Life Sentence:
Understanding the Experiences and Support Needs of Those Bereaved by Murder and Manslaughter

Findings from a replication of Louise Casey's (2011) research into the needs of families bereaved by homicide

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Replication of 2011 Dame Louise Casey study

With special thanks to Dame Louise Casey has supported the replication of this review from the outset and endorses the findings and publication of this review.

Authors

This was a study commissioned by Support After Murder and Manslaughter that surveyed SAMM members using a replication of Dame Louise Casey's survey conducted in 2011. Once surveyed, responses collected by SAMM were independently analysed by academics at Birmingham City University and the University of Nottingham who produced this report.

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History of Support After Murder and Manslaughter (SAMM)

SAMM National has been operating for 35 years, first as Parents of Murdered Children (POMC) then changing the name to SAMM in recognition of the ripple effects of murder within communities. We offer peer support to our members by trained volunteers who have themselves been bereaved through homicide.

In 1999 with the help of the CEO of Victim Support (Dame Helen Reeves) the trustees of SAMM applied to the Home Office for funding to support bereaved families. The bid was successful, and this enabled us to employ two members of staff. Victim Support also gave us an office at their headquarters in London. Our funding was eventually transferred over to the Ministry of Justice (MoJ) and our grant increased, enabling us to reach out to more traumatically bereaved people. As SAMM progressed and grew we eventually moved to the West Midlands Police Training Centre in Tally Ho! Edgbaston, where we remain to date.

Our funding from the MoJ meant we regularly met with their senior MoJ staff, and it was through our work with the MoJ that we met Dame Louise Casey. She he asked us if we would work together on sending a questionnaire out to our members. This led to the publication of the first Louise Casey Review into the Needs of Families Bereaved by Homicide.

In 2016 the trustees and the then CEO (Rose Dixon) approached the National Lottery for future funding to repeat Louise's study and we are very grateful to them for enabling us to carry out this work with the help of Birmingham City University and University of Nottingham.

We offer a range of peer support services by trained volunteers who have themselves been bereaved through homicide. We also provide help and guidance to the bereaved in relation to the criminal justice system including the parole process. We also provide trauma support and education and more. Our services include a monthly newsletter, an annual memorial service in St Martin's-in-the Field in London, as well as weekly online support groups where people can meet and talk in a safe space about how they are feeling. We provide CPD (continuing professional development) approved training to all agencies that come into contact with traumatically bereaved people. We have a telephone helpline and run a secure online forum. In addition, we run weekend non-religious retreats where we help people understand about bereavement and trauma, as well as other relevant issues.

"Thank you for being there for us in what was the most awful time imaginable. your support offered comfort & guidance xxx Thank you." (89)

"Thank you for your help over the years…" (11)

"Thank you SAMM for all you do. Even though it is 11 years since my Mum died I enjoy getting your newsletters and knowing you are there. The forum was essential to me in the aftermath and I don't know what I would have done without it. It made me understand I was not alone. I also attended one of your AGMs and this really helped too seeing people face to face." (274)

"I'm so very grateful for all the help you have given me and my family also everyone else that you help i know there are hundreds. SAMM is so very special." (41).

"A very big thank you." (75)

Quotes from the retreats: "I felt very anxious about going to the retreat but the experience of meeting other people who had been through the same experience was wonderful." Another couple said: "Thank you SAMM, you have saved our marriage! We now understand why we are grieving so differently."

Thank you - very astute/helpful questionnaire… if only I had been asked about this 40 years ago!

- Quote from Respondent

Executive Summary

In 2011, Dame Louise Casey published *'A Review into the Needs of Families Bereaved by Homicide'*, which highlighted how distinctive the experiences of homicide bereaved families are in comparison to other crime victims in the wake of traumatic bereavement. The report emphasised the need for effective use of time, money and efforts when targeting those in greatest need. In the twelve years since the publication of Casey's review there have been significant changes in the political and support landscape - particularly from 2010 onwards - when it comes to understanding and meeting the needs of homicide bereaved families.

This report sets examines the impact of these changes by replicating Casey's seminal 2011 study, examining 1) the experiences of bereaved people in the aftermath of a homicide; 2) their encounters with criminal justice agencies and support organisations; 3) support received and the extent to which this was effective in meeting their needs; 4) additional support needs of homicide bereaved families which aren't being met by current provisions.

The research underpinning this report was conducted in collaboration with Support After Murder and Manslaughter (SAMM). Their membership was surveyed via a questionnaire that was completed either on paper (N = 157) or online (N = 121). The final sample comprised 287 individuals who were homicide-bereaved, 141 of whom were female (50%) and 140 of whom were male (50%).

It should be noted that the gender breakdown found her differs notably from that in the original Casey review, where the majority of respondents were female. However, the problems that males and females reported experiencing were similar.

The average (median) of year of bereavement was 2006. This report therefore includes recent and historical bereavement, enabling comparison of pre and post 2010 experiences, thus allowing reflection across the changing landscape of homicide bereavement provision.

Summary of Key Findings

Findings from this report echoed many of the key concerns highlighted in the original report:

- The impacts on those bereaved by homicide are extensive and long-lasting – it is a 'life sentence'. Mental and physical wellbeing are notably impacted, as well as family/personal relationships and work/schooling. Issues in relation to all of these were noted by the majority of respondents.
- The experiences and needs of those in the present sample did not differ significantly from those found in the original Casey (2011) survey, suggesting that time, money and efforts are still not being used as effectively as they perhaps could be.
- Whilst things have improved post 2010, those bereaved by homicide have extensive support needs which aren't effectively being met by current support provisions.
- Different people find different forms of support more helpful at different stages post-bereavement.
- Some services are viewed as being more helpful/valuable than others; varying needs are met to differing degrees by different provisions.
- We would suggest that it would be advantageous to repeat this survey at regular time intervals (e.g. every 5 years). This would allow us to monitor changes over time, as well as to compare the experiences of those more recently bereaved with those for whom it has been longer

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Introduction

This report replicates and builds upon a 2011 report commissioned by Dame Louise Casey, the Victims' Commissioner at the time, entitled 'A Review into the Needs of Families Bereaved by Homicide'. Casey conducted a survey of over 400 families bereaved through murder or manslaughter, which revealed the toll of traumatic bereavement. Her findings showed both short and long term effects, some of which persisted for many years. It identified physical and emotional impacts, alongside practical problems, including ill health, unemployment, debt, relationship breakdown and housing problems. This review was significant in paving the way for the introduction of new policies and funding pathways for the delivery of support services for bereaved families.

In 2020, academics from Birmingham City University and the University of Nottingham began to work with SAMM on a replication of the study. The purpose of this was to further draw out the criminal justice encounters and experiences of homicide bereaved people while also considering the impacts of improvements to victims' services, and in particular the National Homicide Service. There is an ongoing relationship between Dame Louise Casey and SAMM, and she welcomed the replication of her earlier work.

Despite decades of reforms and improvements for victims of crime, and approximately 60 years of academic research into the victims of crime and the impacts of traumatic bereavement, there remain a number of gaps in our understanding of victims of crime and their experiences throughout the criminal justice process. In particular, there is a paucity of research on homicide bereaved people as a distinct group of crime victims.

This report sets out a brief contextual background, to situate it within the current landscape whilst noting policy developments since the original report was published in 2011. In section 1, it draws out some of the distinctive features of traumatic bereavement as experienced by bereaved families, as this provides essential context to understand how these families interact with the criminal justice practitioners and processes, as set out in Bradford's (2020) doctoral thesis. Unlike other victims of crime, criminal justice experiences of bereaved families coincide with traumatic grief processes and bereavement. This provides an inseparable backdrop that needs to be understood in order to adequately meet the needs of those affected. This survey offers unique insights into the experiences of those collaterally victimised through bereavement by homicide and how these compares with those detailed in Casey's original report.

In section 2, we discuss the methodological decisions taken when replicating the Casey (2011) study. There were a number of key methodological considerations when conducting this research, particularly owing to the sensitive and potentially retraumatising nature of the study. On the one hand, efforts went into ensuring that the two questionnaires and responses were comparable for the purposes of analysis, however steps were taken to refine the language and framing of some of the questions. In order to build on our understanding of how to better meet the needs of bereaved family members, given the specific Government desire to, some questions were added that had not featured in the original survey.

The key aim of this study was to begin to explore the extent to which improvements, such as the National Homicide Service and other developments, have satisfied the recommendations in the Casey report; or whether instead it remains the case that 'the way that the system operates can leave families trembling in its wake' (Casey, 2011: 6). Findings presented in sections 3, 4 and 5 provide some insight with regards to this. Ultimately, in this report we wanted to provide an opportunity for those bereaved through homicide to have a voice in developing our understanding of what they encounter in the aftermath of that traumatic bereavement. This is emphasised throughout the concluding part of the report, in section 6.

What emerges here is that one size does not fit all. Traumatic bereavement and loss as experienced by bereaved families' overlaps with complex criminal justice experiences. Casey's original report allowed us to ascertain the effects of homicide and the extent of these problems among bereaved families (Casey, 2011). The original report justified diverting funding towards specialist services, and this report shows that there is further scope to better understand where and how this funding can be used most effectively.

1 Contextual Background

In 2011, it was acknowledged that "the anguish experienced in those cases where a relative is killed stands alone" (Rt Hon Kenneth Clarke QC MP in Casey, 2011: 3). Louise Casey commissioned a review to improve our understanding of the needs of homicide bereaved families and worked in collaboration with Support After Murder and Manslaughter (SAMM). SAMM is a peer support agency. Conducted over the course of a six-month period, the report draws on the experiences of 417 responses that were received to a request sent out to the full SAMM membership (representing a response rate of 27%). The report's findings played a significant role in subsequent improvements in the entitlements afforded to this group of victims since 2011. There remains very little known about the distinctive experiences of homicide bereaved people, and this report contributed to better understandings of the needs of these families, the problems they face, and their overall experiences throughout the CJS.

There has been some documentation over the impact of homicide on the surviving loved ones; however, much of this tends to focus on the psychological impacts as well as practical implications (Casey, 2011; Connolly and Gordon, 2014; Gekoski et al, 2013; Kenney, 2004; Rock, 1998). In addition to symptoms of Post-Traumatic Stress Disorder (PTSD), which can manifest through shock, anxiety, and depression and other psychological responses (Casey, 2011; Gekoski et al, 2013), Casey found that the bereaved faced problems in relation to their employment, childcare, financial burdens and ability to sustain relationships.

> We do need a voice, we do need to talk about how we're treated when it happens and I just think that you know these people [those who support] need, you know, they need to learn and they need to hear our voices, you know and they just don't understand (Katrina (bereaved in 2014), in Bradford, 2020: 222).

Despite ten years having passed since Casey's study, subsequent research points to the ongoing negative experiences of those bereaved by homicide, where despite positive improvements in *recognising* the distinctive needs of this group of victims, these are not always effectively addressed within the current support framework – which therefore continues to render families helpless.

1.1 What is Distinctive About Homicide Bereavement

> In a homicide, it's sudden. It's complete. There is no fixing it…What you're left behind with is the mother or father, brothers and sisters, husbands, wives – the whole shebang – who have nothing (Rock, 1998:30).
>
> And when that case is 'closed' you're forgotten about. You are totally and utterly forgotten about. And you just think you've been running around all this time and you think 'what do I do now?'. (Melita in Bradford, 2020: 182).

Homicide bereavement is complex and traumatic. It is lasting and transformative – pervious normality is shattered (Rock, 2022). Unlike others forms of bereavement, there is a mandatory sequence of events that is required by the criminal justice process. As such, much of the autonomy that would normally be afforded families is removed from them. This impacts normal grief and bereavement processes. In a recent review, Rock (2022) identified that the people closely affected may suffer survivors' guilt, where many question the "if onlys,". This often leads to new fears and sense of danger in the world. In addition to grief and loss processes, homicide bereaved people are exposed to police interest and – at times - even suspicion. There is often intense and even predatory media attention, all in the midst of a lengthy, uncertain and unfamiliar criminal justice process. This involves a number of complex interactions with police investigations, burial processes, inquests, criminal trials, sentencing, appeals, parole hearings, often spread across years or even decades. What is also clear is the ongoing and lasting impact of the anniversaries of particular events throughout these processes (Rock, 2022; Bradford, 2020).

These families have suffered from the 'absolute worst' breakdown of societal rules and norms (Rock, 2022; Bradford, 2020), and they face a shattering sense of the world as a just and fair place as a result of the unlawful taking of a life (Casey, 2011). Rock (1998; 2022) asserted that loss through murder is different to other types of victimisation, whereby homicide bereaved individuals tackle anomie through the disintegration of meaning, and the structures which represent their self are replaced with feelings of a stolen identity, lack of purpose and loss of future.

Traumatic bereavement has been characterized as a 'unique synergy of loss and trauma' (Armour, 2002). The complexity of homicide bereavement means that support needs to adapt to needs that vary across time and space. For many families, bereavement is not a private and personal matter marked by sadness, but rather a process that is heavily controlled by the social environment, and - in particular - the CJS. They are 'indirect victims', and at times this renders them powerless in their ability to participate in proceedings, with them instead being restricted to being little more than members of the public.

Murder is a crime against the state, and therefore the CJS can limit families, side-lining them as bystanders whose needs are secondary to the state's concern for retributive processes. Mullane (2018) points out that there is an intense need for the bereaved to receive information; however, this is often misaligned with what the state can provide. As such, the need for peer support through the third sector emerges in Bradford's (2020) research. The need for experiential-based information is crucial. Families often feel their 'human rights' (as they are framed) are lesser than those of offenders: - the offender is living, the victim has been robbed of life; the offender is entitled to legal representation, the victim none; trials are conducted in the name of the offender, not that of the victim (see Rock, 1998; Bradford, 2020).

While families identify the need for practical support, for many, the preference is for emotional support to be offered by peers who have also experienced homicide bereavement, due to the perceived inability for 'outsiders' to know or understand the processes underpinning bereavement through such circumstances (Bradford, 2020).

1.2 Policy Developments and Landscape

The 2010 Coalition Government introduced a local commissioning framework. The current Government provides direct funding to Police and Crime Commissioners (PCCs) to provide a range of local support services for victims to meet the needs of local residents.

Under the Code of Practice for Victims of Crime (2021; hereafter 'Victims' Code'), if a case involves an allegation of murder or manslaughter, bereaved family members are entitled to be referred to the National Homicide Service and any other relevant specialist support service. The Ministry of Justice provides around £5.75m per annum in funding to Victim Support to deliver the National Homicide Service. This offers emotional, practical, advocacy and peer support across England and Wales following homicide both at home and abroad. This funding is discretionary and is distributed in accordance with the needs of individuals bereaved by homicide, and witnesses of homicide. They support, on average, 1500 individuals each year.

In 2010 Victim Support launched their National Homicide Service, funded by the Ministry of Justice following an open competition (which they won for the second time in 2018). Victims are mainly referred to the homicide service by Family Liaison Officers (FLOs), which meets victims' entitlements under the Victims Code (2015) to be referred to support based on their needs, which for homicide bereaved people includes enhanced entitlements as families of victims of serious crime.

The Homicide Service was established as a specialist trained branch of Victim Support, offering a variety of practical, emotional and specialist support offered by a number of teams across England and Wales, each team consisting of a team leader, a team support worker and originally four caseworkers (which was increased to five following a review) (Turley and Tompkins, 2012).

It is worth noting that current information as to the number of caseworkers and individuals involved in delivery of the Victim Support Homicide Service are not currently identifiable. The lack of information regarding how funding is being used creates an opacity in terms of understanding how effective allocation and provision distribution currently are in terms of meeting demand.

National measures in place to ensure that all Family Liaison Officers (FLOs) supporting families receive training from the National Homicide Service, and the College of Policing has provided a set of learning standards for forces across the country. Every police force must adhere to these standards. The primary purpose of a FLO is that of an investigator. Their role is to gather evidence and information from the family to contribute to the investigation, and to preserve its integrity. The FLO also provides support and information, in a sensitive and compassionate manner, securing confidence and trust of families of victims of crime.

2 Methodology

In this section we outline the development of the questionnaire, including some of the changes made to Casey's original survey and the rationale for these changes.

From the outset, the design of the research was developed with the interests of bereaved families at the centre. The processes and decisions are set out below.

2.1 Questionnaire Development

While this project was intended to replicate Casey's 2011 survey, there was considerable time spent on reviewing the questions, with particular focus on the phrasing, terminology and framing of the questions. This was to make sure that the survey reflected inclusive language, but also with due consideration being given to the sensitive nature of this research. From the outset, we were concerned with the sensitivities of the project and the potential impacts of taking part on the traumatised people that would be responding. Care was taken not to cause any further trauma, but to allow bereaved families to detail their experiences if they felt able and were willing to do so.

The final questionnaire utilised here was developed through collaborative efforts involving members of SAMM and academics from BCU and UoN, who between them have extensive knowledge and expertise, including personal experience of traumatic bereavement, of working with and/or supporting bereaved families, and more generally in conducting sensitive research with vulnerable groups. The development process is summarised below.

2.1.1 Stage One

Each member of the development team individually read and made comments on the original Casey survey. As part of this review process, each individual paid attention to four key things. The first was the language and terminology used, with consideration of whether it was appropriate and whether it reflected current practices and values in light of developments over the preceding decade (see Section 1.2**). The second was whether the questions were relevant and reflective of criminal justice processes and support mechanisms in the aftermath of a homicide. The third was to think particularly about the potential opportunities for comparison and reflection after a decade of changes. The fourth was to consider other potential areas to further and better understand the needs of bereaved families, and to consider areas for further development in meeting these needs. This final aim explains and justifies the inclusion of free text comments and reflections (see information below re coding). Free text comments were included to allow us to further consider some of the contextual factors why people may have experiences what they did. These will be given due regard and will be discussed in future research.

2.1.2 Stage Two

The second phase saw the development team come together and scrutinise the comments, suggestions and recommended changes. Although this was a somewhat lengthy process, it was vital to the core aim of the project; - to disseminate a survey to bereaved families that reduced the chances of revictimization and prioritised hearing their perspectives and encounters.

On the basis of the steps outlined above, the following adaptations were made to the original Casey (2011) questionnaire to create the questionnaire used in the present study:

1. More detailed demographic questions were included, to capture more detail on the nature and characteristics of the sample employed. Additional questions were based on those used as standard in NHS questionnaires and screening, and included health and disability classifications and questions regarding caring responsibilities, in addition to standard questions and classifications regarding age, gender, sexuality and ethnicity etc.

2. Terminology and phrasing of questions was changed in places:

    - For example, in the original questionnaire, question 19 was as follows: 'Were there surviving children as a result of the bereavement?' This was changed to: 'Were any children in the family affected by the bereavement?'

    - Throughout, we used the term 'bereavement' when referring to the death/index event, as opposed to 'loss', 'trauma' or similar, which all potentially have implicit psychological meanings.

    - Throughout, we referred to the victim as the 'person killed', as opposed to making reference to them having been murdered (which may contradict any official or legal classifications), referring to them as 'lost' (which some SAMM members indicated that they found offensive), or using any terms which imposed some form of meaning on the relationship between the respondent and victim (e.g. 'loved one').

    - Throughout, the offender (person who killed the victim) was referred to as 'the person (or persons) responsible', as opposed to 'perpetrator', which could potentially cause confusion, particularly in the case of multiple offenders).

3. Questions were changed where it was felt that they could be too complex or cognitively demanding. For example, instead of asking respondents 'how long ago did the bereavement occur', which would involve them having to calculate the time that has passed since the death occurred, we instead asked them 'in what year did the bereavement occur?' In addition to this, we also asked them to indicate in what year the trial took place and the year in which they were born, which enabled lengths of time to be calculated automatically, rather than by the participant.

4. Some additional revised response options were included in the current questionnaire, to allow greater flexibility in terms of gathering data for some variables. For example, instead of asking them to indicate, via tick-box options, who was killed (e.g. 'son/daughter', 'mother/father') participants were asked what their relationship was to person killed, and could respond using their own description/categorisation.

5. Other questions were revised to enable more detailed data to be gathered:

    - Where participants were asked whether the conviction was for murder or manslaughter, they were also asked what the sentence given was.

    - Additional questions were included regarding the funeral, to determine what factors – if any – delayed them or stopped them from holding the funeral, whether they had any problems paying for the funeral, and how they had covered the costs of the funeral.

- Participants were asked if they attended the trial (where they had indicated that a trial had taken place).
- Whilst questions regarding whether or not participants or their family members had suffered from any of a specified range of physical and psychological conditions as a result of the bereavement were kept in to enable direct comparisons to be made with results obtained from the original Casey (2011) study, additional questions were included asking more generally whether their physical and/or mental health or the physical and/or mental health of their family members had been affected by the bereavement, with the option of adding details via free-text response options.
- Instead of asking whether they or their family members had suffered from alcohol or drug addiction as a result of the bereavement, questions were revised to ask whether usage of alcohol, prescription drugs, non-prescription drugs and illegal substances had increased as a result of the bereavement. This was because we recognised that some might not identify increased use or reliance as an addiction, and because we felt that increased usage of any of the above was a direct health impact, even if the increase would not be sufficient for the person to be classified as a heavy user or an addict.
- Participants were also asked whether they had taken up smoking or the amount that they smoked had increased as a result of the bereavement.
- We asked respondents to provide additional details regarding their employment status at the time of the bereavement, including whether they were self-employed, a student or retired.
- We asked specifically whether the bereavement had impacted them financially (and how), before then asking the more detailed questions from Casey regarding management of finances and consequences of these.

6. Some additional questions were included to capture more detailed information on the event and their experiences at the time and since it occurred. One example of this is that we asked whether the person killed knew the person responsible, and - if so - what was their relationship to the victim was.

7. Where respondents were asked how supportive they had found different provisions we provided scaled response options, so they could provide relative judgments of the different services. In addition, they were asked both how supportive they had found the different provisions at the time of the bereavement as well as in the long term, as we recognised that their support needs and the type of support they might access would be likely to change over time.

8. Similarly, instead of asking ‘which of the following did you find the most difficult….’, respondents were asked to indicate ‘how difficult did you find each of the following….’.

9. Additional questions were added which asked about transformation, memorialisation and legacy (which were felt to be important impacts of the bereavement experience).

10. Wherever respondents were presented with multiple choice response options (e.g. with regards to whether certain aspects of their health had been impacted, or whether they had accessed different forms of support), they were always given the option to include ‘Other’, and were asked to specify or provide details with regards to this.

11. Free-text response options were included throughout, so that participants had the option to provide additional information in relation to any of the questions asked. This was because we felt it was important to enable them to include any information which they felt was important or that they wanted to provide, and because we did not want them to feel limited to giving specific responses.

12. At the end of the questionnaire an option was added for respondents to provide additional information/qualitative responses: 'If there is any other problem or effect of the bereavement not captured by the above questions, use the space below to give further information if you want to'. Qualitative data collected via these free-text response options will be considered and explored in the future work, in relation to individual differences and broader contextual factors. There are a number of potentially significant and concerning themes that emerged in qualitative responses that require rigorous and sensitive attention that have been intentionally not discussed in this report and will be subject to further consideration and exploration.

2.2 Questionnaire Distribution

The questionnaire was distributed by the SAMM. All members of SAMM were invited to take part, either by postal invitation or email. The questionnaire was also posted on SAMM website, with an invitation to participate if individuals met the inclusion criteria (had suffered a bereavement through murder or manslaughter). Participants had the option of completing the questionnaire online or via a paper copy. Paper copies were sent with a self-return envelope for ease.

An information sheet was given to all participants, outlining the nature and the purpose of the study, and what they would be required to do if they were willing to take part. Participants were advised not to take part if they felt they might be adversely affected by doing so. It was also made clear to them that they did not have to answer any questions that they did not feel comfortable answering.

Participants completed the questionnaire in their own time, and either submitted or returned the questionnaires when they were complete. A final submission date was given, four months after the questionnaire was first distributed, to enable data to then be collated and analysed.

3 Coding and Analysis of Responses

All responses were coded so as to protect the anonymity of all individuals concerned (both the respondent, and any individuals involved in the case – including the victim and or the person responsible). Where information was given which could potentially reveal the identity of an individual this was either edited to remove identifiable features or – where this was not possible – removed from the dataset.

3.1 Coding

Quantitative data was primarily coded using 1's and 0's (yes/no, present/absent), to enable selection on the basis of answer given for the purposes of grouping responses and to enable additional analyses (where appropriate). Where no response was given this was indicated as a missing value (as opposed to being indicated with a 0, and thus represented as definitively not present or as a 'no').

Any written information included where numerical responses were expected were saved and incorporated into the qualitative data. In the quantitative data they were subsequently coded as 'missing'.

Where multiple victims or offenders were detailed, these were coded as separate variables. In the main dataset it was the primary victim and/or offender who was used to classify cases (and their characteristics that were recorded for that case).

3.2 Analysis

Descriptive analyses were conducted on all quantitative variables, with frequencies for each reported in the subsequent sections. Means and standard deviations were included where relevant, and where scaled data was included percentage breakdowns for all response options are provided.

Some comparative analyses were conducted between cases in which the bereavement occurred prior to 2010 and those where it occurred post 2010, to establish the impact of changes implemented as a result of the Victim's Charter on the experiences of those bereaved through homicide. This was primarily for questions exploring how difficult they had found different aspects of the bereavement and associated criminal justice processes, as well as how supportive they had found different provisions – both at the time of the bereavement and in the long-term. Experiences of Victim Support services were also directly compared for those bereaved pre- and post- 2010.

4 General Findings

In this chapter, we set out the general findings that emerged from the questionnaire following the coding process. These findings are discussed below in Chapters 5, 6, and 7, and considered when identifying limitations of the current research and what is recommended for future research.

4.1 Response Rates and Questionnaire Completion

In total, 287 responses to the survey were returned (126 of which were completed online, 161 of which were returned as paper copies). Some responses were incomplete and or were duplicated, and these had to be removed. The final sample consisted of 278 responses; 157 returned as paper copies and 121 completed online.

4.2 Sample Demographics

Age

The average age of respondents was 60.96 years (S.D. = 11.952; median = 61 years). Their average age at the time the bereavement occurred was 43.69 years (S.D. = 13.843; median = 45 years).

Gender

Of the 278 respondents 233 (84%) were female and 45 (16%) were male. In no instances was gender identity different from that at birth.

Sexual Orientation

In terms of sexual orientation, the majority of respondents indicated that they were heterosexual (248; 89%). Three (1%) indicated that they were bi-sexual, four (1%) listed their orientation as lesbian and three (1%) as gay. Four listed their sexual orientation as 'other'. Missing responses were recorded in 16 cases.

Relationship Status

In terms of relationship: 45 respondents (16%) indicated that they were single; 50 (18%) were divorced; 121 (43%) were married; 37 (13%) were widowed; 4 (1%) were in civil partnerships; and 8 (2%) were separated. In all other instances no relationship status was given.

Ethnicity

With regards to ethnicity: the majority of respondents (83%) identified as White-British (N = 233); three (1%) identified as White-Irish; eight (3%) identified as White-Other; five (2%) identified as White-Black Caribbean; 1 (1%) identified as White-Black African; two (1%) identified as White-Asian; three (1%) identified as Mixed-Other; one (1%) identified as Indian; one (1%) identified as Chinese; one identified as Asian-Other; four (2%) identified as Black-Caribbean; and one (1%) as Black-African. In 12 cases no ethnicity was stated.

Religion

In the 261 instances where respondents indicated their religious affiliation the majority (59%) indicated that they were Christian (N = 163). Three (1%) said they were Buddhist, one (1%) said they were Hindu, two (1%) said they were Muslim and one (1%) said they were 'Sikh'. A notable proportion (31%) indicated they were had no religion (N = 87).

Disabilities

Twenty-three respondents (8%) indicated that they had had some form of disability prior to the bereavement and 88 (32%) indicated they that had some form of disability after the bereavement.

It was not possible, from the phrasing of the questions, to ascertain whether disabilities resulted directly from the bereavement, although health consequences and impact of the bereavement were explored in a separate section of the questionnaire.

Caring Responsibilities

Where respondents indicated that they had caring responsibilities (66 cases; 24%), 36 of these indicated that these total 1-19 hours per week, 10 indicated that these total 20-49 hours per week and 20 indicated that these total more than 50 hours per week.

4.3 Circumstances of Bereavement

Time Since Bereavement

The earliest bereavement even occurred in 1954, and the most recent in 2021 (see Figure XX below). The average (median) of year of bereavement was 2006.

The average length of time since bereavement was 15 years (mean = 16.71 years; S.D. = 11.004).

Figure 1: Year in Which Bereavement Occurred.

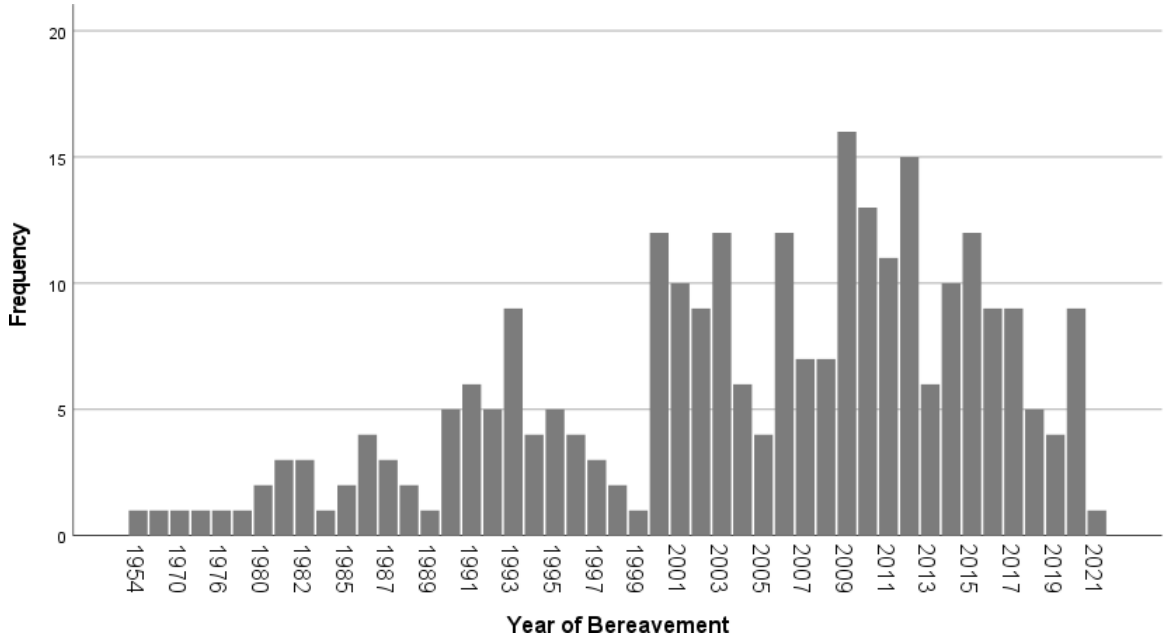
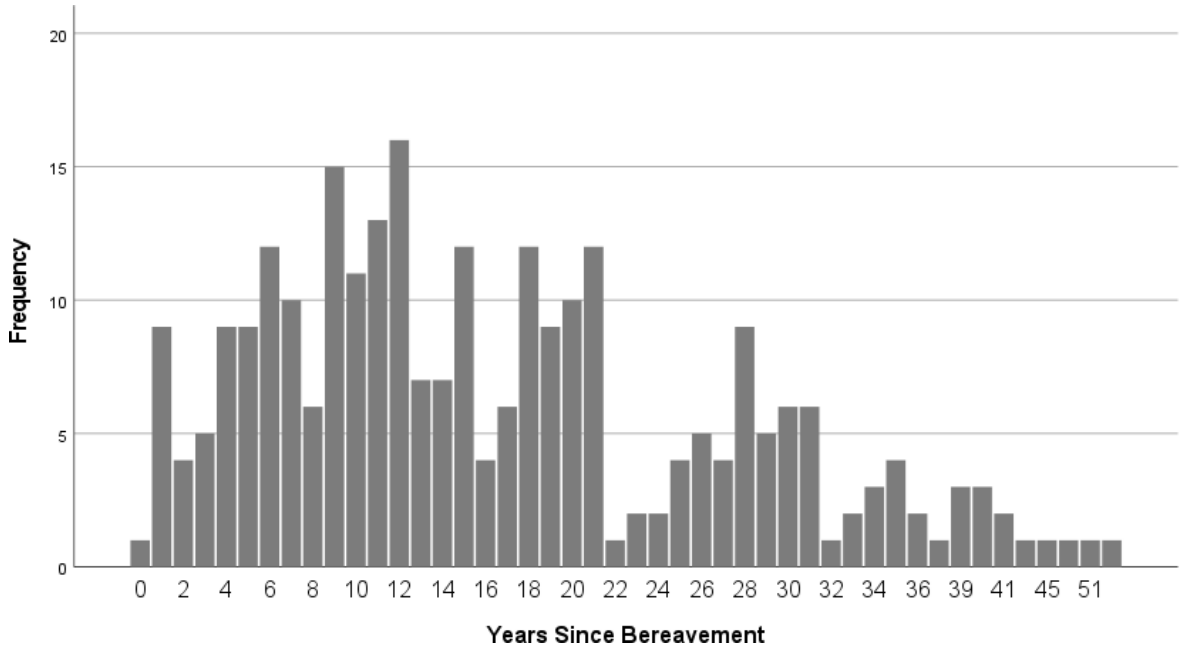


Figure 2: Length of Time Since Bereavement



NB: The total number of instances recorded in this category totals more than the total number respondents as in some cases multiple victims were detailed.

Victim Gender

Victims were female in 141 cases (50%) and male in 140 cases (50%).

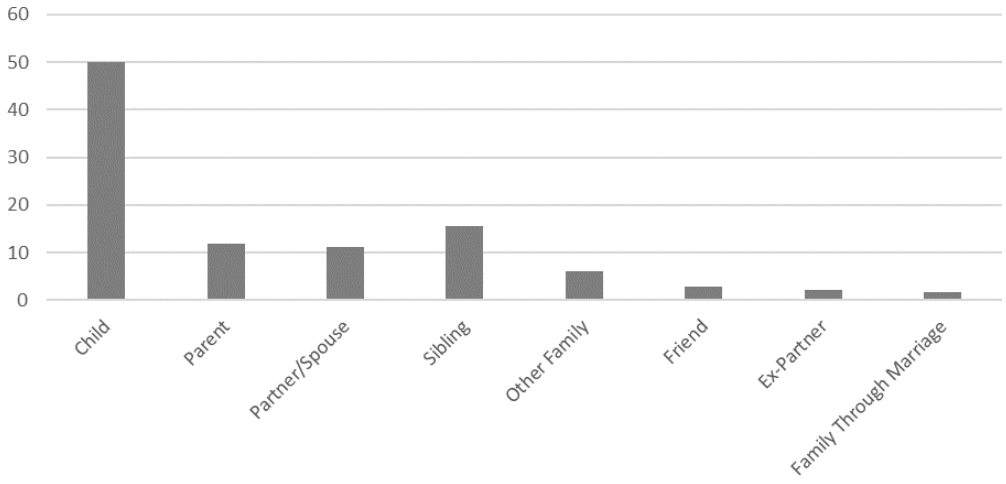
Relationship of Respondent to Person Killed

In terms of the relationship between the respondent and the person who was killed, in the majority of cases (50%) the victim was the respondent's child (N = 139).

In 33 cases (11%) the victim was a parent of the respondent, in 31 cases (11%) they were the partner or spouse of the respondent (and in additional six cases were the respondent's ex-partner), in 43 cases (15%) they were the sibling of the respondent and in 17 cases (6%) they were some other family member.

In five cases (2%) the respondent and victim were listed as being family through marriage. In eight cases (3%) the respondent was the victim's friend.

Figure 3: Relationship of Respondent to Victim (% of Cases)



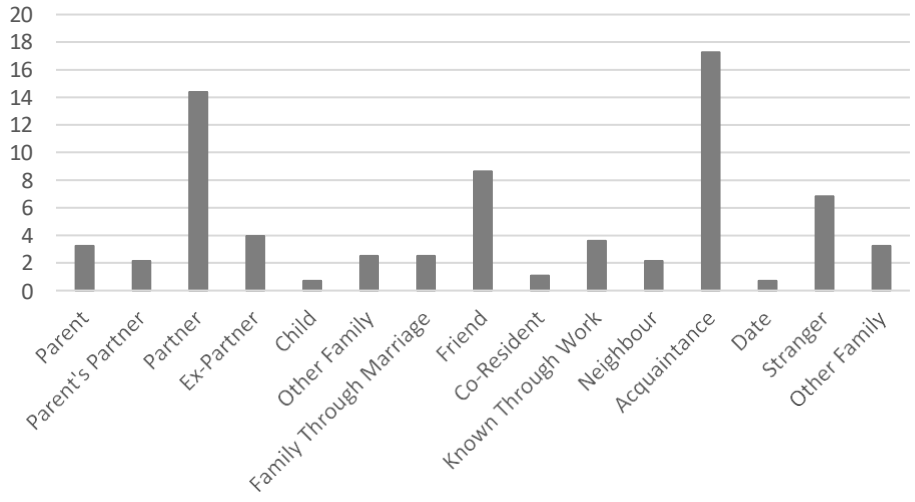
Relationship of Victim to Person Responsible

In 178 out of the 278 cases (64%) the victim and person responsible were known to one another and/or had some prior relationship. In 9 cases (3%) the person responsible was one of the victim's parents and in 6 cases (3%) it was a parent's partner. In 40 cases (14%) the person responsible was the victim's partner, and in 11 cases (4%) it was an ex-partner. In two cases (1%) the victim was the child of the person responsible. In 16 cases (6%) the person responsible was another family member, and in seven cases (3%) a member of victim's family by marriage was responsible.

In 24 cases (9%) the person responsible was a friend of the victim. In three cases (1%) it was a co-resident, and in six cases (2%) it was a neighbour. In 48 cases (17%) the person responsible was an acquaintance of the victim, in 10 cases (4%) they were a person known through work, and in two cases (1%) it was someone who dated the victim.

In 19 cases (7%) the person responsible was noted to have been a complete stranger to the victim. In the remaining cases the relationship between the victim and person responsible was not noted.

Figure 4: Relationship of Victim to Person Responsible (% of Cases)



Gender of Person Responsible

In 29% of cases (N = 81) the person responsible was male, and in 4% (N = 12) the person responsible was female. In all other cases information on gender was not recorded or not run.

Multiple Victims and Offenders

In 25 cases (9%) multiple individuals were noted to have been involved in the killing, and in 16 cases (5%) there were multiple victims.

4.4 Experiences of Criminal Justice Processes

The Funeral

For almost a third of the sample (33%; N = 91) there was no delay to release of the victim's remains and they were able to hold the funeral within a month of the death.

30% of the sample (N = 82) were able to hold the funeral within 1-2 months of the death, 13% (N = 37) within 2-4 months, and 9% (N = 24) within 6 months. Ten respondents (4%) had to wait more than six months before they could hold the funeral.

In terms of reasons respondents said the funeral was delayed: 74 respondents (27%) said that investigative activity (including multiple post-mortems) caused the delay; 36 (13%) indicated that it was delayed by other CJS processes; 12 (4%) said they had to delay the funeral because the victim was killed abroad; 1 (1%) said that they had to delay holding the funeral for financial reasons; 3 (1%) said the funeral was delayed because of COVID; and 16 (6%) reported funeral delays caused by other reasons.

Post-Mortems

In the vast majority of cases (92%; N = 258) respondents indicated that there had been a post-mortem, and in 44% of cases (N = 123) they reported that there had been more than one post-mortem conducted.

It should be noted that a considerable number of respondents indicated uncertainty with regards to this question; many said that they weren't sure, or – when giving a number – indicated that their answer was what they 'thought' it was.

Trial

Just over half (55%; N = 131) said that they received help from the CPS in preparing for the trial.

In 86% of cases (N = 238) respondents indicated that the case had gone to trial. Of these, 121 (51%) indicated that the trial had been delayed. Ten respondents (4%) reported that there had been multiple trials, and in 5 cases (2%) there was a subsequent appeal. In 17 cases (7%) respondents indicated that the case was unresolved, with no conviction having been obtained.

214 of the 238 cases resulted in a conviction being obtained (90%). In 168 cases (71%) there was a conviction for murder, and in 47 cases (21%) there was a conviction for manslaughter. In 6% of cases (N = 14) diminished capacity and/or a detention under the mental health act was noted.

Where a custodial sentence was given, in 20% of cases the sentence given was less than 10 years, and in 28% of cases the sentence given was between 10 and 20 years. In 52% cases the sentence given was for more than 20 years, and in 30% of cases a life sentence was given.

Where there was a trial, the majority of respondents (82%; N = 194) indicated that they had attended the trial. For some, this was noted to have caused a financial burden, with them having to self-fund their attendance, travel, accommodation, and even costs association with hiring an interpreter.

90 of the 278 respondents (32%) said that they had wanted a transcript of the trial. 21 respondents (8%) got a transcript. Where they did not get a transcript, the reason for this was stated as being them not being aware that they could get a transcript in 12% of cases, them not being asked or offered a transcript in 9% of cases, them being refused access to a transcript in 3% of cases, them not asking for a transcript in 2% of cases, them having difficult accessing the appropriate person(s) in 4% of cases, and them being too preoccupied with all that was going on at the time to get a transcript in 2% of cases. Five respondents (2%) said that the expense had prevented them from getting a transcript, and a further four respondents (2%) said that regulations stopped them from getting a transcript. 37 respondents (13%) did not get a transcript for other reasons.

Seven respondents (3%) indicated that they had had to pay for a trial transcript; the average amount they had to pay was £110 (S.D. = 137.386).

A number of respondents also noted the impacts of appeals and parole processes, as well as offender release, suggesting that these elements of the criminal justice process caused a great deal of stress and anxiety.

4.5 Impacts of Bereavement on Personal Health and Wellbeing

Impacts on Personal Physical Health

Three quarters of respondents (76%; N = 213) reported that the bereavement had impacted their physical health. 6% (N = 18) said that they had suffered from heart disease as a consequence, and 21% (N = 59) said that it had caused them to suffer from high blood pressure. 5% (N = 13) reported health impacts relating to some form of cancer, and four respondents (1%) said they had suffered a stroke as a consequence. A further third (32%; N = 88) reported having suffered some other physical health consequence.

Impacts on Personal Mental Health

Almost a quarter of the sample (22%; N = 62) reported having experienced mental health issues as a consequence of the bereavement. 80% (N = 222) said that they had experienced repetitive thoughts or nightmares, 66% (N = 183) said that they felt constantly on guard, 77% (N = 215) said that they experienced feelings of numbness and detachment, 81% (N = 226) said they had suffered from depression as a result of the bereavement, and 85% (N = 237) reported sleep disturbances.

A further 45% (N = 126) reported that they suffered from other psychological problems as a consequence of the bereavement.

Impacts on Personal Alcohol and Drug Use

42% of the sample (N = 117) said that they were drinking more alcohol than they had prior to the bereavement, and 31% (N = 85) were smoking more (or had started smoking). 44% (N = 121) had increased their use of prescription medications, and 6% (N = 17) had increased their use of non-prescription medications. 7% (N = 19) reported increased use of illegal substances.

Help-Seeking for Personal Health Consequences

Two-thirds (66%; N = 184) of the sample reported having sought help for impacts and consequences of their bereavement. Just over a third (34%; N = 95) reported having sought help from their GP, and a third (33%; N = 94) had had trauma counselling. 40% (N = 110) received specialised bereavement counselling, and 16% (N = 46) had attended some form of group therapy. A further 17% (N = 48) reporting having sought/received some other form of professional help.

4.6 Impacts of the Bereavement on the Health and Wellbeing of Family Members

Impacts on Physical Health of Family Members

In 67% of cases (N = 186) respondents reported that the physical health of family members had been affected by the bereavement. In 7% of cases (N = 20) heart disease was recorded and in 19% of cases (N = 52) family members had had increased blood pressure. In 8% of cases (N = 22) family members were reported to have suffered from cancer, and in 5% of cases (N = 13) from stroke. Other physical health effects for family members were noted in 73 cases (26%).

Impacts on Mental Health of Family Members

In terms of mental health of family members: 11% of the sample (N = 31) reported negative impacts of the bereavement. 60% (N = 166) were reported to suffer from recurrent thoughts or nightmares, 49% (N = 135) were reported to constantly be on guard, 50% (N = 140) were reported to have experienced numbness or dissociation, 68% (N = 188) to have suffered from depression, 62% (N = 171) from sleep disturbance, and 26% (N = 73) from other psychological conditions or impacts.

Impacts on Alcohol and Drug Use of Family Members

36% of the sample (N = 101) said that they had noted family members increasing their alcohol use after the bereavement. 27% of respondents (N = 76) said that family members had begun to smoke or increased their smoking post-bereavement. In 27% of cases (N = 74) family members were reported to have increased their use of prescription medications and in 6% of cases (N = 17) their use of non-prescription medications. In 9% of cases (N = 25) respondents reported increased use of illegal substances in family members.

Help-Seeking of Family Members for Health Consequences

46% of the sample (N = 129) reported that family members had sought help for health consequences of the bereavement. In 24% of cases (N = 68) they had sought help from their GP, in 18% of cases (N=50) they had had trauma counselling, in 24% of cases (N = 66) they had had bereavement counselling, in 8% of cases (N = 22) they had had group therapy, and in 5% of cases (13%) they reported family members having sought other forms of professional help.

4.7 Impacts of Bereavement on Personal and Family Situation

Impacts on Family Relationships

62% of respondents (N = 175) said that the bereavement had negatively impacted their family relationships. 32% (N = 88) said it had had a negative impact on their relationship with their spouse or partner.

20% (N = 58) said that it had impacted their relationship with their children, 18% (N = 51) their relationship with their parents, 20% (N = 55) their relationship with their siblings and 16% (N = 45) their relationship with other family members.

15% (N = 42) of respondents said that the bereavement had led to the breakdown of a partnership or marriage, either through separation or divorce.

Impacts on Children and Childcare

In almost two-thirds of cases (65%; N = 180) respondents said that children had been affected as a result of the bereavement. In 53% of cases (N = 146) their behaviour had been affected, and in 36% of cases (N = 99) the children had had difficulties at school.

103 respondents (37%) said that the children had required professional help, but in only 27% of cases (N = 76) did they say that the children had received professional help.

In 15% of cases (N = 43), respondents indicated that they had taken on primary care responsibilities for children as a direct result of the bereavement.

Impacts on Living Situation

76 of the respondents (27%) said that they had to move house as a result of the bereavement.

In 13% of cases (N = 37) this was to enable them to get away from the area, and in 2% of cases (N = 6) this was because the person responsible or their family lived in the area in which they were residing. 4% (N = 10) indicated that they had to move for reasons of fear, 1% (N = 2) for financial reasons, and 3% (N = 9) for family reasons. A further 2 respondents (1%) reported having to move due to other reasons.

Where a move was necessary, in just 9 cases was financial support given to facilitate the move. 4% of the sample (N = 10) indicated that they had wanted to move but were unable to, primarily for financial reasons.

Impacts on Employment

Almost a quarter of the sample (21%; N = 59) said that they had had to leave their employment as a result of the bereavement. Some of the sample were unemployed at the time of the bereavement (1%; N = 3), were not old enough to have been working at the time (1%; N = 2), were retired (1%; N = 2) or were self-employed (1%; N = 4).

Less than half (44%; N = 121) of those who were employed indicated that their employer had been understanding and sympathetic, and/or had supported them at the time of bereavement.

In terms of time off work: 2% of the sample (N = 5) said that they had not taken any time off work or had not been able to take any time off work; 18% of the sample (N = 50) had taken less than a month of work; 8% (N = 23) had taken 1-2 months of work; 9% (N = 26) had taken 2-4 months off work; 5% (N = 13) had taken 4-6 months off work; and 9% (N = 25) had taken more than 6 months off work.

Around half of the respondents (49%; N = 137) said that they returned to the same job after time off due to the bereavement. 47 participants (17%) started a new job when they went back to work: of these, for 23 it was full-time and for 18 it was part time.

Where participants started a new job, for 11 this entailed a lower wage, and for 9 it involved fewer hours. In 5% of cases (N = 15) the new job involved a different type of work.

Impacts on Finances

More than half of the sample (54%; N = 151) reported that they had incurred financial losses as a result of the bereavement. Almost a third (29%; N = 82) said that they had had to borrow money to meet costs.

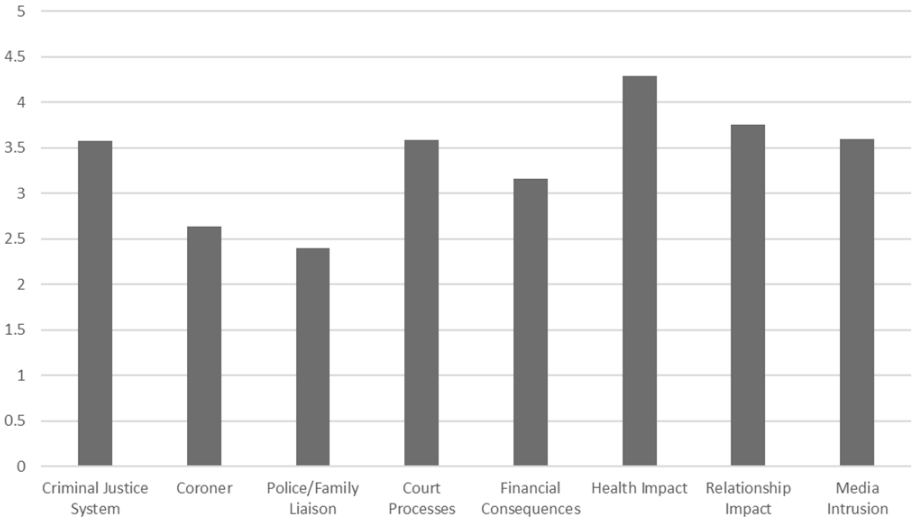
In terms of financing the funeral: 20 (7%) funded the funeral themselves; 38 (14%) had financial help from family or friends and 4 (1%) received a loan from family or friends; 36 (13%) had to use their personal savings, and 16 (6%) took out a loan to cover the costs; 12 (4%) received CICA help, 15 (5%) had insurance which covered the costs, and 7 (3%) received benefits to help them fund it. 9 (3%) undertook fundraising activities to pay for the funeral, 16 (6%) had help from an institution, and 12 (4%) received help from elsewhere. 18 (6%) preferred not to say how they had funded the funeral.

40% of the sample (N = 110) said that they had experienced difficulties in managing their finances after the bereavement. 22% (N = 60) reported that they had CICA issues or difficulties.

4.8 Difficulties Associated With Different Aspects of the Bereavement

Respondents reported that they found the health impacts of the bereavement the most difficult, with a mean rating of 4.29 (S.D. = 0.992) out of 5. The impact of the bereavement on relationships (Mean = 3.75; S.D. = 1.379), media intrusion (Mean = 3.60; S.D. 1.381), court processes (Mean = 3.59; S.D. = 1.291) and the criminal justice system as a whole (Mean = 3.58; S.D. = 1.391) were all rated highly in terms of the difficulties that respondents had with them.

Figure 5: Difficulties Associated With Different Aspects of the Bereavement

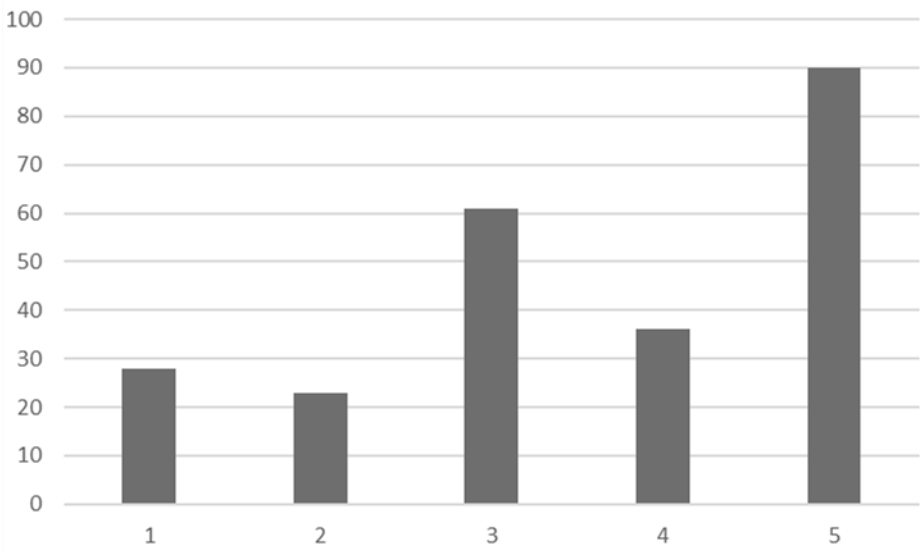


Financial consequences were seen as being generally less difficult than many of the other aspects of the bereavement (Mean – 3.16; S.D. = 1.503).

The coronial process (Mean 2.64; S.D. = 1.453) and the Police/FLO (Mean = 2.40; S.D. = 1.529) were seen as the least difficult aspects of bereavement.

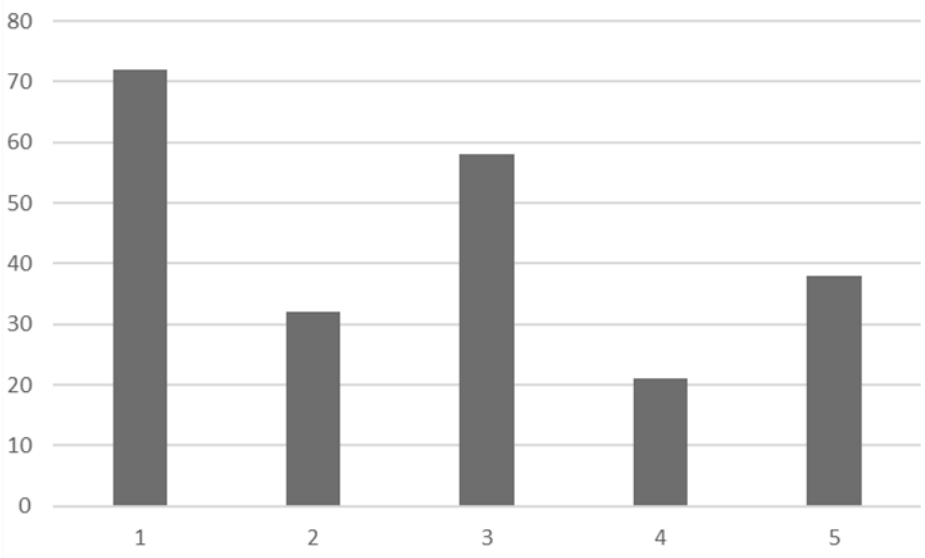
Taking each element in turn; for the criminal justice system as a whole, 12% of the sample (N = 28) gave this a difficulty rating of 1 (the lowest amount of difficulty), 10% (N = 23) a difficulty rating of 2, 26% (N = 61) a difficulty rating of 3, 15% (N = 36) a difficult rating of 4, and 38% (N = 90) a difficulty rating of 5 (the highest amount of difficulty).

Figure 6: Difficulty Ratings Associated with The Criminal Justice System



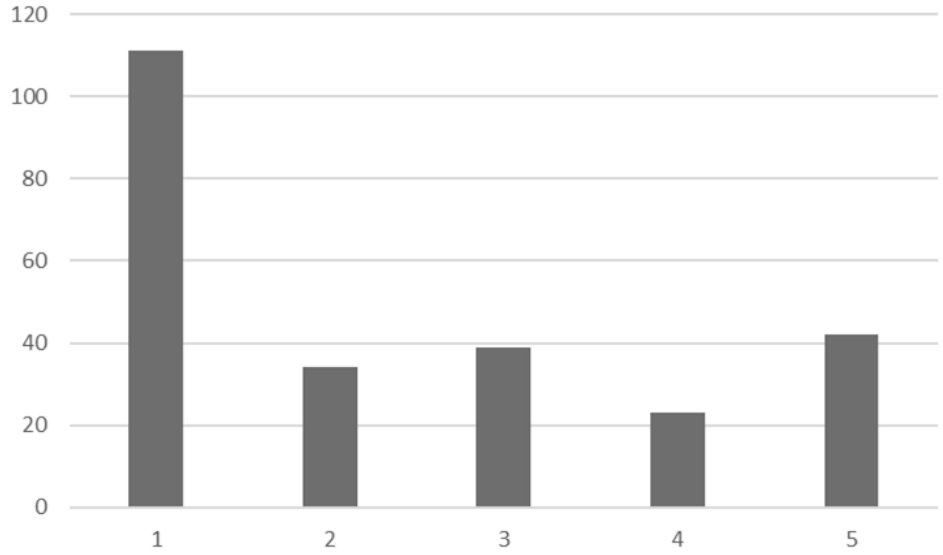
For the coroner and associated processes, 33% of the sample (N = 72) gave this a difficulty rating of 1 (the lowest amount of difficulty), 15% (N = 32) a difficulty rating of 2, 26% (N = 58) a difficulty rating of 3, 10% (N = 21) a difficult rating of 4, and 17% (N = 38) a difficulty rating of 5 (the highest amount of difficulty).

Figure 7: Difficulty Ratings Associated With The Coroner



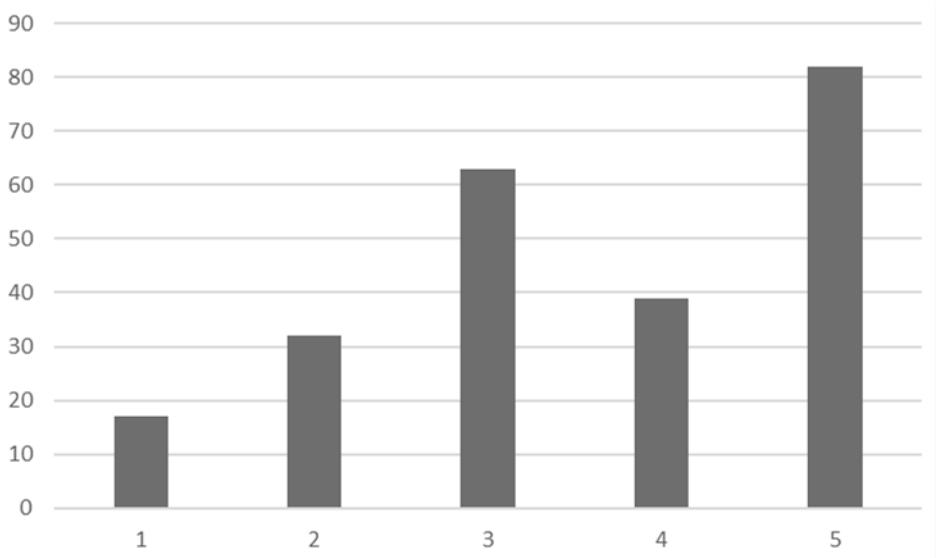
For the police, including family liaison officer(s), 45% of the sample (N = 111) gave this a difficulty rating of 1 (the lowest amount of difficulty), 14% (N = 34) a difficulty rating of 2, 16% (N = 39) a difficulty rating of 3, 9% (N = 23) a difficult rating of 4, and 17% (N = 42) a difficulty rating of 5 (the highest amount of difficulty).

Figure 8: Difficulty Ratings Associated With The Police/FLO



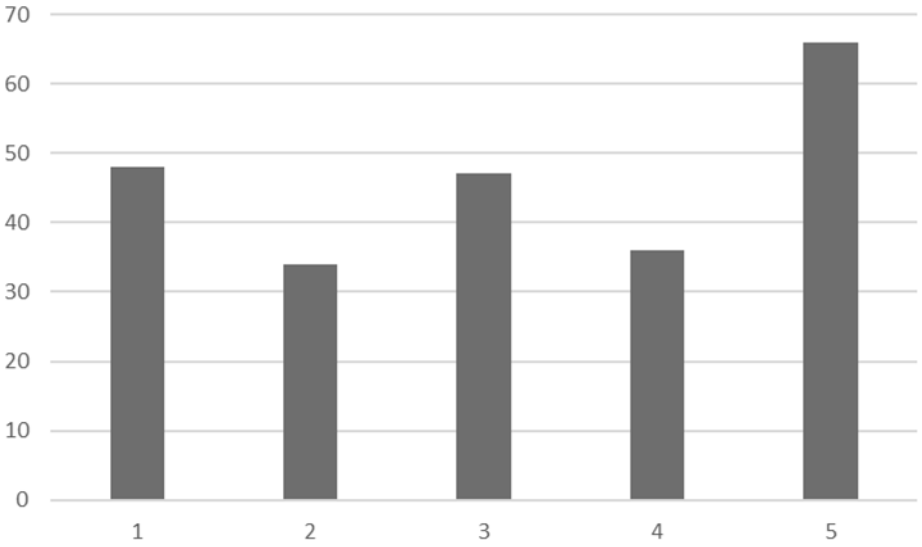
For the court process(es), 7% of the sample (N = 17) gave this a difficulty rating of 1 (the lowest amount of difficulty), 14% (N = 32) a difficulty rating of 2, 27% (N = 63) a difficulty rating of 3, 17% (N = 39) a difficult rating of 4, and 35% (N = 82) a difficulty rating of 5 (the highest amount of difficulty).

Figure 9: Difficulty Ratings Associated With Court Processes



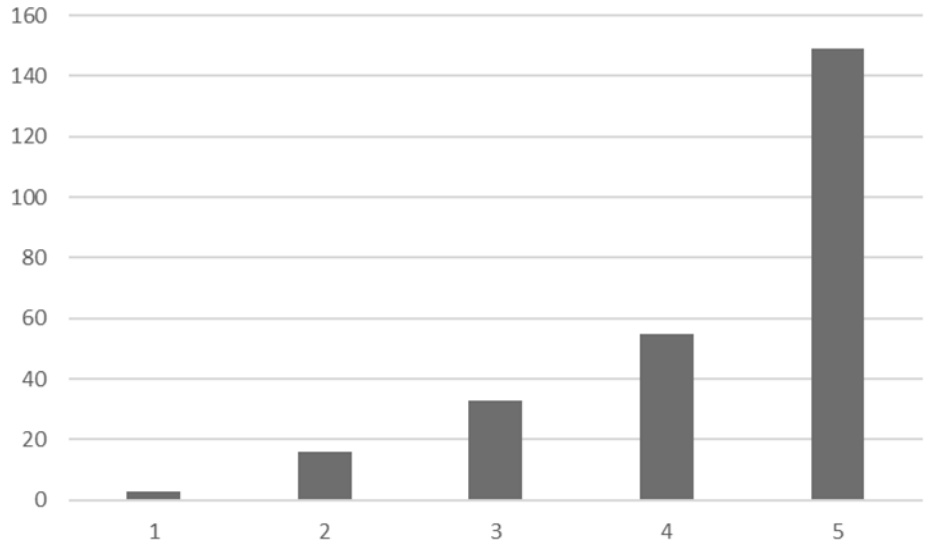
For financial consequences of, 12% of the sample (N = 28) gave it a difficulty rating of 1 (the lowest amount of difficulty), 10% (N = 23) a difficulty rating of 2, 26% (N = 61) a difficulty rating of 3, 15% (N = 36) a difficult rating of 4, and 38% (N = 90) a difficulty rating of 5 (the highest amount of difficulty).

Figure 10: Difficulty Ratings Associated With Financial Consequences



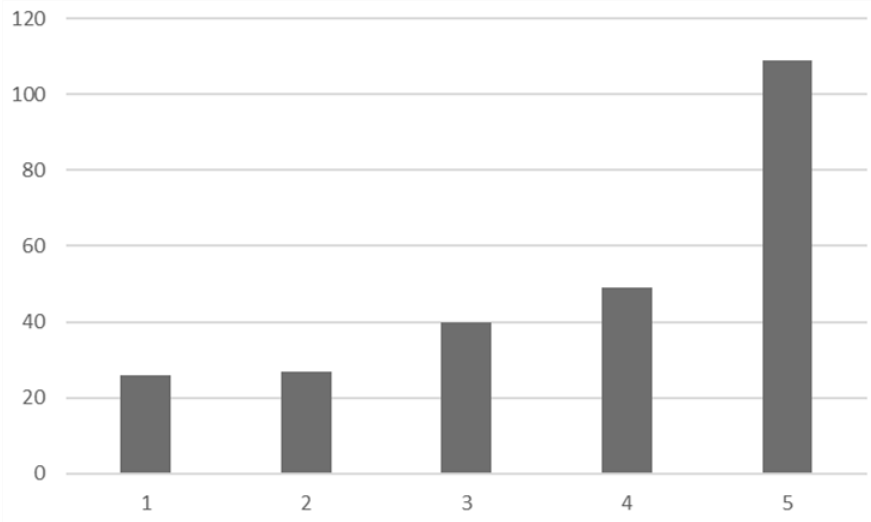
For the health impacts of the bereavement, 1% of the sample (N = 3) gave this a difficulty rating of 1 (the lowest amount of difficulty), 6% (N = 16) a difficulty rating of 2, 13% (N = 33) a difficulty rating of 3, 22% (N = 55) a difficult rating of 4, and 58% (N = 149) a difficulty rating of 5 (the highest amount of difficulty).

Figure 11: Difficulty Ratings Associated With Health Impacts of the Bereavement



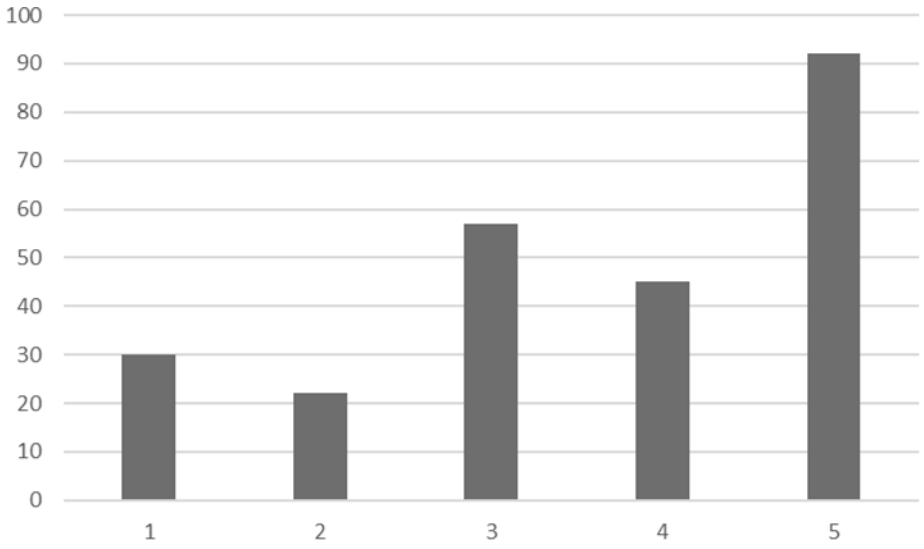
For impacts of the bereavement on relationships, 10% of the sample (N = 26) gave this a difficulty rating of 1 (the lowest amount of difficulty), 11% (N = 27) a difficulty rating of 2, 16% (N = 40) a difficulty rating of 3, 20% (N = 49) a difficult rating of 4, and 43% (N = 109) a difficulty rating of 5 (the highest amount of difficulty).

Figure 12: Difficulty Ratings Associated With Relationship Impacts of the Bereavement



For media intrusion, 12% of the sample (N = 30) gave this a difficulty rating of 1 (the lowest amount of difficulty), 9% (N = 22) a difficulty rating of 2, 23% (N = 57) a difficulty rating of 3, 18% (N = 45) a difficult rating of 4, and 37% (N = 92) a difficulty rating of 5 (the highest amount of difficulty).

Figure 13: Difficulty Ratings Associated With Media Intrusion



4.9 Help and Support

Ratings of the Helpfulness of Different Provisions at the Time of Bereavement

Respondents indicated how helpful they found four different provisions (the Police, CPS, SAMM and family/friends) at the time at which the bereavement occurred, via a ratings scale from 1-5 (with 1 being not at all helpful, and 5 being very helpful)[6][7].

Average ratings were highest for SAMM (Mean = 3.77; S.D. = 1.537), closely followed by family/friends (Mean = 3.77; S.D. = 1.373). They were lowest for the CPS (Mean = 2.81; S.D. = 1.421).

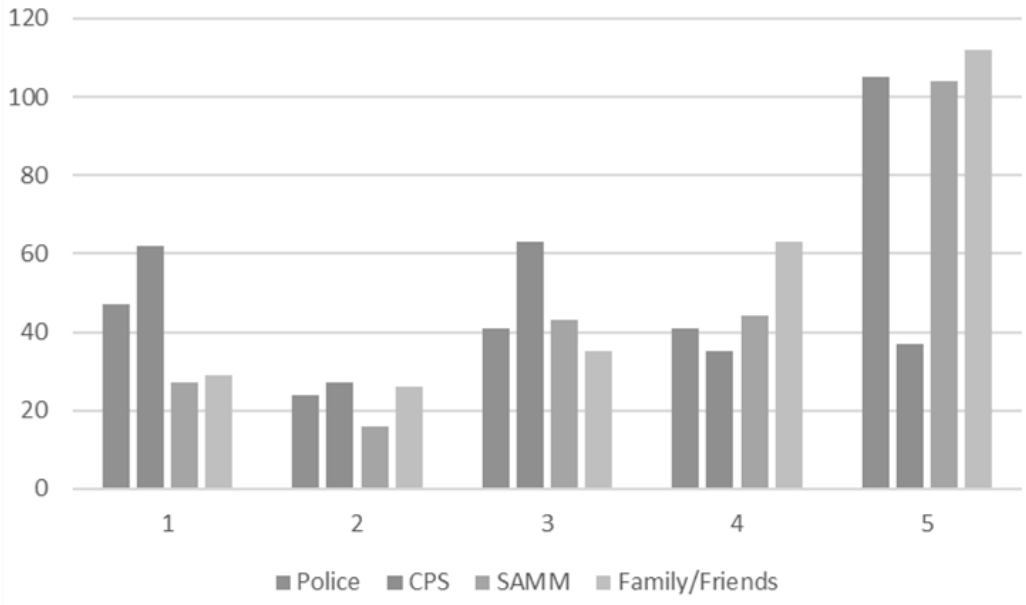
Table 1: Descriptive statistics for responses indicating how helpful provisions were found to be at the time the bereavement occurred.

Support	N	Mean	Std. Deviation
Police	257	3.52	1.536
CPS	224	2.81	1.421
SAMM	234	3.78	1.537
Family/Friends	265	3.77	1.373

Figure 14: Ratings of helpfulness for provisions at the time of the bereavement

[6] Numbers of responses varied for each of the different provisions. The number of responses returned for each provision are detailed in Table 1.

[7] It should be noted that some respondents reported that SAMM was not available at the time: (B7) "There was no SAMM at the time (1982)". Others indicated that they had not been aware that such services existed at the time: (A136) "I did not know about SAMM until about 3 years after the murder".



For the police, 47 respondents (18%) provided a helpfulness rating of 1 (not at all helpful), 24 (9%) a rating of 2, 40 (16%) a rating of 3, 41 (16%) a rating of 4, and 105 (41%) a rating of 5 (very helpful).

For the CPS, 62 respondents (28%) provided a helpfulness rating of 1 (not at all helpful), 27 (12%) a rating of 2, 63 (28%) a rating of 3, 35 (16%) a rating of 4, and 37 (17%) a rating of 5 (very helpful).

For SAMM, 27 respondents (12%) provided a helpfulness rating of 1 (not at all helpful), 16 (7%) a rating of 2, 43 (18%) a rating of 3, 44 (19%) a rating of 4, and 104 (44%) a rating of 5 (very helpful).

For family/friends, 29 respondents (11%) provided a helpfulness rating of 1 (not at all helpful), 26 (10%) a rating of 2, 35 (13%) a rating of 3, 63 (24%) a rating of 4, and 112 (42%) a rating of 5 (very helpful).

Ratings of Helpfulness of Different Provisions in the Long Term

Respondents indicated how helpful they found four different provisions (the Police, CPS, SAMM and family/friends) in the long term, via a ratings scale from 1-5 (with 1 being not at all helpful, and 5 being very helpful)[8].

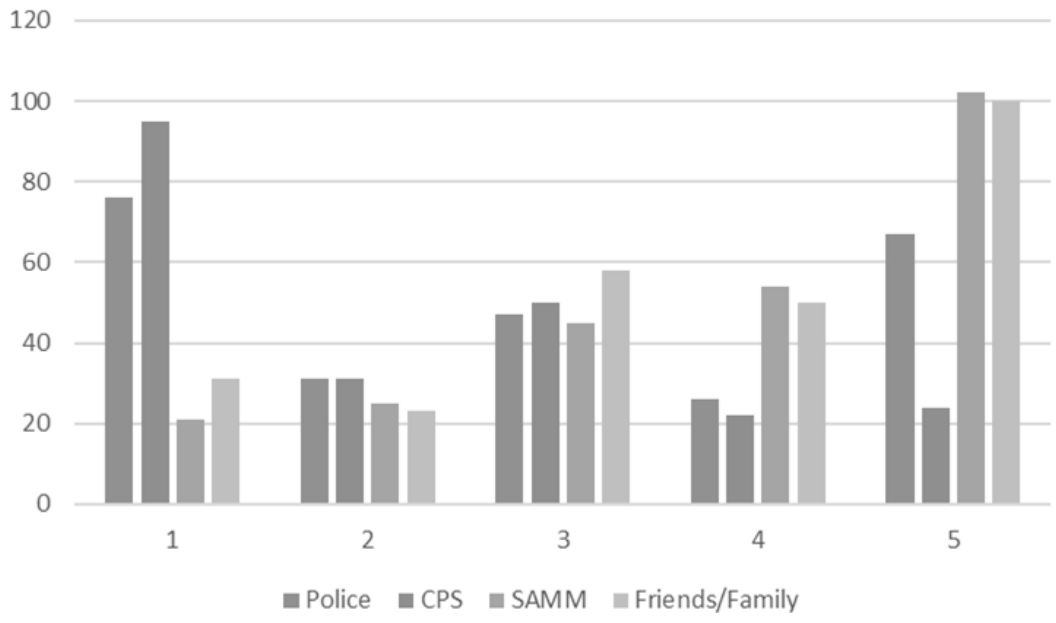
Average ratings were highest for SAMM (Mean = 3.77; S.D. = 1.312), closely followed by family/friends (Mean = 3.63; S.D. = 1.374). They were lowest for the CPS (Mean = 2.32; S.D. = 1.389).

Table 2: Descriptive Statistics for responses indicating how helpful provisions were found to be in the long term

[8] Numbers of responses varied for each of the different provisions. The number of responses returned for each provision are detailed in Table 2.

	N	Mean	Std. Deviation
Police	247	2.91	
CPS			
SAMM			

Figure 15: Ratings of helpfulness for provisions in the long term



For the police, 76 respondents (31%) provided a helpfulness rating of 1 (not at all helpful), 31 (13%) a rating of 2, 47 (19%) a rating of 3, 26 (11%) a rating of 4, and 67 (27%) a rating of 5 (very helpful).

For the CPS, 95 respondents (43%) provided a helpfulness rating of 1 (not at all helpful), 31 (14%) a rating of 2, 50 (23%) a rating of 3, 22 (10%) a rating of 4, and 24 (11%) a rating of 5 (very helpful).

For SAMM, 21 respondents (9%) provided a helpfulness rating of 1 (not at all helpful), 25 (10%) a rating of 2, 45 (18%) a rating of 3, 54 (22%) a rating of 4, and 102 (41%) a rating of 5 (very helpful).

For family/friends, 31 respondents (12%) provided a helpfulness rating of 1 (not at all helpful), 23 (9%) a rating of 2, 58 (22%) a rating of 3, 50 (19%) a rating of 4, and 100 (38%) a rating of 5 (very helpful).

Experience of the Victim Support Homicide Service

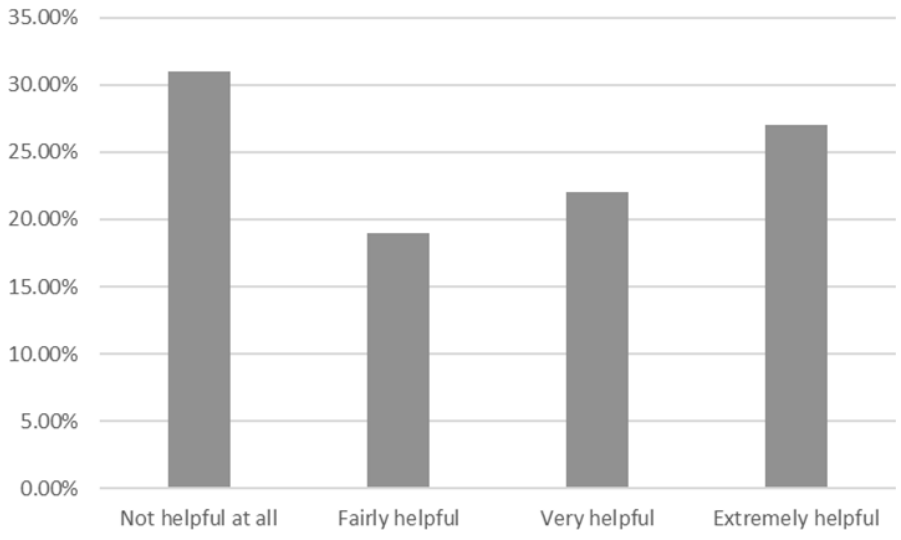
In response to the question of whether they had received support from the Victim Support Homicide Service, around half of the respondents (48.5%; N = 130) said that they had and half (51.5%; N = 138) said that they hadn't.

For those who had been offered support from VSHS, 72% (N = 110) reported that they had been a case worker. 27% (N = 41) indicated that they had not been offered a case worker.

For those who had been offered support from VSHS, 53% (N = 78) said that they had been offered the VS Peer Support Service. 45% (N = 63) indicated that they had not been offered this.

In terms of the overall support received from the Victim Support Homicide Service, 31% (N = 47) said that they had not found this helpful at all, 19% (N = 29) said that they had found this fairly helpful, 22% (N = 33) said that they had found this very helpful, and 27% (N = 41%) said that they had found this extremely helpful.

Figure 16: Ratings of helpfulness of Victim Support Homicide Service



4.9 Other Impacts: Supporting and Helping Others

Many respondents said that whilst they didn't feel they could take on any supportive-type roles themselves at the present time ('I don't feel strong enough to help anybody' – 276), this was something that they would like to consider for the future.

A number of respondents indicated that they had taken on roles supporting and helping others, and that this was helping them in moving forwards from the bereavement.

More than a third of the sample (36%; N = 99) said that they had been involved in supporting and helping others in some capacity since the bereavement.

For 26% (N = 71) this was in a volunteering capacity, with 24% (N = 68) indicating that they had worked with a charity and 19% (N = 53) saying that they had been involved in fundraising activities.

11% of respondents (N = 31) had been involved in educational work. A further 4% (N = 12) had been involved in other activities involving supporting or helping others.

5 Comparing Reported Experiences With Casey (2011)

All figures cited in the original Casey (2011) report were compared with those obtained for the present sample. These comparisons are presented below in relation to the key areas outlined previously.

Experience of Bereavement

In the original Casey (2011) survey it was reported that 79% of families waited longer than a month to bury their loved one. In the present sample this was slightly lower, at 67%. It was still, though, the majority who had experienced delays with regards to being able to hold the funeral.

Table 3: Comparison of Delays to Holding Funeral for Casey (2011) and Present Sample

Time Before Funeral	**SAMM/Casey (2011)**	**SAMM/BCU (2021)**
< 1 month	22%	33%
1-2 months	45%	29%
2-4 months	23%	13%
4-6 months	4%	9%
> 6 months	6%	4%

In the Casey (2011) study, the average number of post-mortems was two, with a range of between one and five. This was the same for the present sample. In the Casey (2011) study 15% of respondents said that there had been three or more; in the present sample only 8% (N = 17) indicated that more than two post-mortems had taken place.

More cases were reported to have gone to a trial and resulted in a conviction in the Casey (2011) study than in the present study. In the Casey study, nearly all (93%) cases that went to trial resulted in a conviction. In the present study, 86% of respondents (N = 238) stated that their case had gone to trial, and 214 of the 238 cases resulted in a conviction being obtained (90%).

Consequences of Bereavement: Impacts on Physical Health

More than half of the sample (53%) in the original Casey (20110 said that ill-health was the hardest aspect of the bereavement they dealt with, and the same was true in the present study. The average rating, on a scale of 1-5 (with 1 being not difficult at all and 5 being extremely difficult) was 4.29, the highest for any aspect of the impacts of the bereavement. 58% (N = 149) gave it the maximum rating of 5.

In the Casey survey, eight-in-ten (83%) indicated that their physical health was affected and three quarters (75%) that the health of their family had been affected as a consequence of the bereavement. In our survey, 77% (N = 213) of respondents indicated that the bereavement had affected their physical health, and 67% (N = 186) said that the health of their family had been affected. Figures were therefore comparable, although slightly lower for the present sample.

Table 4: Comparison of Incidence of Health Conditions in Casey (2011) and Current Samples (Personal Health – Physical Health Conditions)

Physical health conditions	**SAMM/Casey (2011)**	**SAMM/BCU(2021)**
Heart disease	12%	6%
Blood pressure	33%	21%
Cancer	5%	5%
Stroke	1%	1%
Other	28%	31%

Table 5: Comparison of Incidence of Health Conditions in Casey (2011) and Current Samples (Health of Family Members – Physical Health Conditions)

Physical health conditions	**SAMM/Casey (2011)**	**SAMM/BCU(2021)**
Heart disease	14%	8%
Blood pressure	32%	19%
Cancer	9%	8%
Stroke	8%	5%
Other	26%	26%

Table 6: Comparison of Incidence of Health Conditions in Casey (2011) and Current Samples (Personal Health – Mental Health Conditions)

Symptom	**SAMM/Casey (2011)**	**SAMM/BCU(2021)**
Repetitive thoughts	83%	80%
On guard	67%	66%
Detachment	83%	77%
Depression	76%	81%
Sleep Disturbance	86%	85%
Other	21%	45%

Table 7: Comparison of Incidence of Health Conditions in Casey (2011) and Current Samples (Health of Family Members – Mental Health Conditions)

Symptom	**SAMM/Casey (2011)**	**SAMM/BCU(2021)**
Repetitive thoughts	66%	60%
On guard	46%	49%
Detachment	54%	50%
Depression	63%	68%
Sleep Disturbance	66%	62%
Other	16%	26%

In the original Casey (2011) survey 21% of the sample reported that they had suffered from alcohol addiction and 5% from a drug addiction as a consequence of the bereavement, and 21% of the sample said that a family member had suffered from alcohol addiction and 8% from drug addiction after the death.

Questions were phrased differently in the current study (see 'Methodology'), to ask instead about increases in alcohol, medication and drug use. Findings can therefore not be directly compared. In the present study, 42% of the sample (N = 117) said that they were drinking more alcohol than they had prior to the bereavement. 44% (N = 121) had increased their use of prescription medications, and 6% (N = 17) had increased their use of non-prescription medications. 7% (N = 19) reported increased use of illegal substances.

36% of the sample (N = 101) said that they had noted that family members had increased their alcohol use after the bereavement. In 27% of cases (N = 74) family members were reported to have increased their use of prescription medications and in 6% of cases (N = 17) their use of non-prescription medications. In 9% of cases (N = 25) respondents reported increased use of illegal substances in family members.

Thus it appears that rates of alcohol and drug use as a consequence of the bereavement are higher now than they were when previously monitored; however, this is likely to be due – at least in part – to the different measurements used in the two studies.

With regards to help-seeking for physical or mental health problems; in the Casey (2011) study, eight-out-of-ten (78%) individuals had sought help, as had 60% of other family members. Figures for the present sample were slightly lower; 66% (N = 184) of respondents in the present sample had sought help for their own health issues suffered as a consequence of the bereavement, and 46% of the sample (N = 129) reported that family members had sought help for health consequences of the bereavement.

Table 8: Comparison of Frequency of Help-Seeking in Casey (2011) and Current Sample (Personal Health)

Help Received	**SAMM/Casey (2011)**	**SAMM/BCU (2021)**
GP	59%	34%
Trauma	29%	33%
Bereavement	49%	40%
Peer Support	19%	16%
Other	7%	17&

Table 9: Comparison of Frequency of Help-Seeking in Casey (2011) and Current Sample (Personal Health)

Help Received	**SAMM/Casey (2011)**	**SAMM/BCU (2021)**
GP	62%	
Trauma	26%	
Bereavement	44%	
Peer Support	12%	
Other	6%	

Impacts on Relationships

In the original Casey (2011) survey, 37% of respondents indicated that impacts of the bereavement on relationships were – for them – the hardest part of the experience. The current sample similarly indicated that this was an element of the experience that they had found particularly difficult, with an average rating of 3.75 out of 5 (in terms of overall difficulty).

Nearly three quarters (73%) of the sample in the Casey (2011) study said they experienced difficulties in their relationships following the bereavement. In the present sample the number was slightly lower, at 62% (N = 175).

In the Casey (2011) study the difficulties noted were with their spouse or partner in 60% of cases, with children in 45% of cases, with siblings in 38% of cases, with parents in 28% of cases, and with other family members in 28% of cases.

In the present study, 32% of the sample (N = 88) said it had had a negative impact on their relationship with their spouse or partner, 20% (N = 58) that it had impacted their relationship with their children, 18% (N = 51) their relationship with their parents, 20% (N = 55) their relationship with their siblings and 16% (N = 45) their relationship with other family members. In comparison with the Casey sample, then, rates were generally lower across all the different relationship categories in the present sample.

In the Casey (2011), nearly half (44%) of those who experienced difficulties in their relationship with their spouse/partner became estranged, separated or divorced following the bereavement. This rate was much lower at 15% (N = 42) for respondents in the present sample.

Impacts on Children and Childcare

In the original Casey (2011) study, two thirds (66%) of respondents said that there were surviving children as a result of the bereavement, and nearly three-in-ten (28%) respondents said they had been left with responsibility for caring for children. In the present study the proportion of respondents who said that children had been affected by the bereavement was very similar at 65% (N = 180), although the number who had had to take on caring responsibilities for children as a consequence was lower (15%; N = 43).

In nine-out-of-ten cases (88%) where children were reported to have been impacted in the Casey study, respondents reported that children's psychological health had been affected. Of those, over three quarters (77%) said they thought the child required professional help. Of those thought to need professional help, three quarters (73%) were reported to have received it. In the present study it was reported that children's behaviour had been affected in 53% of cases (N = 146), with children requiring professional help in 37% of cases (N = 103), and receiving professional help of some form in 27% of cases (N = 76). Thus, whilst the need for help was reportedly lower in the present sample, the proportion of those receiving help (71%, in the present study) was comparable.

In the present study it was reported that children had had difficulties at school as a result of the bereavement in 36% of cases (N = 99). This was notably lower than was reported by the sample in the Casey (2011) study (73%).

Impacts on Employment

In the Casey (2011) sample, a third of respondents (31%) said they were not employed at the time of the bereavement, although in some cases this was because they were already retired.

Some of the present sample were unemployed at the time of the bereavement: (1%; N = 3), were not old enough to have been working at the time (1%; N = 2), were retired (1%; N = 2) or were self-employed (1%; N = 4). Generally, through, rates of unemployment observed here were lower.

In the original survey, of were in work 70% stopped working for a period of time as a result of the bereavement, and the amount of time taken off varied from less than a month to more than a year (see table 10., below). A quarter of respondents (24%) stopped working permanently.

In the present study, almost a quarter of the sample (21%; N = 59) said that they had had to leave their employment as a result of the bereavement. In terms of time off work: 2% of the sample (N = 5) said that they had not taken any time off work or had not been able to take any time off work; 18% of the sample (N = 50) had taken less than a month of work; 8% (N = 23) had taken 1-2 months of work; 9% (N = 26) had taken 2-4 months off work; 5% (N = 13) had taken 4-6 months off work; and 9% (N = 25) had taken more than 6 months off work. 27 (10%) were off work for a year or more.

Table 10: Comparison of Time Taken Off Work in Casey (2011) and Current Sample

Length of Time Off Work	**SAMM/Casey (2011)**	**SAMM/BCU(2021)**
< 1 Month	10%	20%
1-2 Months	19%	8%
2-4 Months	15%	9%
4-6 Months	6%	5%
6-12 Months	15%	9%
> Year	11%	10%
Permanently	24%	21%

In the original Casey (2011) survey, most said that their employer had been very understanding and of those that returned to work, 80% returned to the same job. Of the one-in-five that took a different job, for 31% it was a different type of work, in 29% of cases it was part-time, 27% it was full-time. For 25% it was for lower-wages, and for 20% it was for fewer hours.

In the present study, less than half (44%; N = 121) of those who were employed indicated that their employer had been understanding and sympathetic, and/or had supported them at the time of bereavement. Fewer than half (49%; N = 137) said that they returned to the same job after time off due to the bereavement. 47 participants (17%) started a new job when they went back to work: of these, for 23 it was full-time and for 18 it was part time. Where participants started a new job, for 11 this entailed a lower wage, and for 9 it involved fewer hours. In 5% of cases (N = 15) the new job involved a different type of work.

Impacts on Living Situation

In the Casey (2011) study, over a quarter (27%) of the participants said they had to move home as a result of the bereavement, but of those that did, only 29% received any help in doing so.

In the present sample, 76 of the respondents (27%) said that they had to move house as a result of the bereavement. Only nine of these (11%) reported that they received financial support/help to do so.

Impacts of Finances

In the Casey (2011) study, it was found that those living in social housing were more likely than owner-occupiers to say they had difficulty managing the financial costs associated with the death. 63% said they had to borrow money (as opposed to 32% of owner occupiers).

In the present sample, 40% (N = 110) said that they had experienced difficulties in managing their finances after the bereavement. More than half of the sample (54%; N = 151) reported that they had incurred financial losses as a result of the bereavement, and almost a third (29%; N = 82) said that they had had to borrow money to meet costs.

22% (N = 60) reported that they had CICA issues or difficulties. This was a smaller proportion of the sample than that reported in the Casey (2011) report (where it was found that 45% of families had difficulties dealing with CICA).

Support

In the Casey (2011) study, 88% of the sample said that family and friends were supportive in the time following the bereavement

In the present study, when considering support provided by friends and family following the bereavement, 29 respondents (11%) provided a helpfulness rating of 1 (not at all helpful), 26 (10%) a rating of 2, 35 (13%) a rating of 3, 63 (24%) a rating of 4, and 112 (42%) a rating of 5 (very helpful).

When considering support provided by family/friends in the longer-term; 31 respondents (12%) provided a helpfulness rating of 1 (not at all helpful), 23 (9%) a rating of 2, 58 (22%) a rating of 3, 50 (19%) a rating of 4, and 100 (38%) a rating of 5 (very helpful).

In the Casey (2011) study, 76% regarded the police as fairly or very supportive in the time following the bereavement.

In the present study, when considering support provided by the police/FLOs in the time immediately following the bereavement, 47 respondents (18%) provided a helpfulness rating of 1 (not at all helpful), 24 (9%) a rating of 2, 40 (16%) a rating of 3, 41 (16%) a rating of 4, and 105 (41%) a rating of 5 (very helpful).

When considering support provided by the police/FLOs in the longer-term; 76 respondents (31%) provided a helpfulness rating of 1 (not at all helpful), 31 (13%) a rating of 2, 47 (19%) a rating of 3, 26 (11%) a rating of 4, and 67 (27%) a rating of 5 (very helpful).

In the Casey (2011) study, more than half of the respondents (55%) indicated that they did not find the CPS supportive of the family and there were serious concerns about them in some cases.

Similar was found in the present study. In terms of how helpful and supportive the CPS were viewed as being in the period following the bereavement, 62 respondents (28%) provided a helpfulness rating of 1 (not at all helpful), 27 (12%) a rating of 2, 63 (28%) a rating of 3, 35 (16%) a rating of 4, and 37 (17%) a rating of 5 (very helpful).

In terms of how helpful they were perceived as being in the longer-term; 95 respondents (43%) provided a helpfulness rating of 1 (not at all helpful), 31 (14%) a rating of 2, 50 (23%) a rating of 3, 22 (10%) a rating of 4, and 24 (11%) a rating of 5 (very helpful).

In the Casey (2011) survey, 32% of respondents found media intrusion to be one of the hardest things to deal with. Similarly, in the present study this was allocated one of the highest difficulty ratings, with a mean of 3.6 (out of 5).

Overall, in the Casey (2011) study the criminal justice system was mentioned as the most difficult thing to cope with by 51% of respondents, second only to the effect on their health. Our findings were again similar, with an average difficulty rating of 3.58 (out of 5) given by the participants.

6 The Experiences of Those Bereaved Pre and Post 2010

The Victim Support Homicide Service launched in 2010. The findings presented below offer some tentative indications as to the potential impacts of the service by comparing the experiences of those bereaved by homicide pre- and post- the introduction of the service. These results offer a means of considering the potential effectiveness of the VSHS in comparison to previous models of provision, and of considering the satisfaction and experience of homicide bereaved families since its introduction.

For the present sample, in 171 cases (62%) bereavement occurred pre-2010 and in 107 cases (38%) bereavement occurred post-2010.

For those who were bereaved prior to 2010, health impacts (Mean = 4.23 out of 5; S.D. = 1.032), relationship impacts (Mean = 3.67 out of 5; S.D. = 1.365), media intrusion (Mean = 3.62 out of 5; S.D. = 1.347) and the criminal justice system as a whole (Mean = 3.59 out of 5; S.D. = 1.395) were seen as being the most difficult elements of the bereavement process. Court processes were seen as being relatively hard to deal with (Mean = 3.50 out of 5; S.D. = 1.216), compared to the coroner (Mean = 2.73 out of 5; S.D. = 1.410) and police/FLOs (Mean = 2.43 out of 5; S.D. = 1.509) – which seen as the least difficult overall.

For those who were bereaved after 2010, health impacts (Mean = 4.38 out of 5; S.D. = 0.928) were also seen as being the most difficult thing to cope with. Relationship impacts (Mean = 3.87 out of 5; S.D. = 1.397), media intrusion (Mean = 3.56 out of 5; S.D. = 1.436), court processes (Mean = 3.72 out of 5; S.D. = 1.389), and the criminal justice system as a whole (Mean = 3.55 out of 5; S.D. = 1.367) all scored relatively highly. The coroner (Mean = 2.51 out of 5; S.D. = 1.516) and police/FLOs (Mean = 2.36 out of 5; S.D. = 1.568) – which seen as the least difficult overall.

Support

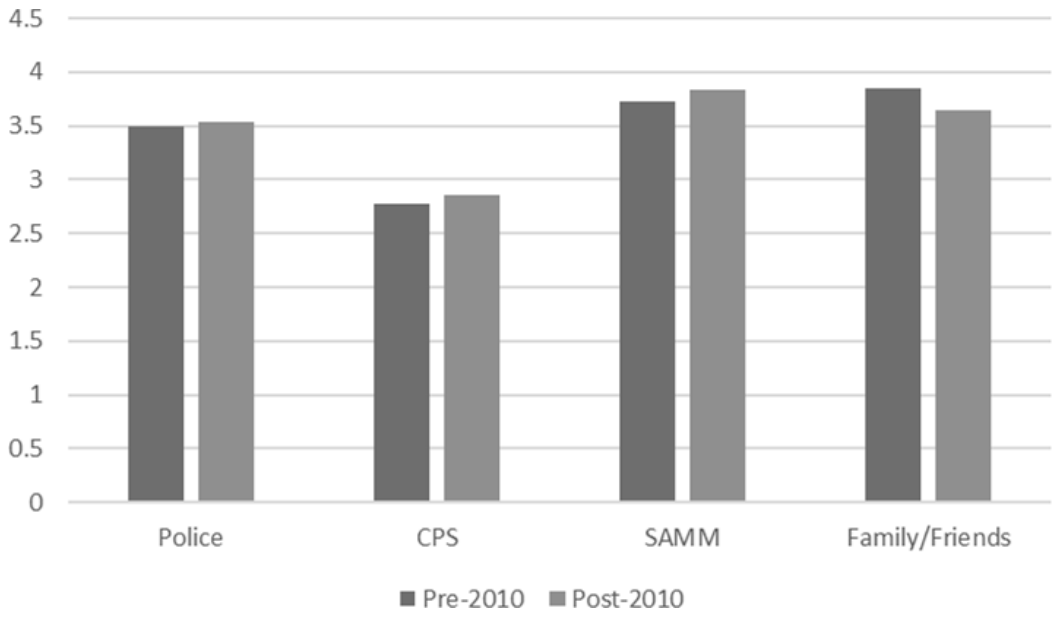
With regards to how supportive different provisions were seen as being at the time of the bereavement, for those where this occurred pre-2010 it was family/friends who were rated as having been the most supportive (Mean = 3.85; 1.290). This was closely followed by peer support from organisations such as SAMM (Mean = 3.73; S.D. = 1.359), then by the police (Mean = 3.50; S.D. = 1.538). The CPS were seen as being the least supportive (Mean = 2.78; S.D. = 1.428).

However, it should be noted that fewer participants provided ratings for peer support and the CPS (N = 138 and N = 137, respectively), than for the police and family/friends (N = 157 and N = 160, respectively); this may be because of the provisions were not available at the time they were bereaved. This is important to note, as it could have influenced the average obtained.

With regards to how supportive the different provisions were viewed as having been at the time for those bereaved post-2010: peer support was seen as being the most helpful (Mean = 3.84; S.D. = 1.409). This was followed by family/friends (Mean = 3.64; S.D. = 1.488) and the police (Mean = 3.54; S.D. – 1.540). Again, the CPS were viewed as having been the least supportive (Mean = 2.86; S.D. = 1.416).

There were slight variations in terms of the number of respondents rating each of the different support provisions (police, N = 100; CPS, N = 87; peer support, N = 96; family/friends, N = 105) – however, these were not so pronounced as in the pre-2010 bereavement group.

Figure 17: Comparison of Ratings of Different Forms of Support at the Time of Bereavement for Cases Occurring Pre- and Post- 2010



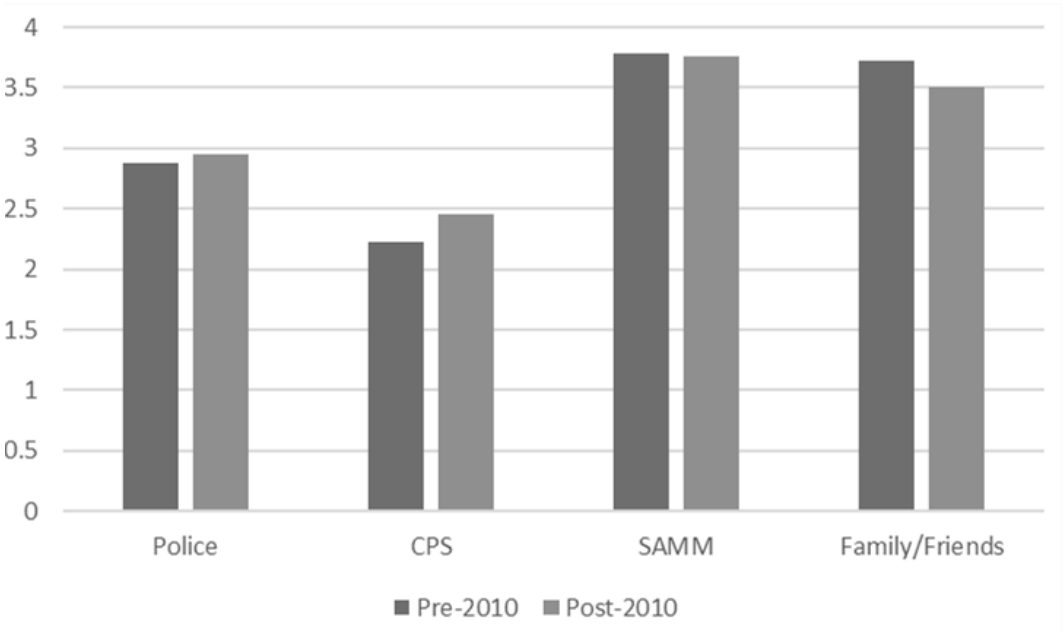
With regards to longer-term support: for those bereaved prior 2010, peer support was seen as having been most helpful (Mean = 3.274; S.D. = 1.274). This was followed by family and friends (Mean = 3.72; S.D. = 1.341) and the police (Mean = 2.88; S.D. = 1.612), with the CPS again being viewed as having been the least supportive (Mean = 2.23; S.D. = 1.319).

There were again some variations in the Ns for each of the groups (police, N = 151; CPS, N = 133; peer support, N = 147; family and friends, N = 159).

For those bereaved post-2010: peer support was also seen as having been the most helpful in the longer-term (Mean = 3.76; S.D. = 1.372), followed by family and friends (Mean = 3.50; S.D. = 1.420). The police (Mean = 2.95; S.D. = 1.579) and CPS (Mean = 2.45; S.D. = 1.485) were perceived to have been the least supportive, longer-term.

The number of respondents providing ratings for each again varied (police, N = 96; CPS, N = 89; peer support, N = 100; family/friends, N = 103).

Figure 18: Comparison of Ratings of Different Forms of Support in the Long-Term for Cases Occurring Pre- and Post- 2010



With regards to support received from the Victim Support Homicide Service, almost half as many of those bereaved pre-2010 had received support (36%, N = 38) compared with those bereaved post-2010 (69%; N = 72). 55% (N = 42) of those bereaved pre-2010 had a designated case worker, compared to 88% (N = 68) of those bereaved post-2010. Those bereaved after 2010 were more frequently offered the VSHS peer support service (63%, N = 44) than those bereaved before 2010 (44%, N = 34).

Overall, those bereaved after 2010 rated the VSHS as having been more supportive (Mean = 2.74; S.D. = 1.163) than those bereaved prior to 2010 (Mean = 2.15; S.D. = 1.163).

Table 11: Comparison of Ratings of VSHS Support For Those Bereaved Pre- and Post- 2010

How Supportive Were The VSHS?	**Pre-2010**	**Post-2010**
Not Very Helpful	41% (N = 30)	22% (N = 17)
Fairly Helpful	22% (N = 16)	17% (N = 13)
Very Helpful	18% (N = 13)	26% (N = 20)
Extremely Helpful	19% (N = 14)	35% (N = 27)

Significant differences were found in responses given by those bereaved pre- and post- 2010 with regards to the following:

- How difficult the court process was perceived to be - χ^2 (2,223) = 12.418; $p < .05$. Those bereaved post-2010 reported finding court processes more difficult than those bereaved pre-2010 (with a mean of 3.72 compared to 3.50).
- Formal support received - χ^2 (2,268) = 29.221; $p < .001$. Almost twice as many of those bereaved post -2010 (69%) reported having been given formal support (e.g. from the VSHS) than those bereaved pre-2010 (35%).
- Being allocated a case worker - χ^2 (2,153) = 21.042; $p < .001$. More of those bereaved post-2010 (88%) were offered a case worker than those bereaved pre-2010 (55%).
- Being offered support from peer support services - $\chi 2$ (2,148) = 7.124; $p < .05$. More were offered peer support (including via the VSHS) post-2010 (63%) than pre-2010 (44%).
- How valuable support received was perceived to be - χ^2 (2,150) = 9.413; $p < .05$. Those bereaved after 2010 rated the support received more highly (mean = 2.74, S.D. = 1.163) than those bereaved prior to 2010 (mean = 2.15, S.D. = 1.163).

7 Concluding thoughts

> This membership questionnaire is extremely useful, and for the first time in 11 years, has allowed me to reflect upon the trauma and loss my family are still going through.
>
> Respondent 36

In this section, we draw together the key findings of this work and make some recommendations. We also point to future research that needs to be done to better understand the needs of those bereaved through homicide. Below, we discuss some of the key themes that emerged from the report, and identify some of the limitations of the research, and point to future research possibilities. In general, what emerges is that we still know very little about the distinctive experiences of this group of crime victims. Despite the developments since the Casey report in 2011 and the replication here, there continues to be a paucity of in-depth data to explain the ongoing difficulties faced by homicide bereave families.

7.1 Re-Establishing the Impact

Since Casey's 2011 report, there have been a number of political and policy shifts in the landscape (see section 1.2). Despite the development of specialist services and directed funding, this report highlights that change has been slow and limited. It is concerning that the experiences of families traumatically bereaved remain 'trembling in [the] wake' of the CJS (Casey, 2011:6). This points to a disconnect between what is being provided and what those bereaved need in the aftermath of a homicide. In fact, when it comes to some experiences, notably court proceedings, there seems to have been a compounding of negative impacts since 2010. In particular, respondents reported notable limits with regards to the helpfulness of the CPS.

The financial burden in the aftermath of homicide was noted in the original Casey (2011) report. Continuing issues over cost were evident in responses received here, particularly costs associated with court attendance and paying for transcripts. Interested parties are required to obtain permission from the court and are entitled to apply to the reporting firm for a transcript and are subject to a commercial charge from the reporting firm. The copyright in all transcripts remains with the Crown. Records of transcripts are generally stored for five years. Costs are variable, depending on factors such as the length of trial/volume of transcripts, which means that it is impossible to assess the costs faced by victims in accessing these records (or, rather, financial barriers to obtaining access); which, given the circumstances, should perhaps be a fundamental right afforded to those bereaved by homicide. In addition to costs, the report highlights the need for further transparency around transcripts and the availability of these. Shock and trauma means that - for some - it can be hard to follow or retain what happens throughout the CJS. Having transcripts that are affordable and accessible could be a meaningful change for families and a way to reflect and remember what happened during this time.

Traumatic bereavement takes an extensive physical, mental and emotional toll, and the consequences and impacts for families – both in the short and long term – that were reported here were as extensive as originally identified in the Casey (2011) study. This was particularly evident in the help-seeking mechanisms employed by respondents as well as the high rates of dependency on drugs (prescription and non-prescription including illegal substances) and alcohol. Findings reported here – which, because of additional questions and response options included offer a greater depth of understanding of such issues – provide some insights as a basis for considering broader forms of more targeted support that may be appropriate and/or necessary as a key element of support provision for the homicide bereaved.

7.2 Understanding Traumatic Grief

Many of the persisting issues identified in this report centre around a continuing lack of understanding and recognition that complex grief processes run alongside a lengthy, complex and traumatic criminal justice process. This is reflected here, for example, in findings on the continued strain that homicide bereavement places on health – both mental and physical. Impacts on personal relationships, difficulties with employment, issues arising from housing and so on all point to the all-encompassing impact of loss through homicide. These impacts are unlikely to change across time, and are relatively unchanged - at least in their occurrence - from the Casey report in 2011. Therefore, one of the key findings here is the need to provide support that at its simplest considers the complexities surrounding traumatic loss. This was a key finding in Bradford's (2020) research, which pointed to the need to recognise the experiences of homicide bereaved people not only as victims, but also as bereaved – the two processes are inextricably linked.

Overall, we need to better understand and support the needs of bereaved families. This is evident, for example, in the perceived lack of understanding from employers that was experienced and reported. The length of criminal justice processes in conjunction with the even lengthier traumatic bereavement process that result from a homicide mean that the impacts are felt beyond the confines of conventional bereavement therefore this report reinforces the need for provisions to be made when it comes to acknowledging this in employment contracts that build in contingencies for such occurrences. The reality is that this does not affect the majority of society, and therefore the financial burden of doing so would not be great. This may offset some of the burden on the health system that forces traumatic bereavement to be seen in medical terms, rather than recognising that traumatic bereavement in itself is a reason to adjust working patterns and conditions.

7.3 Transformative Bereavement; Transformed Victims

Victimisation and subsequent criminal justice experiences cannot be separated from their loss. In her 2020 research, Bradford problematised this as potentially seeing bereaved families as being 'stuck' in their victimisation. However, this report further indicates that the lasting effects of homicide bereavement are exacerbated by a sense of injustice and voicelessness through criminal justice processes. Developments in criminal justice policy, as it pertains to this group of crime victims - whilst welcomed - will not be fully effective until the complexities and all-encompassing life sentence imposed on victims is both more widely acknowledged and better understood. It is also concerning that despite the value of peer support, as set out in Section 1, 45% (N = 63) of respondents who would have been eligible were not offered access to the VSHS Peer Support Service. The fact that - when asked about help and support - respondents who were bereaved post-2010 pointed to peer support as being the most helpful (Mean = 3.84; S.D. = 1.409), with pre-2010 ranking peer support as second after friends and family (Mean = 3.73; S.D. = 1.359), suggests a notable omission in current support service provision and distribution.

This is a complex and difficult task. Within grief and loss, and indeed victimisation, there are collective and individual experiences and therefore there is not a unified approach to what 'needs' are. But by allowing an increased voice through reforms and by emboldening peer support provisions, this may go some way towards better understanding what it is that homicide bereaved people need. Many of the provisions offered centre around the procedural stages of the criminal justice system and occur in the immediate aftermath of bereavement. In Bradford's (2020) research, the pain of a sudden end of interactions with criminal justice agencies once court proceedings had concluded was communicated. She found that, for most homicide bereaved people, uptake and engagement with support agencies came

after judicial proceedings had concluded. This was partially explained by the initial shock that homicide bereaved people encounter, and therefore they need to reflect on their experiences. It also pointed to the crucial role that Family Liaison Officers play in the immediate aftermath until the end of court proceedings. At this point there was a distinctive sense that homicide bereaved people were 'left to it'. This report further points to paucity of continuing support, which needs to occur in light of this transformative experience and the need for 'support' that adapts to needs that vary across time and space.

7.4 Help and Support – Contextualising and Defining

Building on Casey's recommendations in 2011, this report detailed consideration needs to be given to variations in support – both in terms of what constitutes support for different people, and also in terms of the different types of support accessed (e.g. one-to-one, group sessions, retreats, peer support, professional support etc.) and frequency of access/degree of engagement – in future studies. It is important to understand how such factors impact on the perceived value and helpfulness of different forms of support.

Moving forward, it may be that we need to focus on understanding – and consequently being able to manage – expectations regarding different forms of support. Despite the clear value placed on peer support in the responses, it may be that some might expect organisations such as SAMM to be able things that are beyond the scope or remit of these provisions. More than 25 different other types of support were listed in questionnaire responses in the present survey. It would be useful to explore in greater detail whether these helped, and so how/why. It would also be worth considering why participants might not access some forms of support – what some of the potential barriers to accessing support/help-seeking might be. One thing to emerge from the present study was an indication that – in terms of support (and what is perceived to be useful) – one size does not fit all. Variations in terms of ratings of different forms of results reflects the fact that some forms of support can be very useful for some, but less useful for others.

One of the key limitations of both the original Casey report and this report is the need to move beyond a normative approach and further understand some of the cultural, ethnic, and racial barriers when it comes to help-seeking practices. It was not possible to include these factors before establishing the current criminal justice approach to homicide bereavement; however, this would be an imperative inclusion in any future research, to qualitatively explore provisions based of demographic factors and cultural practices.

7.5 Recommendations

As identified above, this research highlights the need for ongoing, rigorous research to better understand the experiences of homicide bereaved families. This may include the following:

1. We would suggest that it would be advantageous to repeat this survey at regular time intervals (e.g. every 5 years). This would allow us to monitor changes over time, as well as to compare the experiences of those more recently bereaved with those for whom it has been longer

2. Exploring the nature of the respondent's relationship with person killed and impacts of this should be explored further. For example, it would be good to further understanding of how close they felt to that person, how regular their contact was with that person, and how these

kinds of factors impact on experience of traumatic bereavement. Existing research on victims often considers the victim-offender relationship, however given the indirect nature of this type of victimisation, a further dimension is included.

3. A focus on understanding perceived fairness and experiences of the various potential criminal justice outcomes, including:
    a. Current criminal justice status of case. In particular, questions could be included to capture victims' experiences when cases are unresolved (e.g. still awaiting trial).
    b. Perceptions based on pleas given – how do respondents feel where the person responsible has made a plea, and does this give a greater or lower degree of resolution?
    c. Attitudes towards cases where there is no conviction or if the suspect is acquitted – how does that influence the impacts and outcomes for those bereaved?
    d. Appeals – how do these impact upon overall experience and outcomes?
    e. Sentence(s) given – do they think this was fair? What do they think would have been appropriate?
    f. Perceptions where an accused is 'at large' or the suspect is unknown

4. Considering the impact of involvement in CJS processes. For example, if they were involved directly in the trial, as a witness or similar, what was their experience and how did it impact them?

5. Determining what happens in situations where the perpetrator is paroled or released; how do they feel about this, and what impacts does this have on experiences and their wellbeing?

7.6 Limitations and Future Research

It proved valuable having made changes so that participants provided ratings of different provisions, enabling direct comparisons to be drawn between them. Such information is likely to be particularly useful when considering how to tailor support to needs (at different stages of the process). It is suggested that further work is needed to better understand the support needs of victims more broadly, representing different communities, groups, circumstances and situations.

A number of respondents noted that they didn't feel the questions were relevant to them, e.g. if they were not an immediate family member of the victim or if the murder took place abroad. Whilst this is testament to the scope and breadth of support offered by SAMM, both in terms of wider family support, and in terms of supporting those affected in other jurisdictions, it does suggest that more targeted tailoring of data capture methods is warranted. It might be worth, for example, considering tailoring the questionnaire (e.g. using drop-down menus) so that specific questions were asked that were most relevant to their particular circumstances.

It is also recognised that some of the nuances and complexities of the traumatic bereavement experiences cannot effectively be captured via a survey method, nor is it necessarily appropriate to do so. It may be that some elements need to be explored more extensively utilising qualitative methods. One example of this may be considering issues around the coroner process, which – as was noted during development of the questionnaire – raises numerous sensitivities.

7.7 Areas for Further Consideration

Below are some areas for further consideration, to build upon the work detailed here:

The sensitivities surrounding some of the issues identified would be more suited to qualitative study owing to the complex and potentially retraumatising nature of the matters. Such an approach would allow for appropriate provisions and support to provided.

Qualitative research (i.e. interviews) should be considered to provide richer, more nuanced insights into experiences regarding the following:

- Experiences of the coroner (process)
- Health/mental health impacts of bereavement – important information is currently missing about the extent and duration of impacts and consequences of bereavement for long-term health and wellbeing of all affected.
- Trial processes and sentencing (including experience of the trial, particularly If they were a witness in the trial/were required to give evidence). It would also be useful to consider in more detail what sentences/outcomes are seen as appropriate.
- Parole hearings (and the impacts of these on those bereaved through murder and manslaughter)
- The Victim's Charter (and its implementation) – the impacts this has had, and how it has influenced the experience(s) of those bereaved by murder and manslaughter
- Transformation
- Memorialisation/Legacy
- Restorative justice

All of these are issues that can't be examined appropriately using a questionnaire methodology, as experiences are likely to be very personal and individualised. Further, it could potentially be very distressing for people to complete an impersonal questionnaire regarding such issues – it could be very sensitive and triggering, and appropriate safeguarding and support would need to be in place, with interview methods being used to discuss the issues in a tailored, sympathetic and responsive manner.

Other focal points for future research include:

1. Exploring the most effective mechanisms for enabling detailed and robust responses. Understanding where there is likely to be a preference for online for paper questionnaires would enable targeted recruitment strategies to be employed, potentially generating a greater number of responses. It may be that each may be most appropriate in certain instances. Online formats enable bespoke tailoring of questionnaires, which might elicit richer data. They could also be used to tailor questionnaires to improve victim engagement and experience. For example; with due ethical consideration, it would be possible to use victim's name in all relevant questions (many respondents did include personal details and references in free-text responses or notes added onto form - when describing who was killed, many seemed to want to name the person). However, some of the respondents here showed a clear preference for offline reporting methods.

2. Further consideration to unpack the health impacts of bereavement. Casey (2011), in reviewing the findings obtained in the original study, notes that medical conditions cannot be said to be caused directly by the murder itself in many cases, but they suggest that ill-health will become a significant problem for bereaved families, and points to the need for GPs to explore physical as well as psychological health issues in these circumstances.

3. It would also potentially be worth considering a broader range of different types of health impact; almost 40 other physical health conditions were listed by participants (including stomach conditions/digestive disorders, eating disorders, dementia). More than 30 other mental health conditions were listed by participants (including anxiety, panic attacks, guilt. Isolation noted multiple times). With regards to health conditions; self-diagnosis (as well as self-treatment/medication) is potentially an issue with the findings obtained. For example; fairly high rates of substance use were observed both in the present sample and in the original Casey study. This could potentially confound findings in relation to the impact(s) of traumatic bereavement on health, and future research should seek to disentangle these factors.

4. It might be worth considering including questions about diagnosed conditions and medications/treatment/interventions/counselling in future versions of the questionnaire.

5. It would also be worth exploring how reported rates compare to those in the general population; Casey (2011) notes that - while not directly comparable - the prevalence of heart disease, cancer, stroke, and high blood pressure in the general population would appear lower (Casey, 2011). More direct comparisons would facilitate a greater understanding of the true impacts of traumatic bereavement on overall health and well-being.

6. PTSD should be included and explored in more depth in future studies. The original Casey report makes reference to PTSD, but doesn't include it as a direct variable (just symptoms that could be indicative, but which arguably could also be symptoms of many other mental and physical health conditions).

7. It also is important to note that a few respondents indicated that they had been suicidal at some point during their bereavement. This clearly needs to be explored more extensively. It could be that the prevalence of this is higher in bereaved samples; however, it would be difficult to include questions regarding this using such a format, because of potential triggering and safeguarding issues.

8. The sample here was primarily White-British, which accords with boarder SAMM membership. It would be interesting to see the extent to which present findings hold across more diverse participant groups (and whether there are unique experiences or needs for different groups).

9. More generally, it would be interesting to compare responses/experiences of those from different demographic groups, in order to understand variations in support needs (and how different forms of support are perceived). It might also be good to consider things like geographical variations in terms of access to support.

10. It would also be good for future questionnaires to try and target respondent groups beyond the SAMM membership – this might provide more comprehensive insights into how needs might differ for those who engage with different provisions. Indeed, it must be noted as a potential limitation that findings both from this and the original Casey (2011) survey may have been biased by the fact that the sample were those who had subscribed to SAMM's services.

7.8 Further Refinement of Data Collection Methods

There were some difficulties with coding responses and interpreting results, which highlighted further ways in which surveying methods might be developed so as to be more accessible and inclusive when seeking to capture data from populations such as this. For example;

1. Throughout, the option 'not applicable' should be added as a response choice for all questions, to ensure that it is clear that they did answer the question but that it wasn't relevant, not that they left it blank for another reason.

2. Tick-box options should be included where there is the chance that participants will misinterpret possible response options or provide an unusable response. For example; some responses were quite vague – e.g.; when respondents were asked how long they had to wait until they could hold the funeral (with responses including things like "quite a long time", "too long" "several months" "a while" and "felt like ages"). Using tick box options would avoid this, as well as making these items easier for respondents to complete.

3. There were some questions (e.g. around health consequences) where answers provided were somewhat contradictory – for example; respondents indicated that their health had been affected, but then didn't select any of the health condition options or provide/specify any conditions (didn't provide any further information). Again, some re-phrasing and clarifications could help avoid this.

4. Some questions may need to be broken down further to enable experiences to be captured more fully (e.g. when asked about time taken off work – was this in one go, or multiple separate periods?).

5. Some items might generate richer information if participants were to provide scaled responses (rather than responding yes/no). For example, questions could be rephrased to "what extent do you think that X impacted on Y?"

6. Where scales are included, using a 10-point scale would allow greater differentiation, facilitating more detailed comparisons.

7. Using a different scaling option would also allow more discreet differentiation (as – for example - the difference between 'very helpful' and 'exceptionally helpful' is quite ambiguous)