Best Practice Domestic Homicide Reviews

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AAFDA (Advocacy After Fatal Domestic Abuse) www.aafda.org.uk

AAFDA Centre of Excellence for Reviews after Homicide and for Specialist Peer Support

- 2008. Info centre for Reviews. Work with families.
- All reviews including Inquests
- International study / influence
- Developed model & quality assure DHRs for Government
- Train Chairs of DHRs

DHRs international

- USA (1989). Canada (2003), New Zealand (2008), Australia (2009), New Zealand & England (2011).

- Some review work in India

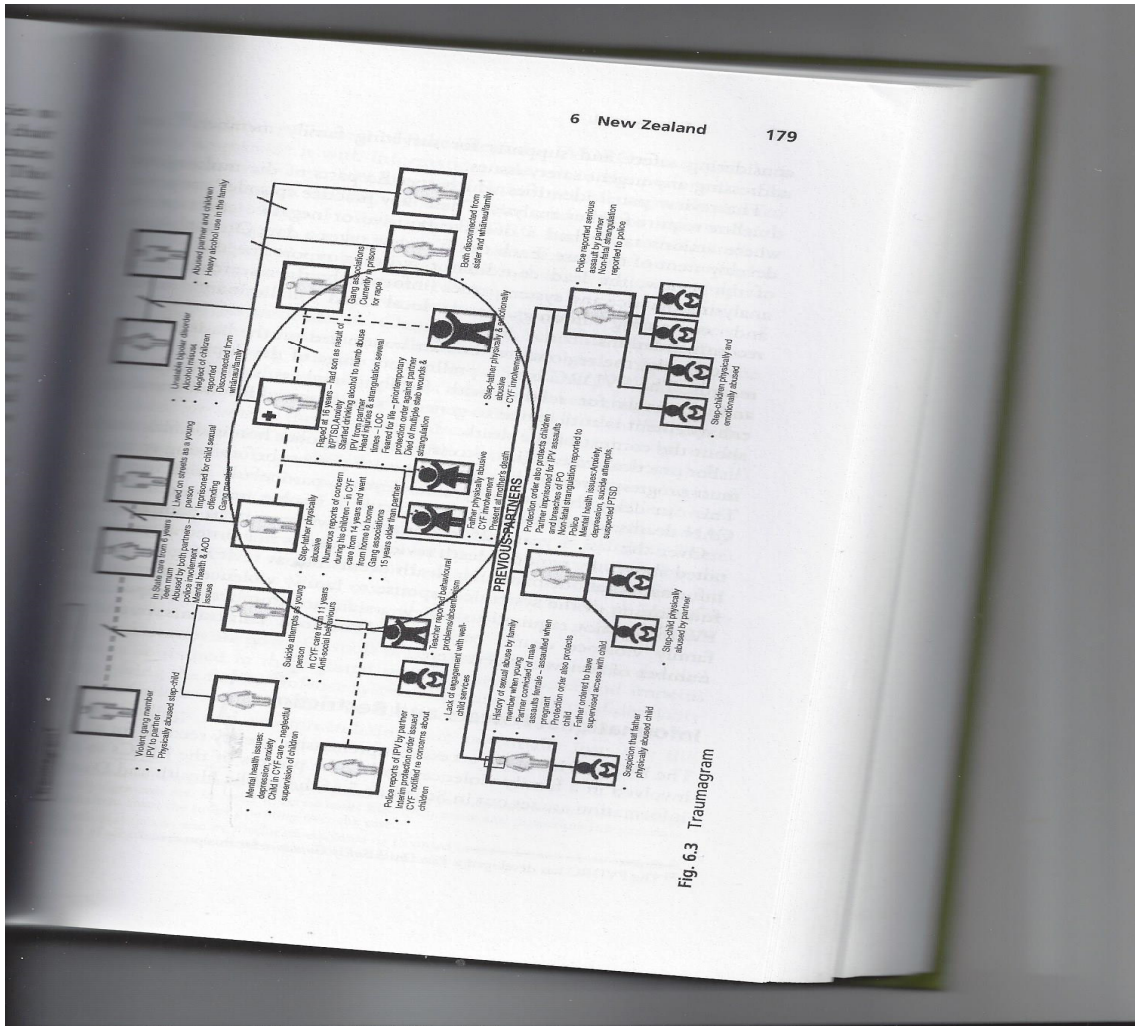
- Portugal, Sweden, Norway, N.Ireland, Ireland

Best Practice

- Find the trail of abuse
- Multiple & multi-disciplinary perspectives
- Expertise (Australia principles)

Traumagram (New Zealand)

- Maps individual's & their family's trauma experiences across extended families
- Includes siblings & step-parents and current and previous relationships
- Includes known children
- Reveals patterns of abuse



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“You are the voice of the dead person ….After having read certain reports, I imagined my sister shouting ‘No, no, that’s not how it was. You need to get this right.’ Accuracy and truth are incredibly important.” *(Monckton Smith et al, 2014).*

Best Practice

- Step outside of process
- Give the family the opportunity to be integral to the review
- Create positive review culture (USA – No blame and shame)

AAFDA Model (Also in Guidance)
7 steps - Family integral in review

- Help of specialist & expert advocate (children to be given specialist help to contribute).
- Assist with scope
- Contribute using preferred medium
- Meet review panel
- Be updated regularly
- Review draft report (privacy, time)
- Be a part of change www.aafda.org.uk

Secondary Trauma

- “It wasn’t my son’s death which crushed my family. it was this organisation’s behaviour that caused the lasting harm”. *(Brown et al, 2018)*
- Going through System as traumatic as the homicide. *(Casey 2012)*

Best Practice

- Learning workshop
- Suicides / unexplained deaths
- Near death

Best Practice

- Plenty of why not what?
- Eschew surplusage
- Change (involve family). Monitor recommendations (Australia). See recommendations as start of conversation (N.Zealand).

New Zealand findings

- Victim empowerment should be the end goal of a collective safety response not the initial premise of any safety work
- Failure to protect paradigm assumes that IPV victims have the ability to choose to stop the abuse ignoring the systemic barriers

Suicide

- Should undertake a DHR where victim takes their own life and there is concern, eg, coercive control present

- Even if a suspect is not charged with an offence or they are tried and acquitted