialist services for Black women and little evidence was found in the review that the victim was signposted or referred to any culturally sensitive organisation following their engagement with services.

Age is another characteristic that influences risk, with increasing evidence showing the older people are at risk of abuse and this abuse is most likely from partners or adult sons. The age of victims may be relevant in two of the reviews analysed and reflect this finding as one woman was murdered by their partner and the other by their adult son.

Another aspect of some women's identities that can be linked to domestic abuse and homicide is pregnancy. Pregnancy increases the risk of homicide significantly and is the leading cause of maternal mortality[12]. 30% of domestic abuse begins during pregnancy while 40-60% of women experiencing domestic abuse are abused during pregnancy[13].

This is overwhelmingly evident in one DHR where the victim had disclosed her pregnancy to the perpetrator immediately prior to her murder. In addition, one victim was unable to stop their substance use during pregnancy, and research has shown these women are particularly likely to have experience violence and abuse, and therefore be using substances as a maladaptive coping mechanism[14], highlighting a need for trauma-informed practice in treatment.

Disability

Disability is considered a risk factor for becoming a victim of violent crime, and disabled women are more than twice as likely to experience domestic abuse as non-disabled women. The domestic abuse experienced by disabled women is also likely to be more severe, frequent, and last for longer periods of time.

Two victims and one perpetrator were recorded as having a disability, defined as *a physical or mental impairment that has a substantial, adverse, and long-term effect on their ability to carry out normal day to day activities* as well as mental health conditions. One victim had long-term physical health problems resulting in limited mobility outside the home and caused them to become increasingly reliant on their husband as a carer and isolated from protective factors such as social relationships and employment activity.

[12] Pregnancy, Alcohol, and Trauma-informed Practice
[13] Idvas in maternity units - SafeLives
[14] Pregnancy, Alcohol, and Trauma-informed Practice

Although, the victim was not considered to require care or support needs under the scope of the Care Act, the impacts of her disability may have increased risk.

Another victim was visually and hearing impaired, as well as suffering from mental ill-health. Whilst the Domestic Homicide Review did not consider this to be a factor in his murder, it may have contributed to their level of vulnerability.

One perpetrator was detained under the Mental Health Act following a suicide attempt less than six weeks before murdering his wife. The suicide attempt had been made following the victim ending their relationship and this wider context should have informed how the perpetrator's relationship with the victim was supported following their detention.

Mental health

The association between mental health and violence is multi-faceted. The factors which influence mental health share similarities with the factors influencing violence, including family situation, lack of engagement with school, adverse childhood experiences, special educational needs and not being in employment, education or training.

Other than gender, mental health was the most common factor for risk evident in the Domestic Homicide Reviews, for both victims and perpetrators. Mental health conditions reported and/or diagnosed were depression, anxiety, PTSD, and schizophrenia.

Sadly, most often reported was suicide attempts, threats of suicide and overdoses. In some cases, the threats of suicide were utilised to control and coerce the victim, but also family members and professionals. Still, attempted suicides were present in almost half of the Domestic Homicide Reviews making this a clear influential factor in the lives of the victims and perpetrators. The support from both primary care and specialist services for those suffering with mental health concerns was varied and inconsistent. One perpetrator was detained under the Mental Health Act for recovery following a suicide attempt, whereas there is no indication that a victim who attempted suicide was offered community support or intervention.

Housing

Safe and stable accommodation can reduce the likelihood of committing a serious violence offence, rates of recidivism and the exacerbation of other vulnerabilities. Unaffordable housing and lack of security can also escalate the incidence of domestic violence.

Generally, across the DHRs analysed, victims and perpetrators were living in insecure housing situations or had had periods of homelessness. It was only clear in five of the reviews that the victim and perpetrator owned their own property (together or separately) or lived securely with family members. The types of insecure housing evidenced across the reviews were living in a caravan on their mother's property, living with parents, facing eviction due to rent arrears and periods of homelessness.

Challenges with housing was a prominent feature in one particular review. The perpetrator in this incident reported to agencies difficulties relating to a lack of housing, threat of homelessness whilst living with friends, sleeping rough and finally, presenting at Leeds Housing due to the breakdown of his relationship with the victim leaving him homeless. The victim also made multiple applications for re-housing to regain custody of her daughter which were all unsuccessful.

Another victim had made multiple requests for re-housing to escape her abusive partner and their increasing stalking and harassing behaviour. Whilst it is recorded that the victim was top priority for rehousing, she was based in a high demand area and agencies suggested she should bid elsewhere for housing. The victim felt *'very angry and distressed at the way she felt she had been passed about from service to service and felt no one cares about her'.* Her access to specialist housing was also limited as the victim carried a knife with her for protection, meaning she was deemed too high risk for shared accommodation through a service such as Leeds Women's Aid.

One of the two female perpetrators experienced challenges around housing linked to her increased vulnerability as a sex worker. Support services specifically for sex workers attempted to find her safe accommodation whilst homeless, but this was refused due to her having '*intentionally made herself homeless'* and being on heroin and involved in sex work. Following this, she re-presented as homeless following an assault by the male perpetrator (in the homicide) and was provided with an offer of temporary accommodation. However, she did not attend the appointment, and no further contact was had. This latter point highlights the lack of understanding by some services of the turbulent nature of the lives of vulnerable women.

Unemployment

Unemployment is combined with income deprivation which is strongly associated with increased risk of violence. Unemployment has also been linked to harmful outcomes such as mental health, substance misuse and intimate partner violence.

Generally, there was a distinction between the employment status of the victims and perpetrators with the victim's more likely to be in secure employment and perpetrators more likely to be unemployed. Societal stereotypes of gender, including men as providers, has been linked to intimate partner violence as an attempt to demonstrate dominance through violence[15].

Where employment was noted, this was mostly positive for victims who were either in secure employment or running their own businesses. Perpetrators, on the other hand, were mainly unemployed and in some cases had become dependent financially on the victim through debt, bankruptcy, or redundancy.

Substance use

The association between substance use and homicide is complex with several factors being mediated by individual and population variables. However, a review of domestic homicides found that substance use was mentioned as a factor in just over half of all reviews.

Substance use was discussed regarding six victims and 11 perpetrators across the Domestic Homicide Reviews. The picture of substance use did not differ greatly between the reviews, but it was an extremely prevalent risk factor identified.

Amongst victims, excessive alcohol consumption was the type of substance misuse most commonly recorded. Fewer victims engaged in drug use, but where they did this tended to escalate throughout their relationship. For those struggling with substance use, engagement with addiction services, even when occurring over a long period of time, was sporadic. One victim was a long-term client of Leeds Addiction Unit and had undertaken multiple detoxifications, which were unsuccessful. A challenge of engaging with detoxes for this victim was the mental health of their partner to whom they felt a sense of obligation but also that their alcohol use prevented them from accessing other support services. Other victim's struggling with alcohol consumption had very limited contact with addiction support services.

Substance misuse amongst perpetrators was more varied, with differing levels of alcohol and drug use present across the reviews. For a number of perpetrators, their substance misuse was linked to their emotional state and behaviour, for example one was described as becoming increasingly angry after consuming alcohol. In addition, two perpetrators

[15] Gender, power, and violence: A systematic review of measures and their association with male perpetration of IPV

were intoxicated when they committed the homicides, one having taken cocaine and heroin and the other with alcohol, cannabis, and cocaine.

Bereavement

Bereavement can create further stressors beyond mental health, such as financial, physical health problems, or social withdrawal. Bereavement was discussed as a relevant factor in only one of the Domestic Homicide Reviews analysed. In this review, bereavement was considered as a factor that increased the victim's vulnerability. Throughout the period of the victim's life subject to review, she suffered a number of bereavements including two brothers, her mother, her mother-in-law, and a miscarriage. In addition to these bereavements by death, the victim also had her daughter removed and lost contact with her birth family. These bereavements are suggested to have worsened her depression, prompted increased alcohol consumption, and exacerbated self-harming behaviours and thoughts of suicide. It appears the victim was not offered any support from services such as her GP to cope with these devastating experiences. If support, for example counselling, had been offered it may have presented an opportunity to explore the victim's interlinked drug dependency and experience of domestic abuse.

Service involvement

One purpose of Domestic Homicide Reviews is to examine whether agencies could have identified whether the victim was at risk from the perpetrator and whether they could have reduced that risk and protected the victim.

The agencies[16] who contributed to the Domestic Homicide Reviews analysed can be grouped into the following categories:

- West Yorkshire Police
- NHS Trusts
- Health agencies
- Probation
- Housing
- Local Authorities
- Education
- Community services
- Children services
- Yorkshire Ambulance Service
- Addiction services
- Crown Prosecution Service

94% of individuals involved (victim or perpetrator) were known to West Yorkshire Police for any reason and 65% were known for domestic incidents and/or offending. In all cases the victim and/or perpetrator was known to a partner agency, even if this was only through attendance to their GP. In some Domestic Homicide Reviews service engagement could not be analysed because the victims, perpetrators and their relationship were effectively unknown to key services.

Analysis of service involvement

To begin the Domestic Homicide Review process a range of organisations that did, or could have, had contact with the victim, perpetrator, or other relevant individuals are contacted. The services who did have contact then conduct an Individual Management Report which includes a chronological account of their engagement with the victim and/or perpetrator, whether internal procedures and policies were followed, and lessons learned[17].

[16] A full list of the agencies can be found at Appendix C.

[17] The themes identified here reflect those identified nationally in the Home Office's 2016 analysis of Domestic Homicide Reviews and MOPACs 2019 analysis

The key themes relating to service involvement identified across the DHRs were:

- Risk assessments
- Professional curiosity
- Understanding of domestic abuse
- Communication and information sharing
- Signposting and referrals

Risk assessments

Several issues with risk assessments were identified across the Domestic Homicide Reviews including failures to complete risk assessments, inaccurate ratings of risk and a lack of consistency.

The most common form of risk assessment discussed within the Domestic Homicide Reviews was West Yorkshire Police's use of the DASH (Domestic Abuse, Stalking and Harassment), but risk assessments conducted by NHS trusts and probation were also referenced. In some cases, DASH risk assessments were not conducted when they potentially should have been. For example, one victim reported stalking and harassing behaviour from the perpetrator from who she was separated. WYP attended an incident between the couple, and this offered the clearest opportunity to undertake a DASH assessment, but the incident was determined to be a "non-domestic, non-crime". As a result, the level of risk present to the victim was left as unknown.

There was also a failure to complete DASH assessments for both parties in cases where the victim was unclear which is considered best practice. One perpetrator had contacted the police alleging he was a victim of domestic abuse from his partner, and on two occasions the police failed to include the (homicide) victim in the risk assessment meaning the opportunity was not present for her to disclose the domestic abuse she was experiencing.

The thresholds established for risk across services may have led to victims not being appropriately identified. This was evident for West Yorkshire Police, Yorkshire Ambulance Service and Adult Social Care. MARACs (multi-agency risk assessment conference) where local agencies share information about high-risk domestic abuse victims, are based upon DASH assessments and require a certain level of risk and/or frequency of incidents to be present for a referral to be made. A failure to connect separate incidents as a pattern of behaviour meant that in a number of cases the threshold for MARAC referral was not made. For Yorkshire Ambulance Service, the threshold to be considered a frequent caller is fifteen incidents over three months. One victim had contacted the

ambulance service fourteen times in two months prior to her death and so this was not recorded as escalation. Since this Yorkshire Ambulance Service has reduced the threshold to twelve incidents in three months or five in one month. Furthermore, Adult Social Care used the definition of a vulnerable adult in their safeguarding procedures to determine if someone was in need of safeguarding. However, domestic abuse victims frequently did not reach this criteria as it focuses on disability, age or illness as well as their ability to take care or protect themselves.

When a DASH is completed, and risk is rated as 'high' these cases meet the threshold for referral to MARAC. However, MARACs were not commonly involved in the DHRs analysed due to the failure to complete a risk assessment or because of the inaccurate ratings of risk recorded. As a result, one DHR comments that *'had [the quality of risk assessments by West Yorkshire Police] been better, a referral to MARAC might have resulted, leading to multi-agency discussions that might have saved [the victim's] life".*

It could be argued that inaccurate ratings of risk were made for some DASH assessments. Across the DHRs analysed, where DASH assessments were completed, risk was mostly assessed as standard or medium. This was even in cases where repeat DASH assessments were completed for the same individuals and where multiple key risk factors such as self-harm and financial insecurity were identified. The attention paid to risk assessments that highlighted multiple risk factors was inconsistent with some assessments resulting in onward support being established whilst others had no safety planning evident. Probation had rated the risk of violent offending as 'Very high' for one perpetrator but there was no evidence that support, referrals, or signposting occurred as a result.

Professional curiosity

A clear weakness of the services engagement with victims was a lack of professional curiosity which highlights the limitations of solely following policies and procedures. Typically, the services lack of curiosity came from not asking victim's whether they were or had been experiencing domestic abuse because this was not disclosed by the victim, there was no obvious evidence, or enquiry was not considered standard procedure.

A lack of professional curiosity was especially evident within health settings, both primary care and NHS trusts, as well as local authority services and community organisations. There is a need for services to enquire more openly about victim's experiences even if domestic abuse is not the reason they are engaging with a service. For example, one victim presented at A&E with injuries that appeared unrelated to domestic abuse and

therefore no formal risk assessment was made but this does present an opportunity for healthcare staff to ask about the victim's circumstances.

Similarly, there was no investigation by addiction services about the underlying causes of a victim's substance misuse, which in many cases were related to their experience of domestic abuse. It may not always be appropriate for a service to ask explicitly about domestic abuse, but there were instances where they could have asked about a victim's feelings of safety which may have indicated whether any safeguarding or signposting was required.

Professional curiosity was encouraged by services, but this did not become present in practitioners' behaviour. Together Housing who engaged with one victim who made an application for housing as they had become homeless because of domestic abuse did not correctly follow the procedures in place to support her. The safeguarding procedures encourage *'staff to look beneath the surface for signs of abuse'* but this did not occur.

This theme is linked to a lack of understanding about domestic abuse (which is explored later) as the reliance on disclosure or obvious evidence ties into the assumption that domestic abuse is solely physical and does not include verbal or emotional abuse or controlling behaviour.

Understanding of domestic abuse

A lack of understanding about the complexity of domestic abuse, and particularly coercive and controlling behaviour was evident within several of the services victims engaged with prior to their death.

There was a tendency across most of the DHRs for services to view domestic abuse exclusively as physical abuse, ignoring coercive and controlling behaviour as well as stalking and harassment as abusive behaviours. One victim had made 20 reports to West Yorkshire Police regarding stalking and harassment from the perpetrator and had reported these experiences to other services as well. However, these reports were rarely responded to with stalking being viewed as an incident as opposed to a pattern of behaviour which caused daily feelings of fear for the victim. Overall, the DHRs emphasised that understanding of escalation within domestic abuse is required, highlighting a need for integration of the Domestic Homicide Timeline within services training provision.

There were clear gaps in understanding relating to specific victims, particularly those who were vulnerable. For example, an older victim was viewed as just *"being in another*

unhappy marriage" and the substance abuse of another victim was viewed in isolation with Addiction Services not exploring the underlying reasons for their drug use. Additionally, there was little understanding across services of the links between domestic abuse and other influential factors, such as mental health and precarious housing so composite pictures of the victims' experience of domestic abuse were not built.

The gaps in understanding of domestic abuse by services is connected to some of the language used by services about victims and their lived experience. For instance, one victim who had experienced years of substance misuse, had their daughter removed from them, and suffered from poor mental health engaged with the Leeds Anti-Social Behaviour Team around housing who are quoted as saying *"yeah DV is tricky to deal with, […] the thing with a case like this is what would be effective? … but maybe if we put pressure on them via the fact, they 'could' lose their home should they continue to behave this way it might do some good?"* Similarly, the perpetrator in another homicide was a sex worker and faced precarious living arrangements and homelessness. The Women in Single Housing Service (WISH) was contacted on her behalf to see if accommodation could be offered to her, but this was declined as in their view the women *'had intentionally made herself homeless and in any event, WISH would not have accepted her because was heroin and crack cocaine dependent, she was not on a methadone prescription, and she was also involved in sex-work'.* In both cases, the services view of the women presented barriers to them being appropriately supported and protected from the domestic abuse being experienced.

Communication and information sharing

Whilst effective communication was evident in some of the Domestic Homicide Reviews, particularly in instances of child protection and safeguarding, limitations in communication and information sharing between services was present. In a number of cases no specific reasons are given for why information was not shared, suggesting it was an oversight by professionals or that the information held by an individual agency was not significant enough to require this be shared with other agencies for a comprehensive picture of the victim's experience. Moreover, the lack of multi-agency communication meant compounding risks were not identified. In one case, agencies neglected to share information following a DASH assessment and if they had *'then the multiple risks (including [the victim] being pregnant and the recent separation) may have been identified'.* In addition, there were inconsistencies in information recorded by the Police, education and Children's Social Care which, if resolved, may have allowed the domestic abuse to be identified earlier.

A failure to share information meant that some key services were unaware of the violent history of perpetrators. This is worsened as MARACs are victim-focused so information about perpetrators history is not shared, and given the limitations identified with risk assessments, this presents a challenge for safeguarding victims.

As well as a failure to communicate and share information about risk, there were failures in joint communication around safety planning when there were repeated assessments of risk and incidents of domestic abuse were escalating, for example between WYP, Yorkshire Ambulance Service and Leeds hospitals in the case of a victim making increasing ambulance callouts for domestic abuse.

Signposting and referrals

Signposting and referrals are mechanisms available to services to provide further support and safeguarding for victims and, where relevant, perpetrators. Across the Domestic Homicide Reviews there are several examples of referrals being appropriately made by services. These include to a mental health team, Police Safeguarding Unit, and Children's Social Care. These referrals resulted in a number of outcomes, including victims who did not take up offers of support, some victims were not deemed to meet the criteria for safeguarding to be applied, where children were involved, assessments were carried out, but some were not considered to be at risk.

Some referrals were not made early enough, for example one victim had made 20 reports of stalking and harassment before the referral to MARAC was made. In another case, a referral was not responded to quickly enough. The victim was referred to Leeds Domestic Violence Service and a number of potential high-risk factors were indicated in the referral, including the perpetrators attempted suicide. However, the service had not attempted to contact the victim before her death which did not meet the standards expected and set by the service. There were missed opportunities for referrals by various services. West Yorkshire Police had been contacted by one victim following a domestic incident, however the alleged threats made were not investigated by the police officer, indicating a potential missed opportunity to signpost the victim for further support and risk assess the perpetrator.

There were instances where the victim's needs were considered to be too high, leaving the victim feeling as though *'she had been passed about from service to service and felt no one cared about her'.* This suggests that appropriate and adequate referrals or signposting was not provided to this victim.

In other cases, inappropriate referrals were made. In particular, one perpetrator was referred to an anger management programme which is contradicted in situations of domestic violence. This further speaks to a lack of understanding about domestic abuse. Anger management programmes aim to help perpetrator learn to control their reactions and manage their emotions, whilst domestic abuse is about power and control over another rather than in inability to control anger.

Was the homicide preventable?

Domestic Homicide Reviews comment on whether the homicide was predictable or preventable. In only 2 out of the 17 DHRs sampled, the victim's death was deemed predictable and/or preventable.

In these cases, the following statements were made regarding the preventability of the death:

- *DHR-4: 'Numerous agencies were aware of domestic abuse but failed to engage with it. No one referred [victim] for specialist support. No effective action was taken to address this escalation, with an over-reliance by police on breach of peace powers and a referral to the anti-social behaviour unit rather than MARAC. The quality of risk assessments by West Yorkshire Police was generally poor. Had they been better, a referral to MARAC might have resulted, leading to multi-agency discussions that might have saved [victim] life.'*
- *DHR-10 '[The victims] first disclosure of domestic abuse was to LYPFT staff on [date]. She was not given information about specialist domestic violence services. Beyond the potential impact of better risk assessment on what agencies did and didn't do, better risk assessment might have influenced what [the victim] did and didn't do. Had police recognised that [the victim] was being stalked, it should have prompted a risk assessment to be conducted. It is also possible that they could have issued [the perpetrator] with a harassment warning.'*

For the remaining Domestic Homicide Reviews a variety of reasons were given for why the death was not deemed to be preventable. Most frequently it was concluded that no agency held any (or enough) information to indicate the victim was at risk. In some cases, it was acknowledged that had been clear missed opportunities to respond to risk and reduce harm but that no action by any agency or individual could have prevented these homicides.

Recommendations made by DHRs

Domestic Homicide Reviews, using the information gathered about the victim and perpetrator and the insight from services, make recommendations to address the gaps identified in services, lessons to be learnt and where practice can be improved. Strategic, agency specific and DHR recommendations were made. This report has focused on the agency specific recommendations to understand where improvements in practice can be made within West Yorkshire.

The themes identified across the recommendations made by the DHRs were:

- Training
- Referrals
- Information sharing
- Understanding of domestic abuse
- Risk assessments & thresholds
- Specific service development
- Policy, procedures and processes
- Awareness raising and communication

These themes map on to the limitations identified in services engagement with victims and perpetrators.

Training

The need for improved training on domestic violence and abuse was identified in several Domestic Homicide Reviews. Training was recommended for a number of agencies, including West Yorkshire Police, General Practices, Leeds Teaching Hospital Trust and Bradford District Care NHS Foundation Trust. Recommendations focused on the introduction of mandatory training on domestic abuse awareness, especially focusing on coercive control, stalking and harassment and the inclusion of this in inductions.

It was recommended to General Practices and NHS trusts that they assess, identify and respond to training and resource needs for GPs and practice staff to equip them in responding to domestic violence and abuse.

West Yorkshire Police were advised to review the need for additional training in domestic abuse, particularly the Domestic Violence Disclosure Scheme, including Clare's Law and Coercion and Control, across the force.

Referrals

Improvements to referral pathways and signposting were recommended in a number of the Domestic Homicide Reviews. Recommendations related to the thresholds in place for referrals, consistency of referrals, and compliance with policy around referral. There were cases where incomplete information regarding victims and perpetrators was included in referrals and so it is recommended that referral processes ensure a consistent standard of risk information is provided.

It was recommended to West Yorkshire Police that they ensure compliance with the Force Domestic Abuse Policy in making referrals to health service professionals when mental health issues are suspected or identified.

A general recommendation was made about improving referral information to ensure ethnicity is recorded, considered, and linked to associated service users. This would help to ensure that by and for services and culturally sensitive services are referred to when necessary.

Information sharing

The importance of agencies communicating and sharing information to ensure a multi-agency response where risk is identified. Effective communication and multi-agency working is critical to identifying repeat and escalating incidents of domestic abuse.

A recommendation was made to Kirklees Communities Board to undertake a review to ensure partner agencies have good quality processes and systems in place for recording information on domestic abuse in the district. Whilst this recommendation was specific to Kirklees it should be noted by all Local Authorities.

It was recommended that West Yorkshire Police consider appropriate information sharing and risk assessments of perpetrator information to partner agencies that may also be providing services to the victim to assess whether there is a potential risk of harm. A further general recommendation made was to identify potential gaps in MARAC information sharing, including contact with A&E and other relevant providers.

Understanding of domestic abuse

Recommendations identified the importance of enhancing services and practitioners' knowledge about domestic abuse. There were clear misconceptions from services about domestic abuse and how it is experienced across the DHRs. Recommendations were

made of specific services but should be adopted by any agency engaging with potential victims of domestic abuse.

Recommendations focused on the need for improved understanding around:

- The potential risks and links between misuse of alcohol and domestic abuse
- Recognising controlling and manipulative behaviours as domestic abuse and when to make referrals
- Evidence-based indicators that someone may be at risk of perpetrating domestic abuse, including self-harm, history of harm to others, substance abuse, pregnancy, separation or significant mental health
- The impact of past and present domestic abuse and the impact on children
- How learning from the Domestic Homicide Timeline can broaden understanding and response to risk
- Making explicit enquiries into domestic violence by health care professions when risk factors are disclosed

Risk assessments and thresholds

The need for a consistent approach to risk identification, assessment and management was identified across the Domestic Homicide Reviews. These recommendations were primarily directed at West Yorkshire Police and the DASH. Overall, West Yorkshire Police need to ensure that DASH risk assessment are carried out for all confirmed reported domestic incidents.

There is a need to remind Police Officers and Staff that when the victim of domestic abuse is not easily identifiable, there is a requirement to complete a DASH risk assessment with both parties independently of one another.

West Yorkshire Police, Leeds and York Partnership Foundation Trust, Leeds Adult Social Care, and Leeds Women's Aid were instructed to ensure that all staff understand when a DASH risk assessment should be conducted and ensure all staff are aware of the referral pathway. Once again, this recommendation should be noted by all districts.

Specific service development

Some Domestic Homicide Reviews identified specific services that should be developed to improve the support available for victims.

The two specific recommendations relevant were:

- All agencies should improve their responses to working with *BME*[18] communities
- Health agencies will put in place a strategy for delivering holistic services for women with substance misuse issues that address experiences of violence and abuse

Policies, procedures and processes

The need for reviews and improvements in policies, procedures and processes relating to domestic abuse was highlighted across the Domestic Homicide Reviews. Improved policies, procedures, and processes should help address the gaps in services understanding about domestic abuse and improve the use of professional curiosity by practitioners.

For GPs it was recommended that they adopt a practice specific protocol for domestic abuse, include recording who the perpetrator of the violence is when a disclosure is made, and incorporate appropriate screening questions relating to domestic abuse in consultations, such as those relating to contraception, mental health and midwifery.

West Yorkshire Police were advised to ensure Police Officers and Staff are compliant with the Force Domestic Abuse Policy in making referrals to Health Service Professionals when mental health issues are suspected or identified.

Recommendations for housing highlighted the need for housing support agencies to evaluate their domestic violence and abuse policy relating to housing discretion to ensure housing will not be denied to a victim of domestic abuse. In addition, a specific recommendation was made to Neighbourhood Housing (Kirklees) to review and update their anti-social behaviour policy and procedures, which include references to clear policies and procedures for staff to follow around domestic abuse.

General recommendations made for all statutory agencies included:

- Ensuring that they have policies and procedures in place for responding to domestic abuse including explicitly addressing coercive control
- Strengthening the use of routine enquiry and embedding this in day-to-day practice

[18] This terminology is quoted directly from a Domestic Homicide Review. The Violence Reduction Partnership would use the term 'Ethnic Minority backgrounds'

Awareness raising and communication

General recommendations were made about the need for increased public awareness about domestic abuse.

Across the DHRs it was clear that family, friends, and colleagues of the victim had knowledge of domestic abuse or the risk of it. Recommendations focused on how services support reporting from these individuals. It was recommended that public awareness campaigns should focus not only on the victim's and perpetrator's lack of disclosure but also the silence of the social circles surrounding the victims.

Public awareness also needs to be raised around coercive control, with the aim of individual recognising when they are in a relationship that is abusive or where family or friends may be in that situation. It was recommended that this is supported by all statutory agencies who will ensure that they provide information about coercive control on their websites and other materials aimed at the public.

In addition, the Community Safety Partnerships should ensure that the patterns of abuse and risks associated with these are recognised by professionals and the public as high-risk indicators for homicide and should be explicitly described in public awareness campaigns.

Discussion

Domestic Homicide Reviews were established on a statutory basis under the Domestic, Violence, Crime and Victims Act 2004. The key purposes for undertaking DHRs are to review the circumstances of a death, establish what lessons are to be learned from the domestic homicide, and apply these lessons to service responses.

This paper reports the findings from a thematic analysis of Domestic Homicide Reviews in West Yorkshire, looking at patterns and characteristics of incidents, trends in characteristics, information held by services and their response, and recommendations.

17 Domestic Homicide Reviews from across West Yorkshire, all of which are publicly available, have been analysed. The reviews were analysed through the lens of two existing frameworks – the Domestic Homicide Timeline and Influential Factors.

The Domestic Homicide Timeline details eight stages that denote a common pattern of behaviour in intimate partner homicides from pre-relationship to homicide characteristics. A limit of DHRs is that they are focused on agencies responses rather than individuals, therefore in some the details of the pre-relationship, early relationship and in some cases, relationship, are not explicitly explored. The stages explored in the timeline were found to be relevant across the DHRs involving intimate partners.

Influential factors are also referred to as risk and protective factors associated with becoming a victim or a perpetrator of serious violence. The influential factors found to be most pertinent in the DHRs analysed were trauma and resilience, gender, mental health, employment and substance use.

DHRs examine whether agencies could have identified whether the victim was at risk from the perpetrator and if this could have been reduced. Limitations of services were identified in relation to risk assessments, professional curiosity, understanding of domestic abuse, communication and information sharing, and signposting and referrals.

The recommendations made within the DHRs address these gaps in service provision focusing on training, referrals, information sharing, understanding of domestic abuse, risk assessments and thresholds, specific service development, policies, procedures and processes and awareness raising and communication.

The key considerations drawn from this thematic analysis are:

- The need for more effective multi-agency working to build a composite picture of the victim, perpetrator, and their relationship to enable services to identify the relevant influential factors as early as possible

- An improvement in risk assessments, both in accuracy and consistency, to better identify risk in escalating and repeat domestic abuse incidents
- A reflection on the language used by services, especially when working with victims facing multiple vulnerabilities and barriers
- An improved understanding of domestic abuse and its connection to other vulnerabilities and risk

Appendix A – Descriptive table to provide a snapshot of each review and overview of the sample

	Region	Date of Publication (offence)	Period of review	Victim/s	Perpetrator	Children	Relationship	Description of index of offence	Broader circumstances of the case
Aadil	Kirklees	2020 (August 2018)	1st September 2009 to 7th September 2018	31-year-old Male British Indian	35-year-old Male British Indian	Yes (youngest child present at incident)	Brothers	Stab wound	Perpetrator was brother of the victim. No agency knowledge of risk between the two. Previous incidents of abuse and business tensions. Perpetrator had substance misuse, mental health, and previous threatening behaviour.
Adult W	Bradford	2015 (November 2013)	1st May 2013 and 5th November 2013	Female	Male	Yes	Former partner	Assault resulting in death	Murdered by former partner. Engagement with services over injuries to children. Retrospective evidence of coercive control and triggering event.

									Perpetrator was on anti-depressants. No identifiable assessment opportunities in respect of their relationship.
Alison	Leeds	2015 (2014)	June 2012 to 2014	61-year-old Female White British	62-year-old Male White British	Yes	Spouse	Multiple stab wounds	Murdered by estranged husband of decades. Described as loveless marriage. Lack of any apparent history of domestic abuse but risk factors present in the relationship. No agency involvement throughout the relationship.
Christine	Leeds	2016 (September 2013)	January 2010 to September 2013	34-year-old Female White British	47-year-old Male White British	Yes	Partner	Brain haemorrhage caused by assault	Murdered by partner. Relationship characterised by substance misuse, mental health difficulties, and threatening behaviour. Agencies were

									aware of domestic abuse being present. Overlaps between victims also being a perpetrator.
Daisy	Bradford	2018 (January 2016)	15th July 2012 to January 2016	38-year-old Female	37-year-old Male	Yes (not present at incident)	Former partner	Multiple stab wounds	Murdered by ex-partner. The end of the relationship was a clear trigger with the victim concerned about the perpetrator's potential reaction. Hindsight shows warning signs and clear escalation but there was a lack of multi-agency view.
Dawn	Leeds	2015 (2013)	January 2009 to 2013	51-year-old Female Black British	Male Black British	Yes	Former partner	Serious assault	Murdered by ex-partner. A violent and abusive relationship for 30 years which had ended prior to the murder. Stalking reported by

									victim. Victim appears to have fallen through the gaps in services referral criteria.
Deborah	Wakefield	2020 (March 2018)	August 2016 to March 2018	62-year-old Female	42-year-old Male	Yes	Mother/Son	Assault resulting in death	Murdered by son who was suffering with schizophrenia. Both victim and perpetrator had significant vulnerabilities including disability, mental health, and isolation. Lack of recording of vulnerability of the victim.
Izzy	Bradford	2019 (December 2016)	April 2014 to December 2016	39-year-old Female	Male	Yes	Partner	Multiple stab wounds during sustained attack	Murdered by partner. Perpetrator was a registered sex offender, evidence of substance misuse and offending history. Disclosure of pregnancy was seen as a

									trigger. No indication that the victim would have disclosed any abuse but previous abuse by perpetrator.
Jenny	Calderdale	2019	June 2012 and August 2017	23-year-old Female White British	27-year-old Male White British	Yes (present in the house)	Former partner	Mechanical asphyxia	Murdered by ex-partner who had separated a few weeks prior to the homicide. Relationship moved quickly and was described as volatile. Evidence of tensions between the couple. Victim did not disclose DA to any services but increased risk due to pregnancy.
Karen	Leeds	2016 (April 2014)	1st January 2010 to 29th April 2014	47-year-old White British Female	48-year-old White British Male	Yes	Spouse	Multiple stab wounds; arson	Murder followed by suicide of spouse. Controlling behaviour throughout 25 years of marriage and

									divorce proceedings was a trigger. This behaviour was disclosed to a number of agencies prior to murder.
Lucy	Kirklees	2019 (February 2017)	3rd March 2014 to 2nd April 2017	43-year-old White British Female	41-year-old Male Black Caribbean	Yes (present in the house)	Partner	Multiple stab wounds	Murdered by partner. Evidence of violence in the relationship and reported concerns by children. Relationship moved extremely quickly. Perpetrator had made previous suicide attempts. No agency knowledge of DA but risk factors were evident.
Maria	Calderdale	2023 (November 2017)	January 2014 and November 2017	Female Polish	Male White Polish	Yes	Spouse	Stab wound	Murdered by spouse with whom the victim shared 3 children. Reports of shouting and

									financial difficulties within the relationship. Evidence of alcohol misuse. Limited contact was had with any agency and evidence of language barriers.
Rosie	Wakefield	2022 (August 2019)	August 2016 to August 2019	30-year-old White British Female	32-year-old Male	Yes	Partner	Severe head trauma	Murdered by partner. Victim had disclosed domestic abuse to family members. Ultimately the victim and perpetrator were unknown to services.
Samina	Bradford	2018 (April 2012)	1st January 2010 to 29th April 2012	34-year-old White British Female	43-year-old Asian British Indian Male	Yes	Former partner	Unknown	Murdered by ex-partner, although it is unclear when the relationship ended. Indications of potentially controlling behaviour. Very little information held about both victim and

									perpetrator. Missed opportunity to signpost victim or partner agencies.
SL	Leeds	2015 (2014)	1st March/May 2012 to 2014	White British Female	White British Male	Yes	Spouse	Severe head trauma	Murder followed by suicide of spouse. Evidence that the perpetrator had extra-marital relations and had been declared bankrupt. Evidence of planning the murder. Generally unknown to services.
Terry	Kirklees	2018 (January 2017)	January 2015 to January 2017	White British Male 40s	White British Female 40s	Yes	Partner	Stab wounds	Murder by partner. Victim had been warned about perpetrators behaviour with whom he was in an on/off relationship with. Victim was open about the abuse he suffered. Perpetrator had

									been violent in previous relationships and misused alcohol. Unlikely any agencies were aware of domestic abuse being present.
William	Kirklees	2016 (May 2014)	January 2012 and May 2014	Male	Perpetrator A – Female Perpetrator B - Male	Yes (not present)	Friend Acquaintance	Strangulation	Murdered by two perpetrators, one of whom the victim may have been intimately involved with and an acquaintance of the victim. Victim had previous experience of self-harm and female perpetrator was vulnerable as a sex worker. There is a need for multi-agency understanding of risk.

Appendix B – Overview table illustrating how the coding frameworks map onto the reviews

	Aadil	Adult W	Alison	Christine	Daisy	Dawn	Deborah	Izzy	Jenny	Karen	Lucy	Maria	Rosie	Samina	SL	Terry	William
Pre relationship					Yes	Yes		Yes			Yes			Yes		Yes	
Early relationship					Yes			Yes	Yes	Yes	Yes	Yes	Yes			Yes	
Relationship		Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Trigger		Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes		Yes		Yes	Yes	Yes	
Escalation		Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes		Yes		
Change in thinking		Yes	Yes						Yes								
Planning		Yes		Yes	Yes				Yes	Yes			Yes		Yes		
Homicide characteristics		Yes	Yes	Yes	Yes			Yes		Yes	Yes				Yes	Yes	
Trauma & resilience	Yes	Yes		Yes		Yes	Yes	Yes	Yes		Yes	Yes					Yes
Race & ethnicity	Yes					Yes					Yes	Yes		Yes			
Gender		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes
Disability							Yes			Yes							Yes
Mental health	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes	Yes	Yes
Housing		Yes		Yes	Yes	Yes	Yes		Yes			Yes					Yes
Employment				Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Domestic Homicide Reviews – Thematic Analysis

Substance use	Yes		Yes	Yes		Yes	Yes	Yes	Yes		Yes	Yes	Yes			Yes	Yes
Bereavement				Yes													

Appendix C – List of agencies who contributed to the Domestic Homicide Reviews

Agency Group	**Agency**
West Yorkshire Police	West Yorkshire Police
NHS Trusts	Mid Yorks Trust South West Yorks Trust Bradford District Care Trust Leeds & York Partnership Trust Calderdale Foundation Trust NHS Wakefield
Health Agencies	Greater Huddersfield CCG Bradford Teaching Hospital Bradford District CCG Leeds Health & Care Partnership Leeds Community Healthcare Leeds CCG Leeds Teaching Hospital Wakefield CCG Calderdale CCG Kirklees GPs Pennine Acute Hospitals Bradford GPs
Probation	National Probation Service
Housing	Kirklees Neighbourhood Housing Leeds Housing Leeds Housing Concern Together Housing Bradford Housing
Local Authorities	MARAC Leeds Floating Support Adult Social Care Single Point of Access - Kirklees
Education	Kirklees Education Leeds Early Years Primary Schools Bradford Education and Learning
Community Services	Locala St Anne's Community Service Leeds Domestic Violence Service Victim Support The Bridge BARCA SWEET Turning Point
Children Services	Children's Services Bradford Children Social Care Leeds Children Social Work Leeds Safeguarding Children

	Kirklees Children's Services
Yorkshire Ambulance Service	Yorkshire Ambulance Service
Addiction Services	Addiction Dependency Solutions Lifeline
Crown Prosecution Service	Crown Prosecution Service