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Early learning from Victim Support's Homicide Service

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National Centre for Social Research

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Disclaimer

The views expressed are those of the authors and are not necessarily shared by the Ministry of Justice (nor do they represent Government policy).

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Summary

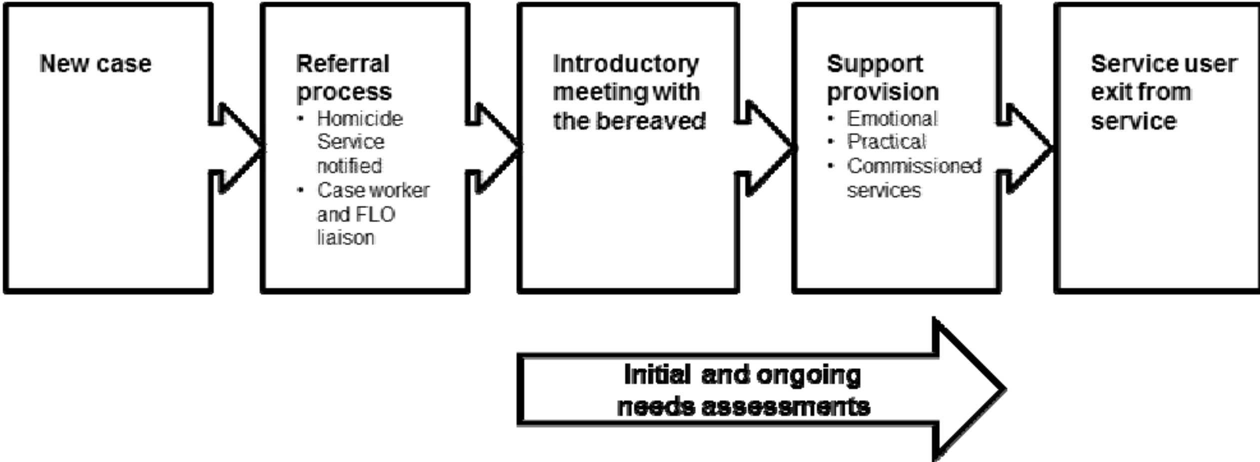
Context

In 2010/11 the Ministry of Justice (MoJ) provided Victim Support with an additional £2 million of funding to develop and run a new 'Homicide Service', covering the whole of England and Wales. Prior to 2010/11, people bereaved by homicide could receive emotional and practical support from Victim Support volunteers who had received specialist training. In addition, there were, and still are, a number of self-help and peer support groups run by people with personal experience of homicide. These groups tend to provide emotional support and information, and are generally small in size and locally based.

Victim Support's Homicide Service was set up to provide a nationally consistent service, run by paid professional staff, specialising in support for people bereaved by murder or manslaughter.[1] Bereaved people who consent to have their details passed on are referred to the Homicide Service by their police Family Liaison Officer (FLO), they may self-refer, or in cases of homicide abroad may be referred by the Foreign and Commonwealth Office (FCO). Bereaved people are assigned a professional case worker who acts as a single point of contact from the point of referral up until the bereaved individual no longer needs support. The case worker provides support to help the bereaved come to terms with their loss and deal with the many practical issues that arise following a homicide.

The planned process for delivering the Homicide Service is set out in Figure S.1.

Figure S.1 Delivery of the Homicide Service



[1] This includes murder, manslaughter and infanticide including cases where the death occurs abroad if the people bereaved by the homicide live in England or Wales. The Homicide Service does not provide services to people bereaved by road traffic collisions; these people are supported via Victim Support's core services.

At the point of implementing the Homicide Service, five teams were set up to cover the whole of England and Wales. Each team consisted of a team leader, four case workers and one support worker, meaning there were 30 staff in total reporting to a National Homicide Manager. In addition, trained Victim Support volunteers working in the core service[2] could be called on to work alongside the case worker, and services from other providers could be commissioned by the Homicide Service, such as specialist counselling.

The Homicide Service went live in London on 1 March 2010, with nationwide roll out taking place on 26 April 2010.

Research approach

Research was carried out by the National Centre for Social Research (NatCen) in 2011 to assess the factors affecting the implementation, delivery and effect of the Homicide Service during its first 14 months of operation. The research study comprised the following components:

- A scoping phase involving five in-depth interviews with strategic leads and regional team leaders.
- A qualitative study comprising 35 in-depth interviews with Homicide Service delivery staff[3] and bereaved service users. Interviews were conducted with 20 staff including Homicide Service case workers, support workers and volunteers, representatives from the police, the FCO, and providers of commissioned services.[4] In addition, there were 15 service user interviews.[5]
- Two 'lessons learnt' workshops with delivery staff to assess the value of the service, highlight good practice and to improve delivery going forward.
- Descriptive analysis of performance management data.

Initial delivery of the Homicide Service

Victim Support's performance management data showed that between 1 March 2010 and 5 May 2011 a total of 757 homicide notifications were received by the Homicide Service from the police. The FCO also notified the Homicide Service of 26 cases of homicide abroad and 74

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[2] The term 'core service' refers to the generic service offered by Victim Support to victims of crime in England and Wales, predominantly via trained volunteers.
[3] The term 'delivery staff' refers to all staff roles interviewed as part of the qualitative study.
[4] In total, six case workers were interviewed, see Appendix A for further details.
[5] Eighteen service users were consulted in total as two of the interviews were paired-depth interviews and an additional service user provided their views by email. There were no interviews conducted with bereaved people who did not take up the service; see Section 1.3 for further details.

bereaved people referred themselves to the service.[6] The Homicide Service is set up so that the police should notify the service of **all** homicides in England and Wales; however, it is unclear whether this was the case during the research period. It was not possible to compare the police recorded homicide statistics and the Homicide Service data due to differences in definitions and time periods in the two sets of figures, for example the Homicide Service data included culpable road deaths, corporate manslaughter cases and suspicious deaths later found by the police to not be homicides. In addition, there were early recording problems with the Homicide Service data which meant that it included some multiple records of the same homicide.

A homicide notification does not always lead to a referral by the police to the Homicide Service; over the 14-month period 83 homicides were not referred by the police. In the majority of cases this was because the bereaved family declined the service (47 cases), in other cases the next of kin could not be identified, or the police decided that there should not be a referral, for example because the bereaved person was being considered as a suspect. Therefore, over this period, a total of 663 homicide cases were referred to the Homicide Service. For each case the number of bereaved people involved varied; in total 1,287 bereaved people were referred.

Homicide Service staffing was originally based on estimates of a manageable caseload of 30 homicides per case worker per year. Performance management data for the first 14 months of the service showed that the average case worker caseload was 26 homicides over this period, but ranged from four to 49 homicides per case worker. As more than one person tended to be referred per homicide case, the average number of people supported per case worker was 51, ranging from 12 to 84 people per case worker.

Case workers provide support for as long as the bereaved person needs it. When the Homicide Service was being developed it was estimated that bereaved people would need support for approximately 18 months, with different levels of support required at different times, for example increased support immediately before, during and after a trial. By May 2011, 214 homicide cases had been closed, around a third of cases referred.

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6 These people may have been an extended relative or friend of a family already receiving support.

Effects of the Homicide Service

In-depth interviews with bereaved service users found that the effects of the Homicide Service on them were overwhelmingly positive; provision of emotional and practical support had improved service users' emotional and psychological wellbeing, including alleviating stress and anxiety and facilitating a more positive outlook.

There were also positive impacts for strategic stakeholders and delivery staff:

- The service improved partnership working between Homicide Service staff and the police, which had a positive impact on police views of Victim Support as an organisation overall.
- Homicide Service staff experienced feelings of personal fulfilment as a result of delivering the service.
- Homicide Service staff and police FLOs felt that the service had helped to clarify roles and responsibilities, with the role of the case worker as a provider of emotional and practical support reinforcing the investigative aspect of the FLO role.

Implications for delivery

In-depth interviews with Homicide Service staff highlighted that they felt there was considerable pressure on resources to deliver a high-quality service, with case workers generally carrying large caseloads and reportedly working in excess of their contracted hours. The research suggests that this pressure could be alleviated by:

- More effective use of Victim Support volunteers.
- Improvements to technology, such as remote access to the Case Management System (CMS).
- Training for case workers on closing cases and exit strategies, focusing on the approach to adopt, timing and ways to prevent service user dependency and case worker/service user co-dependency.

The training provided on the Homicide Service was generally considered by case workers to be insufficient to prepare them fully for service delivery. The research recommends that training is reviewed,[7] with additional training focusing on the practicalities of how to meet the support needs of service users, including:

- Information on practical arrangements following a death, such as probate and arranging a funeral.
- Information on benefit and compensation eligibility.
- Issues related to confidentiality surrounding the support received and how to convey this information to service users.
- Exit strategies for closing cases, as discussed above.

There was a perceived lack of engagement from Victim Support's core service, which impacted on the use of volunteers to help deliver the Homicide Service. Targeted training and/or communication is recommended to increase this engagement. The research also suggests that better communication between case workers and volunteers involved in Homicide Service cases would help to increase engagement, such as regular updates to volunteers about their work on cases and feedback on their achievements and development needs.

Where service users initially decline the Homicide Service there is meant to be ongoing contact between the case worker and police to review consent. However, the research found that not enough was being done to systematically review consent; Victim Support and the police should review this process to ensure that bereaved people get more than one opportunity to take up the service.

[7] Since the fieldwork Victim Support have made some amendments to the training package and intend to keep this under review.

Other learning points

The research found that the Homicide Service's performance management data could be improved.[8] Recommended changes include:

- Moving to a system designed to produce performance management data on individual staff, regionally and at a national level, rather than the existing system, designed to track work on individual cases. This would allow more effective monitoring of service delivery.
- Recording what support is provided at different stages, for example at the first and subsequent needs assessments, and at the trial. This would show whether there were typical patterns of support, and would facilitate better resource planning.
- Measurement and recording of the outcomes of support for service users to help demonstrate the impact of the service.
- Improvements to the processes for entering information on the system. Remote access, access for a wider pool of staff and volunteers and additional guidelines on data entry would help to improve data accuracy.

Methodological challenges

Research in this area is difficult due to the sensitive nature of the subject matter and the practicalities of arranging and conducting interviews with vulnerable individuals. The research approach adopted for this study aimed to be as robust as possible; however, it is important to highlight the challenges faced.

Interview selection

Service users were initially approached to participate in the research by Homicide Service staff. This was due to data protection and ethical issues faced in conducting research with people bereaved by homicide. The Homicide Service staff were best placed to determine whether it was appropriate to approach individuals, as they were able to assess their emotional and psychological wellbeing, the circumstances of their case and what stage it was at in the criminal justice system. For ethical reasons, service users also had to opt-in to the research. Bereaved people who declined the service were not interviewed as part of the study; a number of individuals were approached, but did not consent to take part, therefore the views of non-service users are not represented in this report.

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[8] At the time of writing, an internal review of the CMS was underway within Victim Support.

Information about how many service users were approached to take part in the research but did not consent to be contacted was not consistently recorded by case workers. In addition, the Homicide Service performance management data did not include information on the demographics or circumstances of service users, bereaved people who had not been referred to the service, or those who had chosen not to receive support. Therefore it was not possible to assess whether the demographics and circumstances of the service users interviewed reflected service users and people bereaved by homicide more broadly.

Early implementation

As the research took place shortly after implementation of the service, when it was still developing, it is unlikely that all possible impacts of the service had been realised. Therefore it was not appropriate to conduct a formal outcome evaluation or cost-benefit analysis. However, the research was still able to provide an initial assessment of the implementation, delivery and effect of the Homicide Service, including recommendations for how the service could be improved for future delivery to increase equality of access, efficiency of delivery and outcomes for service users.

1. Introduction

1.1 Policy background

The needs of people bereaved by homicide have been brought starkly into the public conscience in recent months following the media coverage in June 2011 of the trial of Levi Bellfield, the man convicted of schoolgirl Milly Dowler's murder in 2002, and of the reported treatment of her family during the trial and initial investigation. The following month the Victims' Commissioner, Louise Casey, published a review into the treatment of families bereaved by homicide, which suggested they often do not receive the support they need (Casey, 2011). As such, this report provides timely evidence about the support provided to those bereaved by homicide, specifically by Victim Support's Homicide Service.

Established in 1974, Victim Support is one of the largest providers of support to victims of crime in England and Wales, providing support predominantly via trained volunteers. The support needs of those bereaved by homicide are wide-ranging but broadly consist of emotional and practical needs (Paterson et al., 2006). Victim Support began to support people bereaved by homicide in 1986 in what was then called the Families of Murder Victims Project, with unpaid Victim Support volunteers receiving specialist training in order for them to provide practical help, emotional support, advocacy and information (Rock, 1998). This delivery model, of volunteers as case managers, continued until the implementation of the Homicide Service in 2010.

In addition, prior to the Homicide Service, people bereaved by homicide could access a number of self-help and peer support groups, run by people with personal experience of homicide. Many of these groups are still operating today and tend to provide emotional support and information. They are generally small in size and locally based (Casey, 2011).

In 2004 Victim Support conducted a review of the services received by people bereaved by homicide and their support needs (Paterson et al., 2006). Recommendations salient to the subsequent development of the Homicide Service included a review into what an appropriate support service would look like, provision of a more consistent service nationwide and consideration of using more paid practitioners to deliver it. Another recommendation of this review was that police Family Liaison Officers (FLOs) should introduce Victim Support volunteers when they would be of most support to the bereaved person, rather than as a way of facilitating FLO withdrawal. This indicates the extent of partnership working among FLOs and volunteers before the Homicide Service was implemented.

The Ministry of Justice (MoJ) provided Victim Support with an additional £2 million in 2010/11 to develop and deliver a new, nationally consistent 'Homicide Service'.[9] The Homicide Service is arranged so that people directly bereaved by murder, manslaughter or infanticide[10] who take up the service are assigned a paid professional case worker who is responsible for providing practical and emotional support; a departure from the previous model of a trained volunteer as case manager. The case worker acts as a single point of contact from the point of referral up until the bereaved person no longer needs support. For each homicide case the case worker may be supporting a number of people.

The Homicide Service operates across five regions covering the whole of England and Wales.[11] At the point of implementation, each regional team consisted of a team leader, four case workers, and a support worker[12] meaning 30 staff in total reporting to a National Homicide Manager. In addition, case workers can request that a specially trained volunteer from Victim Support's core service[13] works alongside them to support the bereaved person. Meeting the bereaved person's needs may also require the procurement of services, such as trauma counselling or childcare, from other voluntary sector and commercial providers.[14] The case worker is responsible for commissioning these.

The Homicide Service went live in London on 1 March 2010, with nationwide roll out of the service taking place on 26 April 2010.

1.2 Study aims and objectives

Research was carried out by the National Centre for Social Research (NatCen) in early 2011 to assess the factors affecting the implementation, delivery and effect of the Homicide Service during its first 14 months of operation, with specific objectives to explore:

- How the Homicide Service works in practice, particularly the nature of the support offered to service users.

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[9] On 6 July 2011 it was announced that this sum had increased as a result of an additional £500,000 of Government funding to help people bereaved by homicide.

[10] This includes murder, manslaughter and infanticide including cases where the death occurs abroad if the people bereaved by the homicide live in England or Wales. The Homicide Service does not provide services to people bereaved by road traffic collisions, these people are supported via Victim Support's core services.

[11] London; South East and East of England; South West and West Midlands; Wales and North West; and North East, Yorkshire and the Humber and East Midlands.

[12] The Homicide Service team's support worker was responsible for providing administrative support.

[13] The term 'core service' refers to the generic service offered by Victim Support to victims of crime in England and Wales, predominantly via trained volunteers.

[14] A proportion of Homicide Service funding was ring-fenced for the commissioning of these services.

- The effect of the Homicide Service on service users and delivery staff.[15]
- How the Homicide Service can be improved for future delivery, specifically in terms of coverage, equality of access, efficiency of delivery and outcomes for service users.

The research took place shortly after the implementation of the service, when it was still developing, so it is unlikely that all possible impacts of the service had been fully realised at this stage. Therefore it was not appropriate to conduct a formal outcome evaluation or cost-benefit analysis.

1.3 Research approach

The evaluation had four components; a scoping phase, a qualitative study comprising in-depth interviews with Homicide Service delivery staff and bereaved users of the service, 'lessons learnt' workshops with delivery staff, and analysis of performance management data. The key features of each phase are outlined below.

Three of the five Homicide Service regions were purposively selected[16] (Ritchie and Lewis, 2003) for inclusion in the scoping phase and qualitative study to reflect diversity of geographical region, knowledge of specific homicide incidents that have occurred since roll out, and recorded homicide rates in England and Wales in 2008/09[17] (Smith et al., 2010) which were used to select regions with relatively high, low and medium rates of homicide. It was necessary to sample all five regions for some components of the evaluation; this is highlighted in the relevant sections below.

Research in this area is difficult due to the sensitive nature of the subject matter and the practicalities of arranging and conducting interviews with vulnerable individuals. While the research approach adopted for this study aimed to be as robust as possible; the challenges faced are highlighted in the relevant sections below.

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[15] The term 'delivery staff' refers to all staff roles interviewed as part of the qualitative study.
[16] Sampling in this way involves selection based on dimensions that reflect key differences in the study population that are relevant to the study's objectives.
[17] These rates were the most current at the time of sampling.

Scoping phase

This component aimed to explore how the Homicide Service was implemented and to assist in the development of the qualitative study. In-depth interviews were conducted with two national leads with strategic responsibility for the service and three regional team leaders. Team leaders were selected as they have management responsibility as well as their own caseload in some regions. Key documentation supplemented the data gathered, including the service delivery model and minutes from the national implementation group meetings.

Qualitative study

This component aimed to explore how the Homicide Service worked in practice, its effect on service users and staff, and suggestions for improvements. It comprised in-depth interviews with Homicide Service delivery staff and bereaved users of the service.

Interviews with delivery staff

In total, 20 in-depth interviews were conducted with delivery staff.[18] To capture diverse perspectives about Homicide Service delivery and ensure a credible evaluation, a range of staff was interviewed in each region, including Homicide Service case workers, the support worker, at least one specialist trained homicide volunteer and at least one police representative out of the following: a Senior Investigating Officer (SIO), a FLO and a Family Liaison Coordinator (FLC). In addition, two individuals from national organisations were interviewed, including a representative from the Foreign Commonwealth Office (FCO) and an organisation offering trauma counselling that could be commissioned by the Homicide Service to provide counselling to service users.

Interviews with bereaved service users

Fifteen in-depth interviews were carried out with service users; 17 service users were interviewed altogether as two of the interviews were paired-depth interviews. The interviews were face-to-face, although one was carried out by telephone at the participant's request. A further set of service user views was sent by email, bringing the total number of service users consulted to 18.

[18] Further detail, as well as the achieved sample interviewed, is set out in Appendix A.

Service users were initially approached to participate in the research by Homicide Service staff. This was due to data protection and ethical issues faced in conducting research with people bereaved by homicide. The Homicide Service staff were best placed to determine whether it was appropriate to approach individuals, as they were able to assess their emotional and psychological wellbeing, as well as the circumstances of their case and what stage it was at in the criminal justice system (CJS). For ethical reasons, service users also had to opt-in to the research.

To gather a range of perspectives, purposive sampling criteria were initially set. However, due to difficulties accessing bereaved service users, all those who gave consent to be contacted and who were willing to take part in the evaluation across all five regions were interviewed.[19] Despite this, interviews with service users with a range of experiences and circumstances were still achieved.

Bereaved people who declined the service were not interviewed as part of the study; a number of individuals were approached, but did not consent to take part in the research, therefore the views of non-service users are not represented in this report.

Information about how many service users were approached to take part in the research but did not consent to be contacted was not consistently recorded by case workers. In addition, the Homicide Service performance management data did not include information on the demographics or circumstances of service users, bereaved people who had not been referred to the service, or those who had chosen not to receive support. Therefore it was not possible to assess whether the demographics and circumstances of the service users interviewed reflected service users and people bereaved by homicide more broadly.

[19] The sampling and recruitment process and the achieved sample interviewed are discussed further in Appendix A.

Conduct and analysis of the interviews

The interviews with strategic and delivery staff were carried out between February and April 2011, and the interviews with bereaved service users took place between April and June 2011. All interviews were based on topic guides and lasted between 45 and 100 minutes. The qualitative data were analysed using the Framework approach (Ritchie and Lewis, 2003).[20]

The findings in this report give a good sense of the range and diversity of views and experiences among the staff and service users interviewed. As this is a qualitative study, the prevalence of particular views and experiences cannot be estimated.

'Lessons learnt' workshops

The third component of the research involved 'lessons learnt' workshops, the aim of these being to assess the value of the service, highlight good practice and work directly with delivery staff to improve the Homicide Service going forward. The workshops involved Homicide Service delivery staff across the five regions, including staff who had participated in the scoping phase and qualitative study. Two workshops took place, each lasting approximately four hours. Twenty-seven members of delivery staff attended in total. Following presentation of the research findings, feedback was gathered regarding facilitators and barriers to service delivery and incorporated into the findings presented here.

Analysis of performance management data

Performance management data extracted from the Homicide Service case management system (CMS)[21] and data collated by the Homicide Service support workers in each of the five regions were analysed.[22]

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[20] See Appendix A.

[21] The CMS is an electronic system used to store details about each case and person supported by the Homicide Service. Either case workers or support workers record personal data (such as name, date of birth and address), details about the homicide and any Homicide Service activity on the case (such as needs assessments, agreed actions and review dates) on the system.

[22] This data covered a range of measures including: the number of bereaved people being supported; the number of needs assessments carried out; the types of support provided; the number of people exiting the service; and case worker caseload including the number of visits to the bereaved person.

Both sets of data cover the period from 1 March 2010[23] to 5 May 2011 (when the data were extracted and collated). National level data are presented in the main body of the report, with a breakdown by Homicide Service region provided in Appendix B. The data are presented at the following levels:

- Across the service as a whole.
- An average per case worker (the mean number per case worker has been calculated based on the 25 case workers working across the service at the time of the research).
- An average per homicide case (calculated using the total number of homicides referred to the service during the period).
- An average per person supported (calculated using the total number of people supported by the service during the period).

The performance management data presented throughout the report should be interpreted with caution. Case workers were responsible for entering data related to their cases on to the CMS, and individuals' recording practices may have varied. There were also data quality issues in the March to October 2010 period as the recording practices were still being developed. In addition the process was affected by a lack of remote access to CMS. This meant that in some instances there might have been a time delay between activities on the case and when the data were recorded on the CMS, leading to a risk of recall errors.
The CMS was designed to track work on individual cases, not to produce performance management data and monitor service delivery. A number of the performance management statistics provided by Victim Support for this research therefore had to be produced via a manual trawl of the system. The resource implications of extracting the performance management data from the CMS restricted the amount of data that could be provided for analysis in this research.

Recommendations for improvements that should be made to the performance management data collected by the Homicide Service are included in Chapter 5.

[23] The service went live in London on 1 March 2010, with nationwide roll out on 26 April 2010.

1.4 Report outline

The overarching aim of the evaluation was to consider the factors affecting the implementation, delivery and effect of the Homicide Service; the findings are presented as follows:

- Chapter 2: Implementation.
- Chapter 3: Delivery.
- Chapter 4: Effects.
- Chapter 5: Implications.

2. Implementation of the Homicide Service

This chapter explores how the Homicide Service was implemented from the perspective of the strategic leads and delivery staff, as well as facilitators and barriers to implementation, in relation to three areas: planning, management, and training.

2.1 Resource planning

In a climate of fiscal restraint it was imperative for the evaluation to look at service funding and perceived implications for sustainability. This section then goes on to briefly explore decision-making around resource requirements.

Funding

Funding is critical to any service delivery, impacting on staff availability and the nature and scope of the service delivered (Tennant et al., 2007). The MoJ provided Victim Support with £2 million in 2010/11 to develop and deliver the Homicide Service.[24] Strategic staff were initially 'delighted' with the level of funding and felt that it was sufficient to deliver a service that met the needs of people bereaved by homicide. However, it was acknowledged that implementing a service of this nature was an unknown entity and so there was some trepidation at the time of the interviews about how adequate the funding would be.

The 2010/11 funding covered the cost of staffing (recruitment, training and wages);[25] and expenses such as case worker travel costs and mobile phone bills, as well as for service users' urgent needs, such as food. In addition, approximately a third of the funding was ring-fenced for the commissioning of services that respond to needs outside of Homicide Service delivery, such as trauma counselling and peer support. At the time of fieldwork there were also plans for the FCO to extend their funding to support people bereaved by homicide abroad, as in such instances there are additional costs such as repatriation if the victim did not have travel insurance. Initial Homicide Service funding did not meet these costs and so it was envisaged that this additional funding would go some way to providing this support. This was an ongoing development at the time of the research.

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[24] The MoJ have agreed a funding settlement with Victim Support for the next three years (2011/12, 2012/13 and 2013/14), a proportion of which is ring-fenced for the Homicide Service.

[25] For team leaders, case workers and support workers.

Homicide Service strategic staff and team leaders knew that MoJ funding of the service had been secured until 2013/14. MoJ funding rounds have historically lasted for one year, and so the duration of funding provided some reassurance regarding the sustainability of the service. However, the current restraint on public spending had caused some concern about the future of the Homicide Service after this time. Team leaders felt that case workers might look for alternative employment if plans for future funding were not announced soon, which would have a bearing on the development of staff expertise, continuity and consistency of service delivery. As MoJ currently settles spending on a three-year basis, decisions about future funding will not be finalised until the end of 2013/14. Consequently, there is a potential risk to staff retention that may impact on service quality.

Resource requirements

To determine staffing levels, an accurate assessment of need was crucial. Strategic leads drew on a range of sources, including historical statistics of where and how many homicides occurred as well as numbers of people bereaved by homicide and supported by Victim Support pre-roll out. Supplementing this data was a projection of what caseload a case worker could reasonably be expected to carry, based on discussions with police family liaison strategic leads. Service development was based on estimates of a manageable caseload of 30 homicides per year for each case worker, corresponding to approximately 70 bereaved people receiving support. The perceived adequacy of staffing and implications for service delivery is discussed further in section 3.3.

2.2 Management

How a service is managed is a key building block to supporting service delivery and outcomes. Strategic and delivery staff identified a number of facilitators and challenges to implementation management, including support from strategic stakeholders, communication and awareness-raising, and provision of guidance and support to operational staff.

Strategic stakeholder support

The motivating and momentum-building role of senior staff when a new service or policy is being implemented is well documented (Turley and Webster, 2011; McNaughton Nicholls et al., 2010) and this was also the case for the Homicide Service. Strategic leads and team leaders stressed the importance of support and commitment to the Homicide Service by high-level strategic stakeholders, particularly those from the police given their role in the referral process (see section 3.1). A multi-agency national implementation group was established to plan and manage implementation and delivery, and facilitate strategic support

to regions. Membership of the group comprised key stakeholders from the Homicide Service, Victim Support, Association of Chief Police Officers (ACPO), National Policing Improvement Agency (NPIA), Crown Prosecution Service (CPS), HM Courts Service (HMCS) and MoJ. The group was credited with securing cooperation from police at a strategic level to commit to the Homicide Service and allaying initial police concerns about the impact of early intervention from the case worker on the investigation. That one of the strategic leads was seconded from the Metropolitan Police was considered a critical factor underpinning this success, due to their understanding of police culture and processes. The secondment also facilitated communication with the police.

Communication and awareness-raising

The referral pathways in to support and the needs of those bereaved by homicide are complex (Paterson et al., 2006) and so beyond the remit of one organisation. As such, effective communication and awareness-raising was critical to effective implementation and delivery, particularly to police and Victim Support's core service.

The police are vital to the delivery of the Homicide Service given their role in the referral process and ongoing liaison with the case worker. It is therefore important they have a comprehensive understanding of delivery processes, as well as the aims of the service, so that they can accurately convey these to service users. A range of techniques were deployed to raise awareness of the service among police pre- and post-implementation, including presentations and email communications by strategic leads and senior police staff respectively. However, accounts suggested varied awareness of the service among FLOs, with some still not having sufficient understanding after having managed a case where the Homicide Service was taken up. In the period following roll out case workers were concerned that bereaved people who could have engaged with the service might not have done so due to an inaccurate portrayal from their FLO.

> '*When you talk to a FLO and you mention what you're doing, and they say to you "Oh, I didn't realise you did that", you think oh no, how many people have we missed because FLOs weren't properly briefed?*' (Case worker)

These issues were reportedly addressed as the service bedded in, with FLOs hearing about the service through word-of-mouth and ongoing awareness-raising events delivered by strategic leads and operational staff. It was ultimately felt that implementation of the Homicide Service had encouraged a positive, collaborative relationship between case workers and FLOs.

Victim Support's core service is also key to the Homicide Service delivery, as it is their local volunteer managers who have responsibility for volunteers trained to undertake Homicide Service work and who liaise with Homicide Service staff[26] about their availability and case allocation. As such, timely and effective communication with Victim Support about the Homicide Service is critical. However, due to the fast roll out of the Homicide Service, communication surrounding implementation was considered insufficient in terms of explaining the aims of the service. This was perceived to have resulted in a lack of engagement from core service staff,[27] which impacted on volunteer managers' communication about volunteer availability and case allocation (discussed further in section 3.3). These issues were reportedly being addressed at the time of the research.

Two further factors were felt to underpin the perceived lack of engagement among volunteers. Firstly, prior to the Homicide Service, Victim Support staff and volunteers provided support to people bereaved by homicide, a role they reportedly enjoyed. Secondly, Victim Support was going through a period of restructure at the time of the research and core staff were at risk of losing their jobs. This had reportedly led to resentment among some Victim Support staff toward the Homicide Service, which had secured a significant amount of government funding and whose staff were not at risk of redundancy. The perceived lack of engagement was felt to have an ongoing impact on service delivery and indicates a need for targeted training and/or communication at the strategic and operational level.

[26] Homicide Service staff refers to team leaders, case workers and support workers unless otherwise specified.
[27] No Victim Support core service staff were interviewed for this evaluation and so these perceptions are those of Homicide Service strategic and delivery staff.

Guidance and support

Guidance and support is fundamental to effective implementation as it helps staff stay on task and seek supervision to ensure high standards of delivery. Support was provided to Homicide Service staff at a national, regional and individual level. National team meetings took place quarterly and were attended by strategic and operational staff across the regions. They provided a welcomed opportunity for support from colleagues and to learn about aspects of the service that staff had yet to experience. This was considered important by case workers in particular, who were mindful that all homicide cases are unique and so unfamiliar issues could arise regardless of their individual experience. Monthly regional team meetings provided similar opportunities for support from colleagues, with an additional focus on referrals and caseload. Homicide Service staff were very much in favour of opportunities for support of this nature, with one team also setting up 'coffee mornings' for this purpose. This was made possible by the team being co-located; members of the other Homicide Service teams were based in Victim Support offices across regions spanning a large area, which was identified as a barrier.

In addition, support was also provided at the individual level. This was important not only to ensure effective service delivery but also to help protect staff against vicarious trauma.[28] It took two forms: monthly line management meetings and supervision provided by an external support service. Supervision delivered by an external agency was compulsory for Homicide Service staff managing a caseload, including support workers where they had begun to take on this responsibility. The sessions allowed staff to discuss feelings about their cases and receive advice about potential coping strategies in confidence and staff welcomed this support. However, while only lasting for an hour each month, fitting this session in alongside a heavy caseload was seen as challenging. This demonstrates the need for managers to ring-fence time for external support to ensure staff remain healthy and so continue to deliver the most effective service.

Due to being line managed outside the Homicide Service, support for volunteers trained to undertake Homicide Service work was generally less formalised, comprehensive and consistent than that provided to the Homicide Service team. It was also expected that volunteers would approach their manager for support as well as other volunteers in internal supervision sessions. Within the Homicide Service, volunteers had debriefs with their case

[28] Vicarious trauma refers to the negative changes that can happen to people who witness other people's suffering.

workers but the nature of these was dependent on the individual concerned, with experiences ranging from a sporadic 'catch up' to scheduled monthly meetings. In addition, external supervision was not available to volunteers. The rationale given at a strategic level was that it was unnecessary, as volunteers' involvement with service users is less frequent and intense than that of a case worker. Whilst this was echoed by some volunteers, others welcomed provision of external supervision due to feelings of vicarious trauma. Some volunteers also suggested that case workers attend their supervision sessions to provide feedback about the Homicide Service. The view was that this would alleviate feelings of being 'out on a limb' with regards to the service (see section 3.3). Both suggestions point to the need for improved support mechanisms for homicide volunteers.

2.3 Training

Comprehensive training is crucial to ensuring the ethical, effective, and consistent delivery of any service (McNaughton Nicholls et al., 2010) and the Homicide Service was no exception.

Content and sequencing

A compulsory training programme was delivered to Homicide Service staff prior to roll out and comprised three modules: Victim Support Core Learning,[29] Bereaved by Homicide (BbH)[30] and a course explaining how to deliver support in line with the service delivery model.[31] The Core Learning and BbH modules predated the Homicide Service, with the BbH module being modified slightly to reflect the new service.

Strategic leads and team leaders explained how homicide volunteers attended a compulsory refresher of the BbH module if they had trained more than a year prior to implementation. While not raised as an issue by the volunteers, Homicide Service staff felt that enforcing this training session had caused resentment among volunteers, given their experience in delivering services to people bereaved by homicide pre-roll out. This resentment was also felt to have resulted from the difficulties engaging Victim Support's core service, as discussed.

[29] Introductory training delivered to all new Victim Support staff and volunteers.
[30] Training originally delivered to volunteers wanting to specialise in supporting people bereaved by homicide.
[31] These modules were supplemented by various needs-specific training, such as child bereavement training.

Homicide Service staff felt the sequencing of the Core Learning and BbH modules was important, with the ideal order being Core Learning followed by BbH. However, some staff had received BbH first and felt they had been 'thrown in at the deep end'.

Evaluation of training provision

The BbH module was generally felt to provide a useful insight into the support needs of those bereaved by homicide as well as the grief and bereavement cycle.[32] However it came under criticism from Homicide Service staff who considered it insufficient in preparing them fully for service delivery. Suggestions for additional areas that the BbH module should cover focused on the practicalities of how to meet the support needs of service users such as:

- How to assess trauma.
- The process of arranging a funeral.
- Dealing with issues relating to probate and intestacy.
- Information on benefit eligibility.
- Clarification on the court process.
- How to bring support to a close (referred to as the 'exit strategy' by delivery staff).

More generally, it was felt that training needed to be tailored according to the role. For example, support workers would have welcomed more extensive training on relevant administrative tasks such as the process of applying for Criminal Injuries Compensation (CIC) as liaising with the Criminal Injuries Compensation Authority (CICA) was a key to their role.[33]

[32] It is commonly accepted that grief involves a five-stage cycle of denial, anger, bargaining, depression and finally acceptance. This cycle is often referred to as the Kübler-Ross cycle, after the doctor who developed it.

[33] The CICA are a government organisation that can pay compensation to people who have been physically or mentally injured or bereaved as a result of a violent crime. It offers a free service, processing applications and making awards ranging from £1,000 to £500,000. More information is available here: http://www.justice.gov.uk/guidance/compensation-schemes/cica/

As with the BbH module for Homicide Service staff, Homicide Service staff felt the training for volunteers needed further updating in line with the new service. To address this, Homicide Service staff in one of the regions had produced a pack for volunteers containing up-to-date information about the service. At the time of the interviews, strategic leads were reviewing the pack for nationwide roll out. Notwithstanding suggestions for improvements to volunteer training made by Homicide Service staff, it is worth acknowledging that the volunteers interviewed were satisfied with the training received and felt sufficiently prepared for service delivery.

3. Delivering the Homicide Service

This chapter explores the referral process, the delivery of the Homicide Service and factors affecting delivery.

3.1 The referral process

Analysis of the performance management data showed that from March 2010 to May 2011 a total of 757 homicide notifications were received by the Homicide Service from the police. The Homicide Service is set up so that the police should notify the service of **all** homicides in England and Wales. However, it is unclear whether this was the case during the research period as it was not possible to compare the police-recorded homicide statistics and the Homicide Service data due to differences in definitions and time periods in the two sets of figures; for example, the Homicide Service data included culpable road deaths, corporate manslaughter cases and suspicious deaths later found by the police to not be homicides. In addition, there were early recording problems with the Homicide Service data which meant that it included some multiple records of the same homicide.

Over this period, the FCO also notified the Homicide Service of 26 cases of homicide abroad. In addition, 74 bereaved people had referred themselves; such individuals may have been an extended relative or friend of a family already receiving support. It is not possible to calculate a total number of notifications due to the different notification processes.[34] Overall a total of 663 homicide cases were referred to the Homicide Service over this period.[35] For each homicide case that was referred the number of bereaved people involved varied. In total 1,287 bereaved people were referred, and on average two per homicide case.[36]

The interviews with staff supported these findings, with the majority of referrals felt to come via the police. The process was generally described as operating in line with the service delivery model, discussed below.

- **Homicide Service notification**: The FLO/SIO notified the Homicide Service of a new homicide case within 24 hours of the start of the investigation, via secure email. The support worker also checked national and local news coverage, with

[34] Police and FCO notifications indicate that a homicide has occurred. These homicides could involve a number of bereaved individuals, but this is not specified at the time of the notification, whereas self-referrals are of a bereaved individual or families and do not indicate whether multiple notifications relate to the same homicide.

[35] See Table B1 in Appendix B. A notification of a homicide does not always lead to the case being referred to the Homicide Service.

[36] See Table B2 in Appendix B.

the team leader contacting the SIO if they came across a case they had not been alerted to.

- **Case worker and FLO liaison**: The Homicide Service team leader contacted the SIO to give them the name of the allocated case worker, with the case worker then contacting the FLO within 24 hours of notification to discuss the case and describe what support the Homicide Service could offer. Case workers considered this stage in the process important, as they hoped their explanation would encourage FLOs to 'sell' the benefits of the service to the family. There seemed to be differences in practice developing across the regions, with one Homicide Service team describing how the case worker would contact the FLO directly without involvement from the team leader due to the positive relationship established, demonstrating how effective partnerships can facilitate efficient delivery.
- **Service user consent**: The FLO then introduced the Homicide Service to the bereaved family. If they consented to a case worker being deployed the FLO informed the case worker, who made contact with the family within 24 hours of receiving the referral to suggest a meeting. The description given of this stage by delivery staff deviates from that outlined in the service delivery model, with the case referral meeting between the case worker and FLO taking place over a series of telephone calls rather than face-to-face. Whilst it is not clear what impact this had on service delivery, this set-up could arguably enhance efficiency as it does not rely on the FLO and case worker finding a suitable time to attend a face-to-face meeting.

At any of these stages, the police could decide not to refer to a case worker. Analysis of the performance management data showed that 83 homicides were not referred by the police to the Homicide Service between March 2010 and May 2011. The reasons for this varied. In the majority of cases it was because the family declined the service (47 cases). Other possible reasons were that the next of kin could not be identified or the SIO determined that there should not be any engagement with the Homicide Service, for example because the bereaved person was also being considered as a suspect in the homicide enquiry.[37]

[37] See Table B3 in Appendix B.

Accounts given by the police also suggest some underlying resistance to the Homicide Service among FLOs more widely, with concerns being voiced about the disruptive impact early involvement of the Homicide Service might have on the investigation.

> '*It's a recipe for disaster [to involve the Homicide Service early] because the family lose focus. I want the focus to be on the investigation, because we're the important ones here … and it's so important for the family … to help with the investigation. The minute you put another person into that equation, you lose focus.*' (FLO)

Strategic leads felt that this barrier had been overcome (as discussed in section 2.2), but that this view prevailed suggests more work needs to be done around communication and engagement with police at an operational level.

Service user motivations and expectations

Understanding the reasons why service users chose to access the Homicide Service is important as it provides key information on how to introduce the service and encourage take up. However, there were differences in the degree of clarity service users had about their experiences of the Homicide Service, particularly of the referral as this had taken place near to the time they were informed about the death, where they described themselves as 'all over the place' cognitively and emotionally. Therefore while some service users were able to talk in detail about their experiences, others had a less comprehensive recall. Where service users were able to articulate them, reasons for taking up the Homicide Service were three-fold:

- **To meet their needs**: Explanations of what the Homicide Service could offer facilitated take up due to service users' perception that it could meet their needs and ultimately help them in the aftermath of the death. Service users either had a specific need in mind, such as help with arranging the funeral or translation requirements where the case worker spoke the service user's first language, or a more general sense that they needed some sort of support at a time of confusion and upheaval.

  > '*I think you're always dubious when you meet someone as to what you're going to get out of it [and] whether it's going to be beneficial. But with the case worker she said what we wanted to hear and we found her useful.*' (Service user)

- **Encouragement from others**: Encouragement from family members was an important factor underpinning take up when the service user was initially hesitant or reluctant. These service users were not able to articulate the reasons behind their

uncertainty, other than a vague sense of not knowing whether the service was for them. Family members either recommended take up after having been referred to the service themselves, or felt that it would be beneficial to receive support of this nature.

- **'Going along with it'**: Not all service users made a considered or deliberate decision to take up the Homicide Service, with some describing how there was an almost unconscious or unwitting agreement to the support offered.

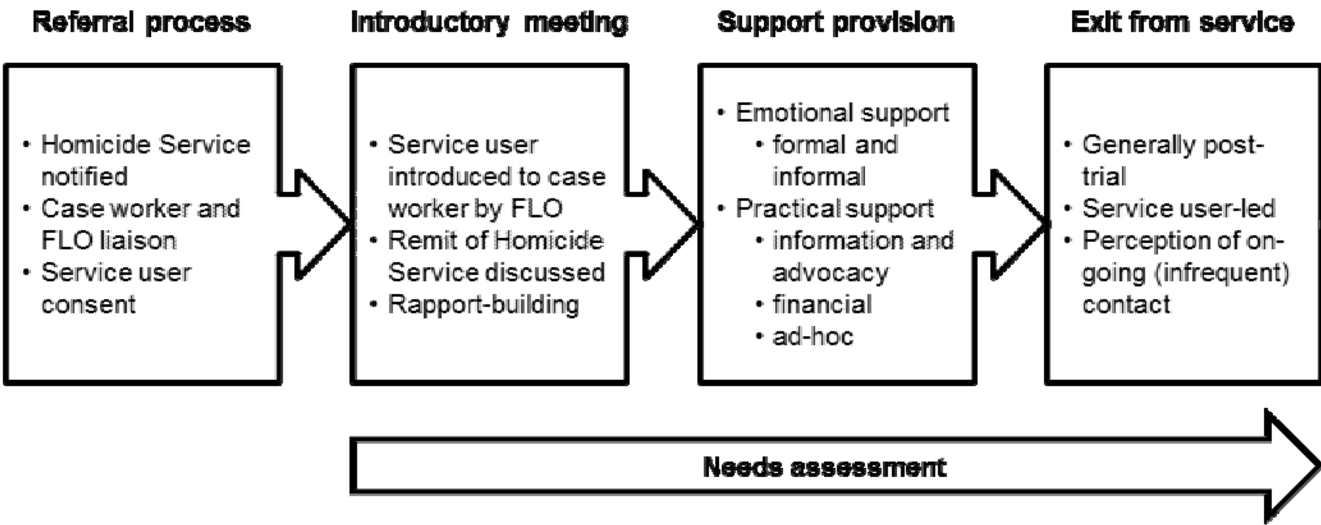
  '*I think the grief forces you into it. You find yourself like a stick on the river and you really do go along with a lot of it because you haven't got that control.*' (Service user)

Individuals from families who declined the service were not interviewed as part of the evaluation; a number of bereaved people who had not engaged with the service were approached, but did not consent to take part in the research. FLOs and case workers suggested two reasons why people might have declined support from the service. The first was that they felt they did not need additional support as they already had a strong network of family and friends providing this. The second was that some people did not want a witness to ongoing conflict or tensions within their family and preferred to keep this private. Where service users decline the Homicide Service the service delivery model prescribes ongoing contact between the case worker and FLO to review consent, and raise this with the bereaved person as and when appropriate. Whilst this occurred in some cases, some case workers and FLOs felt that not enough was being done to systematically review consent, with some bereaved people not necessarily getting another opportunity to take up the service.

3.2 Delivering the service

This section explores delivery of the Homicide Service after the service user has consented to the referral. Broadly speaking, delivery comprised four phases: the service user's first face-to-face meeting with the case worker, the provision of support and exit from the service, all underpinned by ongoing needs assessments.

Figure 3.1 Delivery of the Homicide Service



Introductory meeting with the case worker

In the final stage of the referral process outlined in section 3.1, the FLO informs the case worker if the service user consents to the referral, with the case worker making contact with the service user within 24 hours to suggest a face-to-face meeting. This meeting tended to take place at the service user's home, and delivery staff explained how the FLO would try to accompany the case worker to provide a level of continuity for the service user.

At the meeting, case workers described how they introduced the Homicide Service in terms of the support it could provide. Service users echoed this, recalling how they were told that the case worker would be able to help them claim specific benefits and provide information about the progress of the investigation and what to expect at the trial. However, as discussed in section 3.1, some service users had a less comprehensive recall of the initial stages of service delivery and were not able to describe what had been discussed beyond the case worker telling them they would be able to 'help'. Some case workers acknowledged that it was not always appropriate to discuss the aims and remit of the service at length at this stage, and that the nature and extent of information offered depended on how receptive the service user appeared to be. Some service users described how their case worker had given them information leaflets at the introductory meeting, so that they could reflect on what support was available to them in their own time. Importantly, service users described this first meeting as lasting an appropriate length of time and how they did not feel 'rushed' by the case worker at any point. Case workers described carrying out the initial needs assessment at this meeting. This and ongoing needs assessment are discussed in the next section.

Assessing service user need

Needs assessments are a crucial aspect of service delivery allowing case workers to understand how they can most effectively support a service user. The service delivery model explains how the aim of the first needs assessment is to identify urgent and immediate needs only, with other needs being identified throughout the ongoing support provided, and this was echoed by case workers.

In terms of the first needs assessment, case workers described finding out about the service user's current circumstances to ascertain what support they needed. From this point delivery staff described case workers broadly adopting one of two approaches. The first involved asking service users what support they needed. However, service users did not advocate this approach, describing how, in the midst of their grief, they often did not know what support they needed or indeed what was available to them. The second involved the more directive approach of highlighting the support available that met their requirements and proactively helping them decide what to take up. This is the approach promoted by the service delivery model and previous research (Paterson et al., 2006) and, importantly, was service users' preferred approach.

> '*I would rather [the caseworker] sat me down and said "my name is (x) and I can help you with this and this and this…" But they didn't really.*' (Service user)

After the first meeting, needs assessments took place on an ongoing, informal basis during face-to-face meetings, with the details documented on a needs assessment form and transferred to the CMS after the visit. Case workers were reportedly told in their training that a new needs assessment form should be completed after each meeting, but some felt this was too time-consuming so would add new information to the original form. It is not clear what implications this had for service delivery, if any.

The performance management data showed that a total of 8,664 needs assessments were carried out over the first 14 months of the service (on average seven needs assessments per person supported). Of these, 5,883 needs assessments (68%) were 'positive' i.e. they identified that there was a need for some form of support at the time of the assessment, such as emotional support or information provision.[38, 39]

Table 3.1 Needs assessments (March 2010 to May 2011)

	Total
Number of needs assessments carried out	**8,664**
Number of positive needs assessments[40]	**5,883**
Average number of needs assessments per person supported	**7**
Average number of needs assessments per homicide referred	**13**
Average number of needs assessments per caseworker	**347**

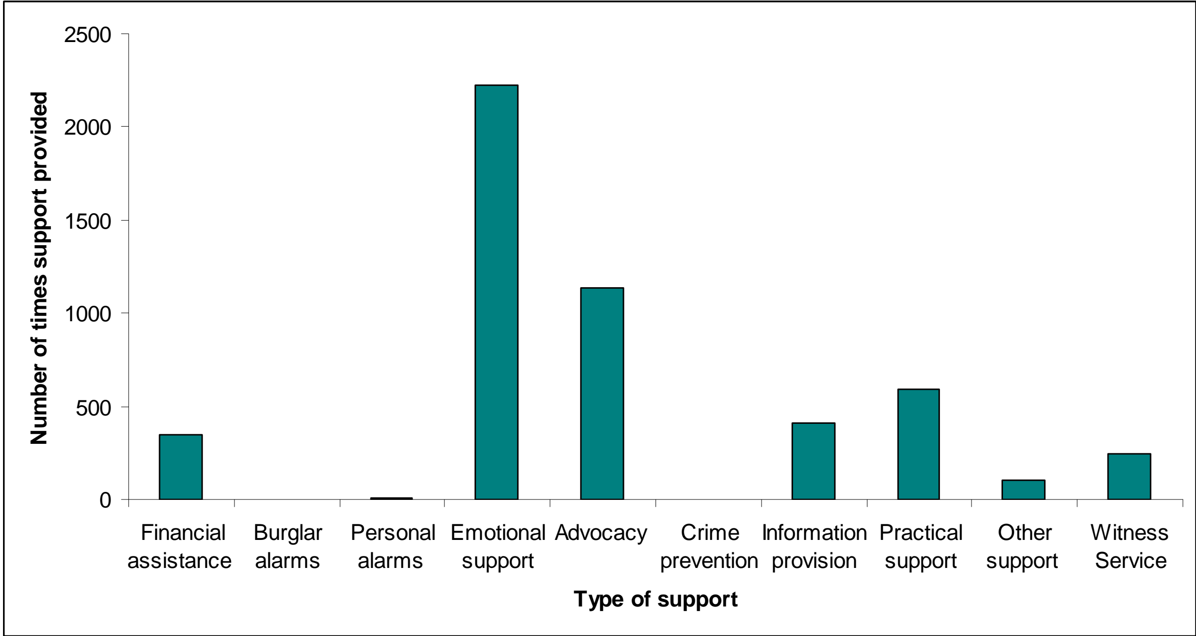
Information was not available on the number of needs identified at each assessment, therefore it was not possible to assess whether the needs of a service user were declining over time.

Support provision

The support provided to service users broadly comprised emotional support (both professional and informal), practical support, information and advocacy provision, financial assistance, and response to more ad hoc needs. Support was either delivered directly by the case worker or via another agency that the case worker accessed on the service user's behalf or signposted them to. The performance management data shows that between March 2010 and May 2011 emotional support[41] (provided 2,223 times) and advocacy (provided 1,139 times) were the types of support most often provided by the Homicide Service (see Figure 3.2).

[38] See Table B4 in Appendix B.
[39] Needs assessments took place on an ongoing basis and where a needs assessment did not identify a need for support (32% of all needs assessments carried out) this did not necessarily mean that the service user no longer required support from the Homicide Service. They may have been receiving longer-term support that was identified in an earlier 'positive' needs assessment or developed needs that were picked up in a later 'positive' needs assessment.
[40] A needs assessment was defined as 'positive' if a need for some form of support was identified.
[41] The data on the provision of emotional support should be treated with caution as there was over-recording for this type of support early on in the evaluation period. A number of case workers were recording a separate instance of emotional support every time that they provided this to a service user, even if the instances were linked (i.e. discussing the same concerns and/or needs).

Figure 3.2 Non-commissioned support provision (March 2010 to May 2011)

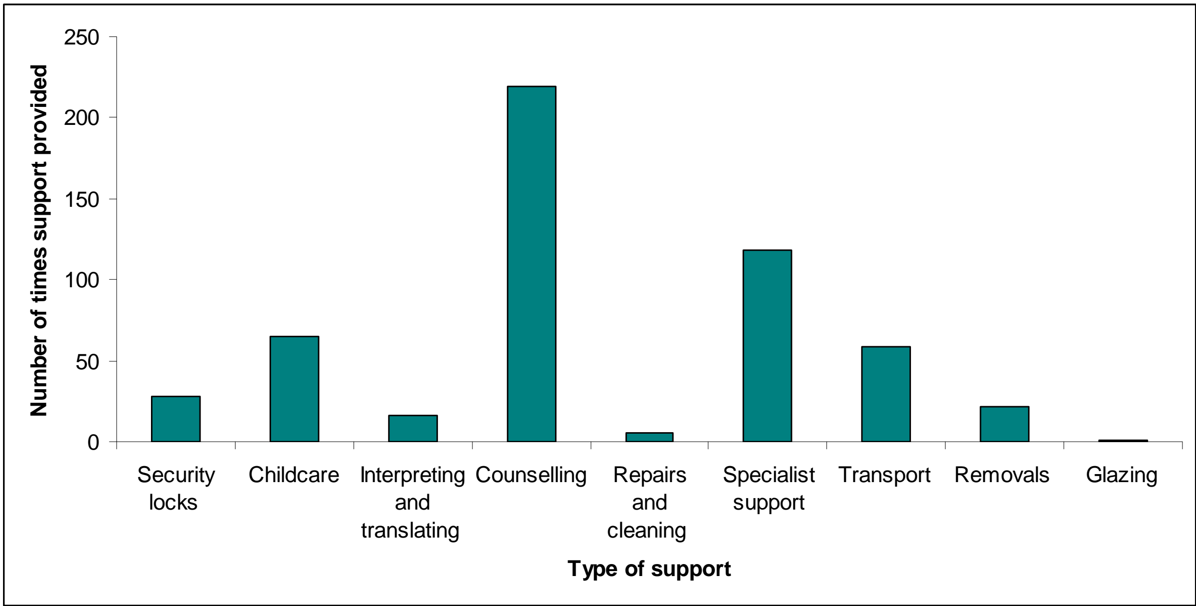


On average over the period, five instances of support were provided per person supported and nine instances per homicide case were provided.[42] Information was not available on what support was provided at different stages, for example at the first and subsequent needs assessments or during the trial. Therefore it is not possible to examine through the performance management data whether service users received different types of support at different stages in their contact with the service.

Figure 3.3 provides data on the number of times commissioned services (services delivered by another agency) were provided during the first 14 months of the service. Counselling (provided 219 times) and specialist support[43] (provided 118 times) were the services commissioned most often by the Homicide Service. The average number of times that commissioned services were provided per person was less than 0.5; however, on average one commissioned service was provided per homicide case.[44]

[42] See Table B5 in Appendix B.
[43] Specialist support refers to any other form of support provided by an external agency that does not fit into the other categories, for example peer support groups or respite weekends.
[44] See Table B6 in Appendix B.

Figure 3.3 Commissioned support provision (March 2010 to May 2011)



Exiting the service

It is intended that case workers provide support for as long as the service user needs it and when the service was developed it was estimated that bereaved people would need support for approximately 18 months. The service delivery model does not indicate how and when case workers should bring their contact with a service user to a close. This is due to the service being user-led, with the exit strategy determined on an individual basis. However, case workers expressed uncertainty and confusion in relation to the exit strategy, both in terms of the timing and approach they should adopt. This seemed to be underpinned by few service users having exited the service at the time of the interviews, meaning that case workers had largely not yet gained experience of this process.

The performance management data showed that by May 2011, 214 homicide cases had been closed in total; around a third of cases that had been referred to the service. On average nine cases per case worker had been closed although this ranged from zero to 24 cases per case worker.[45] It is not known how long these cases had received support as this information could not be readily extracted from the CMS.

[45] See Table B7 in Appendix B.

Delivery staff felt that case workers should provide support for as long as the service user needed it and that it was imperative that exit was user-led. Whilst it was acknowledged that service user needs were unique, envisaged points of exit included:

- A couple of months after the trial (as the trial tended to lead to an intensive period of support).[46]
- After the first anniversary of the death.
- The point at which the service user had no further practical support needs.
- When it was clear that the service user had other support networks in place, such as family members. However, service users felt that this should not be a reason in itself to bring support to a close as they did not always want to involve family or friends in providing support (see section 4.1 for further discussion).

Whilst it was undisputed that exit should be user-led, there was concern that service users had sometimes become overly reliant on their case worker, with some case workers inadvertently facilitating this, and that this was a barrier to exiting the service. This was echoed by some service users who described how their case worker had told them they would 'always be there' if the service user needed them and that while contact would become more infrequent, their support was ultimately never-ending. This was very much welcomed by service users who wanted to know they had someone to rely on if the need arose.

> '*[The case worker] said "It doesn't stop, once this trial is over. It's an ongoing thing". Oh God, I was relieved, you know … I thought, what happens if I need [the case worker] and they're not there?*' (Service user)

There were mixed expectations in relation to how this more infrequent support would be provided in the long-term, with service users and case workers either of the view that this should be service user-led, or that case workers should instigate this with the occasional phone call or text message to 'check in' with the service user. However, this would have implications for caseload and might prove unsustainable in the long-term.

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[46] The performance management data showed that 108 cases had reached the trial stage by May 2011.

Homicide Service staff acknowledged that service user expectations about the nature and duration of support might have been raised in the phase immediately after roll out. At this early stage caseloads had been small which meant that case workers were able to provide intensive support. Staff had learnt from this experience, with strategic leads and team leaders particularly keen to stress that case workers needed to broach exit from the service in advance of the actual exit point to manage expectations and to avoid dependency.

It was also recognised that service users may not always feel able to tell case workers when they no longer want support for fear of offending them, and that part of the case workers' role should be to facilitate this conversation, or better still, empower the service user to raise this themselves. Where service users did feel able to raise this with case workers, the reason given was that they were in a 'better place' and wanted day-to-day life to go 'back to normal', without the reminder of the death that the case worker was sometimes felt to be. There was also an understanding among service users that people more recently bereaved by homicide had a greater need for the service and that they should be given priority.

The uncertainty and confusion expressed in relation to the exit strategy makes it clear that there is a training need among case workers. This should focus on the timing, the approach to adopt, as well as strategies to prevent service user dependency. Team leaders and case workers also identified the possibility of case worker and service user co-dependency which would also need addressing. Ensuring timely and appropriate exits might go some way to relieving the pressure case workers feel in relation to their increasing caseloads. This is discussed further in section 4.3.

3.3 Factors affecting delivery of the service

While the picture of service delivery is generally a positive one, there are factors affecting delivery that need to be considered in order to enhance and improve service delivery going forward. These include: resources and infrastructure, continuity of support, communication between delivery partners, and case worker attributes.

Resources and infrastructure

Staffing levels

As discussed in section 2.1, Homicide Service staffing was based on estimates of a manageable caseload of 30 homicides per year. However, the performance management data indicated that although the average case worker caseload was 26 homicides over the 14 month period, this ranged from 4 to 49 homicides per case worker.[47] As discussed in section 3.1 more than one person tended to be referred per homicide case, so although the average caseload was 26 homicides, the average number of people supported per case worker was 51 (this ranged from 12 to 84 people per case worker).

The qualitative interviews revealed that Homicide Service staff considered the initial estimate of 30 homicides to be unrealistic, with case workers reportedly carrying caseloads of between 30 and 80 at any given time and frequently working outside their contracted hours. It was suggested that some case workers were working in excess of 60 hours a week without being paid overtime or taking time off in lieu. Strategic staff and some team leaders felt that such caseloads were inadvertently exacerbated by the dedication of individual case workers and the high, perhaps unrealistic, expectations they have for the service they want to provide. Regardless, there was a concern among strategic and Homicide Service staff about a decline in the quality of service delivered due to heavy caseloads. This decline had been noted by some service users, who were aware that it was a result of staff being overstretched.

> '*The few times that they didn't get back to me, I felt that I really needed that support but I didn't feel they could give it to me. Then later on it transpired that they (case workers) are finding it really hard to juggle everything behind the scenes … they've told me that much.*' (Service user)

The analysis of the performance management data provided an indication of the typical workload of a case worker.[48] Between March 2010 and May 2011, on average a case worker had carried out 152 visits to service users (a total of 3,797 across the Homicide Service), made 335 telephone calls to service users (a total of 8,380) and 170 telephone calls on behalf of service users (a total of 4,243).

[47] See Table B8 in Appendix B.
[48] See Table B9 in Appendix B.

Support workers had begun to take on a caseload in some regions, particularly where case workers had been signed off on long-term sick leave or left the service completely. In such instances support workers had helped to provide cover. Responsibility for cases is not part of the support worker remit according to the service delivery model, and so highlights the need for additional case worker resource. These issues are discussed further in section 4.3.

The issues surrounding case worker caseload and workload more generally point to the need for more effective utilisation of homicide volunteers. However, whilst case workers can request that a volunteer works alongside them to support the service user, Homicide Service staff and volunteers identified barriers to realising this and, as such, there had been a lower utilisation of volunteers than had been envisaged pre-implementation.[49] Case workers were reluctant to use volunteers due to them only being available on a part-time basis. This was felt to make them unresponsive to the needs of service users, who often required quick responses to actions and needed their contact to be readily available if an issue arose or they needed a 'sounding board'. Contact with other services would often require regular and timely follow-up too, and this was felt to sit awkwardly with volunteer availability. As such, case workers would reportedly often decide to support service users alone. If a need then arose where a volunteer could be effectively utilised, for example provision of informal emotional support, it was felt that the service user would not be receptive to receiving support from someone new, having already established a relationship with the case worker.

Homicide Service staff and volunteers agreed that barriers to utilising volunteers needed to be addressed going forward, both in order to alleviate case worker caseload and to engage volunteers in Homicide Service delivery. Before this became possible, however, clarification as to the role and remit of homicide volunteers was felt to be crucial, as there was confusion among Homicide Service staff and volunteers about whether volunteers should provide emotional or practical support.

[49] This was reflected in the sample of service users, with only one describing having contact with a homicide volunteer. The performance management data echoed this, and showed that across the Homicide Service as a whole there had been 437 volunteer visits in comparison to 3,797 case worker visits between March 2010 and May 2011. However, there were issues around incorrect recording of volunteer activity and so the number of volunteer visits recorded is likely to be higher than this, although still lower than the number of case worker visits.

Location

Case workers described how the majority of appointments took place at service users' homes, unless a risk assessment suggested this was unsuitable, in which case the service user would visit a local Victim Support office. The size of the Homicide Service regions ranged from 609 to 19,253 square miles which meant case workers often had to travel long distances to and from service user appointments. This was felt to exacerbate the problem of heavy caseloads described above, with time spent travelling perceived by case workers as time 'wasted' when they could be doing something constructive to support a service user. One case worker recalled a day where six hours were spent driving and just one hour in direct contact with a service user. Time spent travelling also had implications for the quality of service delivered, with case workers and service users describing how appointments occasionally had to be cut short or cancelled entirely due to travel problems.

Information-sharing systems

The pressure felt by case workers in relation to their heavy caseloads was thought to be further exacerbated by inadequate technology, specifically, insufficient access to the CMS. Case workers were required to update the CMS within 24 hours of meeting with their service user and due to data security this had to be done at a Victim Support office. Travelling to the nearest Victim Support office used up time that could have been spent supporting service users. Time spent travelling, alongside prioritising appointments with service users, meant that the information entered into the CMS was reportedly less accurate and complete than it could have been, which has implications for the monitoring of individual cases as well as the service at a more strategic level. Case workers were strongly of the view that secure, remote access to the CMS was crucial to ensuring effective service delivery and suggested that access be permitted through the laptops they had already been issued with.

Continuity of support

The case worker as a single point of contact is a key strength of Homicide Service provision, and welcomed by both delivery staff and service users. However, challenges were identified in relation to the continuity of support provided to service users during the trial, with case workers, FLOs and the Witness Service[50] all providing support to varying extents.

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[50] Victim Support's Witness Service provides emotional and practical support before, during and after trial for people who have been a victim of or witnessed a crime.

Case workers described how they generally did not have the capacity to provide support for the duration of the trial, but would try to attend on the first day and for the day of the verdict as a minimum. The service users interviewed understood the restrictions on case workers' availability but appreciated them being there at these pivotal times. However, delivery staff expressed concern that case workers were not present for the duration and felt that some service users had been disappointed about this. To this end, it was considered vital that service user expectations about case worker attendance were effectively managed from the outset, and that the case worker introduced them to their Witness Service representative to facilitate continuity of care. In addition, where the FLO attended the trial they would feed back what had taken place to the case worker so that they could provide support over the phone or by text message if need be. It was important for the case worker to be kept informed so that the service user did not have to 're-live' distressing aspects of the trial by recounting them to the case worker.

Communication between delivery partners

As discussed in section 2.2, effective communication between delivery partners was critical to successful service delivery, particularly between the Homicide Service, the police and Victim Support's core service. Given the issues surrounding the use of volunteers discussed above, communication between Homicide Service delivery staff and homicide volunteers is also crucial, as some volunteers felt disengaged in relation to their role within the service. Whilst this could be explained by the perceived lack of engagement from the core service more generally (discussed in section 2.2), it was also felt to be underpinned by a shift in the volunteer remit post-implementation, from case managers to a more supporting role. This had left some volunteers feeling uninformed about their cases, and frustrated as a result.

> '*The main frustration is a lack of knowledge; I feel that if I did ask I'd be told to mind my own business. When I've asked questions about the lady I'm working with I was told "Yeah, that's being dealt with". But if that had been happening in (the Victim Support core service) I would have known … who was dealing with it (and) what they were doing, and perhaps that would have helped me feel that things were under control.*' (Volunteer)

Challenges were also identified in relation to communication between the Homicide Service and the Witness Service. Case workers were of the view that the Witness Service felt their role was under threat where a case worker attended the trial with the service user.[51] This view appeared to be exacerbated by the restructure Victim Support was experiencing at the time of the research, with core staff at risk of losing their jobs. To this end, case workers described how they had been careful not to 'take over' from the Witness Service, acknowledging that resource issues meant this would be logistically impossible anyway.

The views outlined above indicate the need for training and/or communication at the operational and individual level, if volunteers and the Witness Service are to feel fully engaged with Homicide Service delivery.

Case worker attributes

The attributes of case workers had an impact on service users' perceptions of Homicide Service delivery, and given the importance of meeting service users' needs it is important these are explored further. Service users identified four overarching qualities that they valued in their case worker:

- **Availability**: Service users appreciated case workers being readily available and generally felt that case workers were very quick to respond to contact from them. Considerable importance was placed on this.[52] Service users felt unsupported and less inclined to ask for help where case workers did not respond to contact from them or missed appointments.
- **Reliability**: Service users also highlighted the importance of case workers being reliable. Feeling confident that case workers would do what they said they would had alleviated stress and anxiety (discussed further in Chapter 4), and enhanced service users' perception that the case worker was honest and someone that they could trust. A trusting relationship underpinned provision of emotional support.

  '*When [the case worker] said to me "You will get through it; it will get easier", somehow I believed them. I trusted them and I believed them.*' (Service user)

[51] No Witness Service representatives were interviewed for this evaluation and so these perceptions are those of Homicide Service strategic and delivery staff.

[52] Existing research highlights the need for timely information among people bereaved by homicide (Rock, 1998).

- **Objectivity**: Service users valued receiving support from someone outside of the family, with this perceived ‘distance’ enabling service users to disclose circumstances and feelings. However, perceptions of objectivity were minimised where the case worker was supporting a number of the victim’s relatives. In such instances some service users described how they would have preferred a different case worker, as they were concerned about confidentiality and what their relative might discuss with the case worker, particularly where there was conflict or tensions within the family. This had implications for how able service users felt to talk openly to their case worker and therefore the extent to which their needs could be met.
- **Case worker circumstances**: Some service users expressed a preference for case workers with whom they shared similar background and experiences, such as having children, speaking the same first language or being the same age. Where this had not been the case, service users were disappointed and suggested that this had impacted on the ease with which they could confide in the case worker. One service user described how she would have preferred a case worker who had experienced bereavement by homicide themselves. This suggests the need for contact with peer support groups, which this service user did not have at the time of the research.

4. Effects of the Homicide Service

This chapter explores the effect of Homicide Service provision on service users, strategic and operational outcomes, and staff. As the research took place shortly after implementation, while the service was still developing, it is unlikely that all possible impacts had been fully realised at this stage.

4.1 Effect on service users

Service users experienced a range of effects as a result of the Homicide Service. Primary effects relate to the direct result of taking up the Homicide Service, so the receipt of emotional and practical support. Secondary effects relate to the impact these have on other aspects of service users' lives, namely improved emotional and psychological wellbeing. A map of these effects is provided in Figure 4.1 and discussed further in the following sections. Although separated here, the outcomes for service users were complex and overlapped various aspects of their lives. The effects outlined are based on the views of 18 service users.

The difficulty assessing service user effect

There are two challenges in exploring the impact on service users: the positive nature of service user accounts, and the clarity of recall.

The positive nature of service user accounts

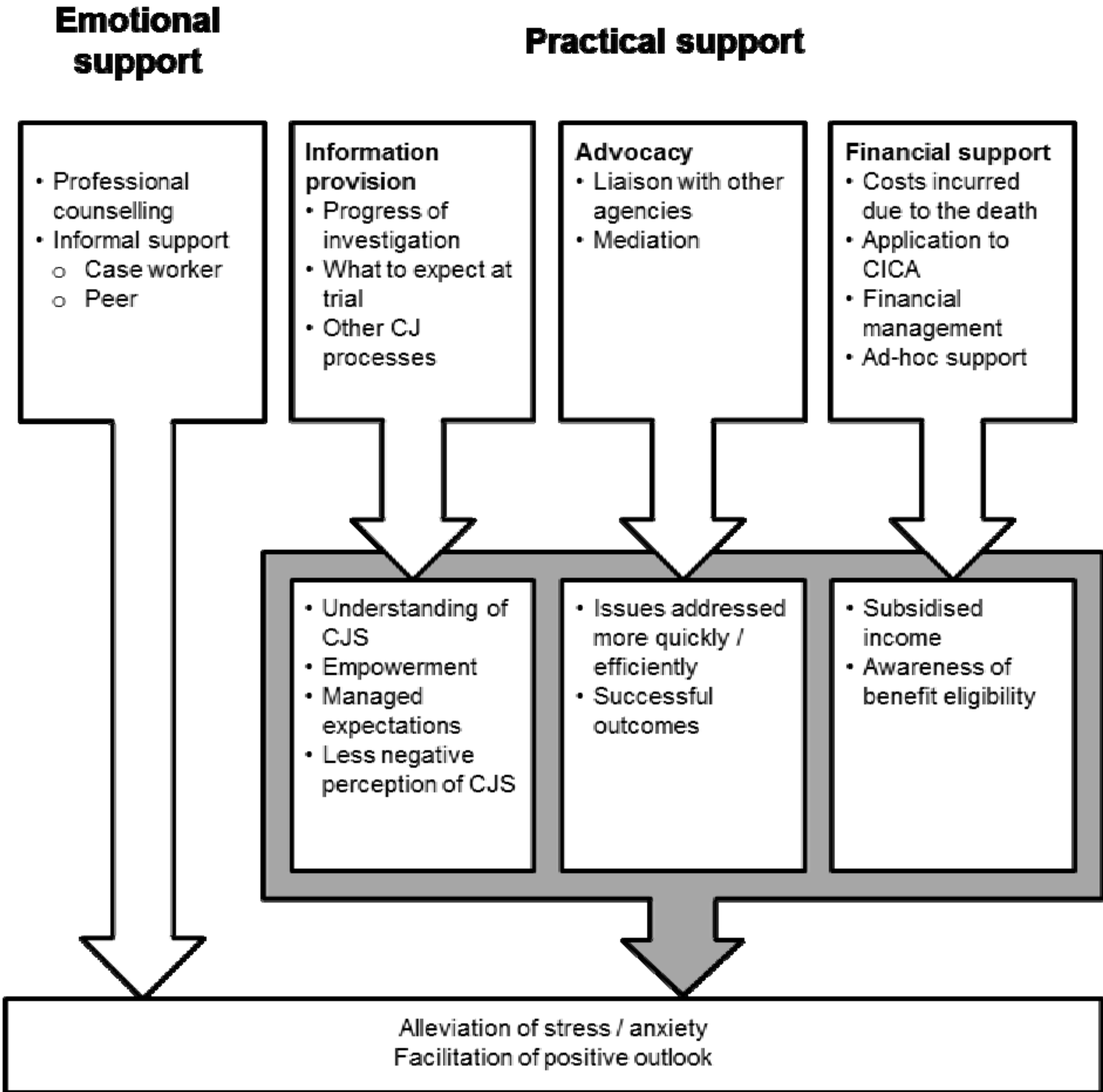
The outcomes described by service users interviewed were almost wholly positive. While it is important not to detract from the clear impact of the Homicide Service on service users, there are two possible explanations for the overwhelmingly positive views of those interviewed. The first involves the sampling approach, with team leaders and case workers responsible for approaching service users for interview. As a result, there was potential for staff to 'cherry pick' service users with more positive experiences. The second explanation relates to perceptions of the CJS and support services more widely. Public perception of the CJS is generally negative in terms of public confidence (Roberts and Hough, 2005), a view expressed strongly by service users here. It is therefore possible that positive outcomes from a service perceived to be related to the CJS were amplified due to low expectations. Research also suggests that support received from third sector organisations might be perceived as a charitable act rather than a service that users have a right to make demands of (Tennant et al., 2007). Therefore it is possible that service users did not feel in a position

to criticise and were grateful for any support received, given the traumatic and unfamiliar situation they faced.

The clarity of recall

As already discussed, there were differences in the degree of clarity service users had about their experiences of the service and the outcomes achieved. Therefore the picture of impact might be somewhat incomplete.

Figure 4.1 Effects of the Homicide Service on service users



Provision of emotional support

Paterson et al. (2006) describe how grief after a homicide is usually intense and long-lasting, and that bereaved people will often feel the need for independent emotional support at some point. The emotional support provided by the Homicide Service either took the form of professional counselling services by external agencies, or was more informal and provided by case workers and volunteers.

If the case worker felt it would benefit the service user and if they consented, the case worker would refer them to a professional counsellor. Some service users, who had been bereaved by the death of their child (young and adult), described how their case worker had referred them to a counsellor specialising in traumatic bereavement. In instances where the service user's partner had been murdered, the victims' children had been referred. Trauma counselling had been taken up to varying extents, with some still receiving counselling at the time of the interview and others having decided after a couple of sessions that they did not want to continue. One service user described how she did not want her son to see the counsellor that the case worker referred him to and instead found him an alternative one. This was due to concerns that what he disclosed to the counsellor would inform the police investigation and be fed back to the perpetrator. The service user said she had got this impression from her case worker, which suggests the need for further training for case workers about how to accurately convey information about confidentially surrounding the support provided to service users.

Service users also highlighted how provision of emotional support on an informal, ongoing basis was an extremely important outcome of contact with the Homicide Service. Case workers were a 'sounding board' if the service user was angry or upset in relation to a particular incident, such as the perpetrator appealing their conviction or sentence, or if the service user wanted to talk more generally about how they were feeling on a particular day.

> '*[My case worker is] fabulous; full of encouragement, full of support. If I'm feeling angry or bitter, then I always phone [them] and have a moan.*' (Service user)

As discussed in section 3.3, service users spoke appreciatively about the value of having someone to talk to and that this was available 'around the clock'. This was equally true of service users with strong support networks in place. Service users explained how they did not always want to talk to family or friends about how they were feeling in case they upset them, or because they just 'didn't feel like it'. It was clear that the case workers' perceived impartiality was a key factor underpinning the effectiveness of emotional support.

Case workers had also referred service users to peer support groups, such as Support After Murder and Manslaughter (SAMM), in order for them to talk to others bereaved by homicide. While service users welcomed the suggestion and acknowledged the value of such support, this had not been taken up at the time of the interviews, with one service user describing that their loss was still 'too raw' for them to be able to speak to others who had experienced what they had.

Whilst provision of emotional support was an important outcome of contact with the Homicide Service for some service users, others did not take up this support. These service users described feeling uncomfortable talking about their feelings. There was no evidence from these interviews to suggest this was due to particular service user characteristics such as their relationship to the victim, or gender, as previously suggested by the literature (Kenney, 2003).

> '*I would imagine [the case worker] probably said it [counselling] was available but I would run a million miles from that suggestion… and I never, ever felt that I needed [the case worker] to lean on, I just was grateful for what they told me and then I got on with it.*' (Service user)

Provision of practical support

Paterson et al. (2006) describe how, in addition to coping with the emotional strain of traumatic grief, those bereaved by homicide are faced with an array of practical issues and processes that need to be dealt with. Case workers described how the provision of practical support at this time allows the service user space to grieve, without having to worry about these other issues 'on the periphery'.

> '*We were left to our grieving whilst [the case worker] did everything else including dealing with the Criminal Injuries Compensation, supplying a hotel for the duration of the trial – as we do not live close and to save us from the trauma of travelling every day – and liaising with the court officials. We cannot praise [the case worker] enough.*' (Service user)

Practical support centred on meeting information and advocacy needs, provision of financial support, as well as meeting other, more ad-hoc practical needs. Each of these is discussed below.

Information and advocacy needs

Research on bereavement by homicide highlights the bereaved person's need for timely, accurate and impartial information and the upset and frustration that arises when this information is not forthcoming (Rock, 1998). Service users echoed this, particularly in relation to the need for information about the progress of the investigation, what to expect at the trial and other criminal justice processes.[53] Case workers provided this, often without having to be prompted. Service users placed great value on receiving information of this nature, and identified four outcomes arising from its provision:

- An enhanced understanding of criminal justice processes.
- A feeling of empowerment to make decisions about their own involvement in these processes. For example, one service user described how the case worker would explain what to expect from various court hearings, which helped the service user decide whether or not to attend.
- Managed expectations in relation to criminal justice processes and outcomes, for example who might attend the trial and the likely sentence that the perpetrator would receive.
- A less negative impression of the CJS, where case workers were able to provide acceptable explanations for criminal justice processes that had angered some service users. For example, one service user described being very upset on being informed by her FLO that the victim's funeral had to be delayed because further forensic tests were required. Whilst still frustrated, the service user felt less anger towards her FLO after the case worker explained the reasons behind this decision. This finding supports other research suggesting that contact with Victim Support may enhance victims' sense that the CJS is procedurally fair (Bradford, 2011).

Research also suggests that people bereaved by homicide often need someone to advocate on their behalf (Paterson et al., 2006). Service users interviewed for this study were no exception and described how case workers communicated with an array of services and organisations on their behalf including local councils regarding housing issues, funeral directors, employers in relation to time off work, and utility providers regarding the

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[53] Paterson et al.'s (2006) research with people bereaved by homicide identified two further information needs: the circumstances leading to the victim's death, and grief reactions and how to cope with the emotional aftermath. These were not raised by the service users interviewed for this study, but it is possible that the latter need was being met by the case worker by way of emotional support, and so not identified as a need as such.

cancellation of the victim's account. Case workers also mediated in disputes. For example, one service user was very upset on being told by her solicitor that the victim (the father of her child) could not be named on her baby's birth certificate. The case worker liaised with the solicitor and overturned this decision.

Service users spoke with a great deal of appreciation about the advocacy role taken on by case workers, perceiving the key outcome of this support to be the alleviation of stress and worry and also addressing issues more quickly and efficiently than if they were dealing with them themselves. This was particularly the case if mediation was required, as service users felt they did not have the authority that case workers had and were not able to articulate themselves as well in challenging situations. This was certainly the view of one service user who had been angry and upset when she tried to close the victim's bank account and was told by staff that this would take a number of weeks. She immediately called her case worker, who spoke to the bank manager and arranged for the account to be closed the next day.

> '*Maybe [the case worker] could tell the bank things which I can't … It's like they've got a bit more authority. To the bank manager I'm nobody.*' (Service user)

Financial support

Research has shown it is not unusual for families bereaved by homicide to experience substantial financial problems, particularly if the victim was the sole or main wage earner (Casey 2011; Paterson et al., 2006). While this was raised by some of the service users interviewed, it was not given the same emphasis that this other research suggests. This is possibly due to the fact that half of the service users interviewed were parents of the victim, meaning issues around earnings were not as relevant. Regardless, financial support was a valued facet of the practical support provided by the Homicide Service and broadly fell into one of four categories: costs incurred because of the death, issues around compensation, help with financial management and support with more ad hoc costs.

Service users identified a range of costs incurred as a result of the death, including funeral expenses and travel, accommodation and childcare costs during the trial. There were cases where service users had not been able to afford these, particularly funeral expenses. In such instances, the case worker had provided financial support by arranging applications to organisations that subsidise funeral costs (such as the CICA and the Social Fund for people on low incomes) and paying for costs during the trial out of the Homicide Service budget. For service users, support of this nature alleviated the stress they felt in relation to their finances and was of particular value when the support received related to the funeral. The FCO and

Homicide Service staff identified further costs associated with homicide abroad including travel and accommodation expenses, repatriation and translation of legal documents. As discussed, there were plans for the FCO to provide funding to support people with these costs at the time of fieldwork.

An application to the CICA was a key element of support from the Homicide Service, with the performance management data showing that 452 applications had been dealt with by the Homicide Service by May 2011.[54] Case workers suggested applying for CIC and, with the service users' agreement, accessed the application form and completed it either with them or on their behalf. These tasks were sometimes performed by volunteers too. This was welcomed by service users who would not necessarily have had the time or the energy to make the application without support. One service user described how these feelings were exacerbated by her own sense of obligation to complete the form 'well' on behalf of the victim.

> '*I didn't want to do any mistakes, you see, so she filled it all in for me. She were really good. I would have been lost; I just wouldn't have filled it in.*' (Service user)

A CIC payment can help alleviate some of the financial problems that bereaved families can face, but service users' applications were still being reviewed and processed by the CICA at the time of the application, so the impact of any compensation received cannot be explored further. However, case workers noted that an unsuccessful application to the CICA could cause added frustration and disappointment for the family. This was echoed by one service user whose application was unsuccessful due to the victim having a criminal record. This highlights the need for case workers to give accurate information to service users regarding eligibility so as not to raise expectations and cause further upset.

Paterson et al. (2006) describe how people bereaved by homicide may have to learn how to deal with financial matters for the first time. People may also have difficulty with routine tasks, meaning that bills are not paid. To this end, case workers provided support with financial management by helping to pay bills and assisting with benefit applications, particularly those relating to childcare. Service users were very appreciative of assistance with benefits, particularly as they were not always aware of what support was available.
To this end, one service user who had been granted custody of her young granddaughter

[54] See Table B10 in Appendix B.

(after her mother was murdered by her father) described how the case worker informed her and her husband about Guardian's Allowance.[55] She had not known about the allowance and it provided a valuable subsidy to their income.

Financial support was also provided on a more ad hoc basis in response to individual need, thus validating a core aim of the service: needs-based intervention. For example, some service users described how their case workers had obtained funding from peer support organisations for a short respite holiday. Other service users had been given supermarket vouchers at Christmas when they were 'strapped for cash', while another described how the case worker had bought her nappies and other supplies for her baby. Whilst such gifts were valued as a form of financial support, they also took on a greater significance for service users, who saw them as reflecting kindness and thoughtfulness, at a time when they felt depressed or isolated. Support of this nature went some way to facilitating a more positive outlook among some service users.

> 'W*hen [the case worker] turned up, I mean two big bags of nappies, a big pack of baby wipes … Honestly, little things like that do actually count and show that someone is still bothered … I had tears in my eyes.*' (Service user)

Other practical needs

Practical support was also provided on a more ad hoc basis in response to individual need. Service users described how their case worker supported them with an array of different tasks, for example organising funeral cars, registering them with a GP, arranging a family day out for the service user and her children, and helping them to understand and action various letters they received in relation to the death.

Secondary effects

The wide range of effects outlined above led to secondary impacts on service users' emotional and psychological wellbeing, including alleviating stress and facilitating a more positive outlook. These were outcomes of case worker support more broadly and as such it is not possible to attribute them to a particular form of support or task.

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[55] Guardian's Allowance is a tax-free payment added to Child Benefit payment for people bringing up children whose parents have died. In certain circumstances, people can qualify where only one parent has died, for example, if the other is in prison.

Ongoing contact with and support from a single point of contact was a highly valued outcome, with service users variously describing their case worker as a 'God send', 'safety net', and 'life-line'. Having a case worker on hand who was responsive to their needs and circumstances therefore alleviated service users' stress and anxiety and promoted peace of mind, as they felt confident that the case worker would be able to react to whatever issue arose, and quickly. Some service users went on to describe how they would not have been able to cope in the aftermath of the death without their case worker, such was their impact.

Service users also highlighted how their case worker had facilitated a more positive outlook. This arose from what some service users perceived as acts of kindness from their case workers (as discussed above) or simply by the case worker 'being there'. Service users described feeling positive either on a temporary basis or in relation to their and/or their family's future.

> '*[The case worker] always says if I phone her for anything "not having a good day today, are you?", "no, it's a bad day today" – she can tell by the tone of my voice … But she makes me feel as though I'm on an even balance. There are times when I've been as low as I could have got but… she brings me back up.*'
> (Service user)

Whilst these positive feelings were described as largely short-term, they were felt to go some way in building up service users' ability to cope and recover in the long-term. Some service users described how their more positive outlook was due to case workers instilling a sense of confidence in them which had enabled them to achieve what they otherwise would not have been able to, such as leaving the house, speaking to friends, going on a short holiday organised by their case worker, and even to come off anti-depressants.

4.2 Strategic and operational outcomes

Strategic stakeholders and delivery staff identified a range of impacts resulting from implementation of the Homicide Service. These centred on partnership working between the Homicide Service and other agencies involved in service delivery.

Partnership working

Delivery of the Homicide Service had encouraged agencies to work collaboratively, particularly the Homicide Service and the police. Partnership working between Homicide Service staff and the police during the referral process (discussed in section 3.1) had been

made a requirement through an ACPO/Victim Support agreement that set out the roles and responsibilities of the FLO and case worker as well as the referral procedures. The ways of working prescribed were felt to have led to a positive, collaborative relationship between case workers and FLOs, with FLOs reportedly keeping case workers informed about progress with the police investigation so that case workers had accurate information to inform and supplement needs assessments. In working alongside case workers, FLOs had generally received very positive impressions of the Homicide Service, with some describing how they would 'sell' the service to bereaved families at the referral stage, exemplifying their confidence in its benefits. This was supported by ongoing promotion of the Homicide Service to the police at a strategic and operational level, as discussed in section 2.2.

Effective partnership working between the Homicide Service and police was seen to impact on police views of Victim Support as an organisation more broadly. The perceived effectiveness of the Homicide Service was felt to have enhanced Victim Support's reputation and credibility among the police, countering more negative stereotypes of the organisation.

> '*Victim Support didn't have the credibility that it's got now … the Homicide Service is the best thing that's come out of Victim Support for an awfully long time … Some police officers perhaps didn't believe in Victim Support, but because of the Homicide Service and the job that we've been doing, I think our credibility has gone through the roof.*' (Team leader)

Whilst the development and growth of a positive working relationship between the police and the Homicide Service (and Victim Support more widely) was undoubtedly a positive outcome, partnership working more generally was not without its challenges. The perceived lack of engagement from Victim Support's core service was felt to have impacted on delivery of the Homicide Service, as discussed in sections 2.2 and 3.3.

4.3 Staff outcomes

Strategic and operational staff identified a range of outcomes for their individual practice as a result of delivering the Homicide Service.

Personal fulfilment

Homicide Service staff and volunteers expressed a clear sense of personal fulfilment as a result of their role in delivering the service. Whilst describing their jobs as challenging, team leaders and case workers were proud of their work and found it motivating and rewarding due to feeling that they were having a positive impact on service users.

> '*I don't think there's another job that would give you this sort of satisfaction in terms of helping people and knowing that you're making a difference.*' (Case worker)

However, heavy caseloads were seen as a threat to personal fulfilment. The perceived pressure felt by some case workers and the intensity of their workloads was such that there was a concern about the risk of 'burnout' and case workers being signed off on long-term sick leave or leaving the service completely, with staff describing cases where they thought this had already happened. In such instances, the team leader, support worker or other case workers had provided cover, but given that they have their own caseloads and/or other responsibilities, this is clearly not sustainable in the long-term. With caseloads increasing and comparatively few users exiting the service, it was felt that instances of burnout would escalate without strategic intervention, and that additional case worker resource was crucial. In July 2011 it was announced that an additional £500,000 of Government funding would go towards helping victims of homicide; some of which would be used to employ five extra Homicide Service case workers.

Financial impact

There was a financial impact on case workers as a result of delivering the Homicide Service that was of real concern to some. Case workers incurred considerable expenses in the course of their job, which they would fund themselves and then claim back from Victim Support. To this end it was not unusual for case workers to claim up to £400 a month, a large proportion of which was spent on petrol due to the amount of travel involved. The amounts claimed combined with case workers rarely being in the office in order to submit their claim caused case workers to 'struggle' financially. Whilst each Homicide Service team had a corporate credit card, case workers suggested that issue of a credit card for each case worker would help alleviate the financial pressure they experienced each month.

Practice and performance

Delivery staff identified two issues related to impact on practice and performance: career development and retention, and roles and responsibilities.

Career development and retention

Levels of job satisfaction meant that career development prospects had been considered by Homicide Service staff, particularly support workers, with some believing there would be opportunity for progression to case worker. Strategic leads acknowledged that career development was crucial to staff motivation and retention and that this warranted further consideration and communication to staff. This was underpinned by concerns that retention might be low among case workers, given the perceived issues of burnout discussed above and questions about ongoing funding discussed in Chapter 2.

Roles and responsibilities

Understanding and reinforcing aspects of one another's roles and responsibilities was another consequence of Homicide Service delivery. The primary function of a FLO is that of an investigator, while all the time ensuring that the bereaved are offered an appropriate, professional service in accordance with their diverse needs. However, while NPIA/ACPO guidance makes clear that the FLO role is not one of a counsellor (NPIA, 2008), Homicide Service delivery staff were of the view that some FLOs had, with the best of intentions, taken on too much of a supportive role prior to roll out of the Homicide Service, which had reportedly led to confusion amongst families about the nature of the FLO's involvement (Morgan, 2003). Some Homicide Service staff and FLOs felt that the formalised role of the case worker as a provider of emotional and practical support had reinforced the investigative aspect of the FLO's role. This in turn had alleviated pressure on FLOs' workload and allowed them to focus on their key roles and responsibilities.

5. Implications

This study was designed to explore the implementation, operation and effect of the Homicide Service; the findings will be of interest to policy-makers and staff involved in Homicide Service delivery, as well as other services providing support for people bereaved by homicide or victims of serious crime. This chapter explores the main implications of the research.

5.1 Delivery of the Homicide Service

Despite the challenges involved in implementing a new service at a time of fiscal restraint, the Homicide Service was fully supported by staff and service users. Service users in particular experienced a wide range of overwhelmingly positive impacts in relation to their emotional trauma and the practical issues they faced. Such support had improved service users' emotional and psychological wellbeing, by alleviating stress and anxiety and facilitating a more positive outlook.

However, delivery staff stressed that there was considerable pressure on the resources required to deliver a high-quality service, with case workers reportedly often working in excess of their contracted hours. The negative impact this could have on case workers in terms of personal fulfilment, coupled with the risk of 'burnout', led to concerns about staff retention and the bearing this would have on the development of staff expertise, continuity and consistency of service delivery. It was thought that additional case worker resource was crucial in order to reduce case worker caseload on a day-to-day basis, but also to provide support in the event of annual or sick leave.

In July 2011 it was announced that the Government was funding an additional £500,000 to help families bereaved by homicide, with money ring-fenced to fund five more case workers. This will most certainly be welcome news to Homicide Service staff and will go some way to addressing issues surrounding staffing. However, a number of issues still need to be addressed in order to facilitate effective Homicide Service delivery. These are outlined below:

- The current restraint on public spending raised concern about the future and sustainability of the Homicide Service after current funding ends in 2013/14. It was felt this uncertainty might lead to case workers seeking alternative employment, which would have implications for staff expertise and consistency of service delivery. Given levels of job satisfaction and personal fulfilment, one way to mitigate this risk is strategic level consideration of career development

prospects for staff and timely communication of these prospects. It was felt this would impact on staff motivation and retention.

- The training provided on the Homicide Service was generally considered insufficient in preparing case workers fully for service delivery, and so a training review is highly recommended.[56] Suggestions for additional coverage for case worker training focused on the practicalities of how to meet the support needs of service users and included:
  - How to assess trauma in service users.
  - The process of arranging a funeral, in order to guide service users through this.
  - Dealing with issues relating to probate and intestacy.
  - Information on benefit eligibility.
  - Issues surrounding confidentiality of support offered and how to convey this information to service users.
  - Accurate information about CICA eligibility.
  - Clarification on the court process.
  - Exit strategies.
- Where service users initially decline the Homicide Service, the service delivery model prescribes ongoing contact between the case worker and FLO to review consent, and to raise this with the bereaved person as and when appropriate. However, the findings suggest that not enough is being done to systematically review consent. This warrants further investigation by Victim Support and police at the strategic level to ensure that bereaved people get more than one opportunity to take up the service.
- There is a need for more effective utilisation of homicide volunteers, in order to alleviate case worker caseload and to engage volunteers more fully in Homicide Service delivery. The perceived lack of engagement from Victim Support's core service was seen as a barrier to developments here, and targeted training and/or communication at the strategic and operational level is recommended in order to overcome this. The need for better communication between case workers and volunteers was also highlighted, in terms of regular updates to volunteers about their individual cases (where the case was primarily handled by the case worker),

[56] Since the fieldwork, Victim Support has made some amendments to the training package and intends to keep this under review.

feedback as to their own achievements and development goals, and about Homicide Service developments more broadly.

- Uncertainty and confusion around exit strategy was felt to have further exacerbated issues surrounding caseload. As raised above, it is recommended that training for case workers on exit strategies is reviewed at a strategic level, with delivery staff suggesting that training should focus on timing, the approach to adopt, and strategies to prevent service user dependency and case worker/service user co-dependency. Caseload aside, it is important that this issue is addressed so that the Homicide Service does not inadvertently create a culture of dependency among its users.
- The infrastructure underpinning service delivery was also felt to exacerbate demanding caseloads, specifically access to and requirements regarding updating the CMS, with case workers sometimes having to travel long distances to the nearest Victim Support office to update it. Case workers were strongly of the view that secure, remote access to the CMS was crucial to ensuring effective service delivery and suggested that access be permitted through the laptops they had already been issued with. Time spent travelling also had implications for the quality of service delivery, with appointments occasionally being cut short or cancelled entirely due to travel problems. This suggests that service delivery could be improved by case workers covering smaller regions. Finally, case workers suggested issue of a credit card for each case worker to help alleviate the financial pressure they experienced each month as a result of expenses incurred.

5.2 Other learning points

This research suggests that the Homicide Service's performance management data could be improved to allow Victim Support to better monitor service delivery. Recommended changes to the performance management data are set out below:

- The introduction of a system designed to produce performance management data on individual staff, regions and at a national level, rather than the existing CMS which is designed to track work on individual cases, is recommended.[57] This would allow data to be more accurately and efficiently monitored.

[57] At the time of writing, an internal review of the CMS was underway within Victim Support.

- The performance data currently recorded on the system could be improved. Information that would be useful for assessing the performance of the service as well as assisting resource planning includes:
  - Recording notifications from different sources (police, FCO and self-referrals) with a consistent definition of a homicide case would allow a complete count of the number of notifications to the Homicide Service. In addition, recording notifications from the police in a way that allowed comparison with police recorded homicides would enable an assessment of how well the police notification process was working.
  - It would be useful to have data on support provision per case or individual service user at different stages of contact with the Homicide Service (for example at each needs assessment, at the trial) and the length of contact with the service. This would allow the service to build up a picture of a 'typical' support package for service users and 'typical' case worker work package, as well as helping with resource planning for new cases.
  - The use of volunteers by the service, including how many have been deployed on a case and what support they provided. This would help the service plan future use of volunteers and could help to alleviate pressures on case workers.
  - Those who declined support, at what stage this occurred (for example prior to referral, following first contact with the service) and subsequent contact with these individuals by the service.
- To demonstrate the impact of the Homicide Service, additional data should be collected and recorded:
  - The demographics of people being supported and of those who decline support. This would allow assessment of who was being supported and identification of groups not being reached by the service.
  - The outcomes of support for service users to demonstrate service effectiveness.
- The process for accessing and entering information on to the CMS should be improved. Suggestions for how this could be done include:
  - Secure remote access to the CMS. This would help to improve the quality of the data recorded on the system by allowing case workers to update it immediately after contact with the service users.
  - Volunteer access to the CMS would allow them to enter details about their activity on a case. Currently this is done by case workers and has to be

flagged on entry as volunteer activity, meaning that it is likely that there is currently under-recording of volunteer activity.

- Some changes have been made to data recording practices as the service has developed, for example trying to prevent double counting of instances of emotional and CICA support. More comprehensive guidance for those entering data on the CMS might help further standardise the information recorded.

References

Bradford, B. (2011) Voice, neutrality and respect: Use of Victim Support services, procedural fairness and confidence in the criminal justice system, *Criminology and Criminal Justice*, 25/05/11, 1–22.

Casey, L. (2011) *Review into the Needs of Families Bereaved by Homicide*. London: Ministry of Justice.

Kenney, J.S. (2003) Metaphors of loss: Murder, bereavement, gender, and the presentation of the 'victimized' self, *International Review of Victimology*, 9(3), 219–251.

McNaughton Nicholls, C., Callanan, M., Legard, R., Tomaszewski, W., Purdon, S. and **Webster, S.** (2010) *Examining implementation of the stable and acute dynamic risk assessment tool pilot in England and Wales*. Ministry of Justice Research Series 4/10. London: Ministry of Justice.

Morgan, D. (2003) Family matters, *Police Review*, 12/12/03, 20–21.

National Policing Improvement Agency (on behalf of the Association of Chief Police Officers) (2008) *Family Liaison Officer Guidance.*

Paterson, A., Dunn, P., Chaston, K. and **Malone, L.** (2006) *In the Aftermath*. London: Victim Support.

Ritchie, J. and **Lewis, J.** (2003) *Qualitative Research Practice. A Guide for Social Science Students and Researchers.* London: Sage Publications Ltd.

Roberts, J.V. and **Hough, M.** (2005) *Understanding Public Attitudes to Criminal Justice.* Maidenhead: Open University Press.

Rock, P. (1998) *After Homicide: Practical and Political Responses to Bereavement.* Oxford: Oxford University Press.

Smith, K., Flatley, J., Coleman, K., Osbourne, S., Kaiza, P. and **Roe, S.** (2010) *Homicides, Firearm Offences and Intimate Violence 2008/09: Supplementary Volume 2 to Crime and England in Wales 2008/09.* London: Home Office.

Tennant, R., Webster, S., Callanan, M., Maher, J. and **O'Connor, W.** (2007) *Helping older people engage with benefits and services: An evaluation of the Partnership Fund.* DWP Research Report No.441. London: Department for Work and Pensions.

Turley, C. and **Webster, S.** (2011) *Implementation and Delivery of the Test Beds Virtual Campus case study*. London: Department for Business, Innovation and Skills, URN 11/827.

Appendix A
Qualitative methodology

This appendix gives further information about the qualitative methodology.

Interviews with delivery staff

A range of staff was interviewed in each region, as follows:

- Two Homicide Service case workers, who act as the single point of contact for the bereaved person to ensure the provision of practical and emotional support.
- The Homicide Service team's support worker, responsible for providing administrative support.
- At least one specialist trained homicide volunteer, who delivers tasks as allocated by the case worker to meet the specific needs of the bereaved person. Volunteers were part of Victim Support's core service as opposed to the Homicide Service directly.
- A police representative, including at least one of the following:
  - A Senior Investigating Officer (SIO), who has overall responsibility for the homicide investigation and family liaison strategy.
  - A Family Liaison Officer (FLO), an investigator who assists the SIO and is responsible for the day-to-day management of the interaction with the family.
  - A Family Liaison Coordinator (FLC), who is responsible for strategic and tactical support to the FLO and SIO.

In addition to the staff specific to the three regions, two individuals from national organisations were interviewed, including:

- A representative from the Foreign Commonwealth Office (FCO), to explore delivery of the Homicide Service when the death occurs abroad and the bereaved are resident in England and Wales.
- A representative from an organisation offering trauma counselling, to explore the commissioning of such services under the Homicide Service.

In total, 20 in-depth interviews were conducted with delivery staff. The achieved sample interviewed is set out in Table A1 (omitting the interviews carried out for the scoping phase).

Table A1 Achieved sample of delivery staff (n=20)

	Region			Numbers across regions	Total
	1	**2**	**3**		
Case worker	2	2	2	-	6
Support worker	1	1	1	-	3
Volunteer	1	1	2	-	4
Police[58]	1	2	2	-	5
Commissioned service	-	-	-	1	1
FCO	-	-	-	1	1
Total	5	6	7	2	20

Interviews with bereaved service users

As highlighted in Chapter 1, Homicide Service team leaders and case workers were responsible for selecting service users for interview in the first instance. This was necessary from an ethical perspective as they were in the best position to determine which service users it was appropriate to approach in terms of their emotional and psychological wellbeing, as well as their circumstances with regards to the stage of their case in the criminal justice system. For example, it would not have been appropriate to introduce the evaluation to a service user who had just found out that the perpetrator was appealing their conviction. While team leaders and case workers were encouraged to approach service users with a range of experiences, it is possible that they selected those with more positive views of the Homicide Service.

On being invited to participate in the evaluation by their case worker, service users had to consent to their contact details being passed to NatCen. A NatCen researcher then contacted the service user by telephone to answer any questions they had, check that they were still willing to participate, and arrange an interview at a time and place that was convenient to them. All service users who consented to being contacted by NatCen took part in the study.

The achieved sample interviewed is set out in Table A2 (this includes the service user who provided their thoughts via email). The 18 service users correspond to 16 different cases.

[58] Comprising a SIO, a FLC and three FLOs.

Table A2 Achieved sample of bereaved service users (n=18)

		Numbers across regions
Gender[59]	*Male*	7
	Female	11
Relationship with victim	*Parent/guardian*	10
	Partner	4
	Son/daughter	2
	Sibling	1
	Extended family/friend	1
Service received[60]	*Emotional support*	13
	Practical support	14
	Financial support	11
	Commissioned service	9
Number of people being supported in relation to case[61]	*1–2*	9
	3–4	5
	5+	3
Stage of criminal justice system	*Pre-trial*	6
	Post-trial	10
	No trial	2

Topic guides

Tailored topic guides were used in all in-depth interviews to help ensure a consistent approach across interviews and between interviewers. However, the guides were used flexibly to allow interviewers to respond to the nature and content of the discussion, so the topics covered and the order in which they were discussed varied between interviews. Interviewers used open, non-leading questions and answers were fully probed.

Topic guide for delivery staff

The main headings and sub-headings of the topic guide used for the interviews with delivery staff are provided below. A slightly different version of this guide was used for interviews with strategic staff at the scoping phase.

1. **Introduction**
    - Introduce self and NatCen
    - Reiterate study aims
    - Explain confidentiality and anonymity, and potential caveats

[59] This includes both service users taking part in each of the two paired in-depth interviews.
[60] The numbers total more than the 18 due to service users receiving multiple types of support.
[61] The service user who expressed their thoughts by email did not provide this information.

- Interview practicalities
- Questions

2. **Background**
    - Current role and responsibilities
    - Brief overview of Homicide Service
    - Perceived aims of Homicide Service
    - How compares to what offered before
    - Who Homicide Service targeted at (eligibility)

3. **Training and support**

    Training
    - Nature of training received to deliver Homicide Service
    - Satisfaction with training received
    - Suggestions for improvements

    Support/guidance
    - How well supported nationally
    - How well supported locally
    - Perceived adequacy of support received

4. **Delivering the Homicide Service**
    - Regional team composition and role and responsibilities within Homicide Service
    - Where located
    - Regional caseloads

    Service delivery
    - Referral
    - Introductory meeting; what is discussed and initial needs assessment
    - Support provided
        i. Practical support
        ii. Emotional support
        iii. Financial support
        iv. Information provision
        v. Advocacy
    - When appropriate to refer to specialist agencies/commissioned services
    - Factors influencing support provided

- Facilitators/barriers to effectiveness of support provided
- End of service
- Partnership working: how relationships established, nature of communication, impact of partnership on service delivery

5. **Service impact/outcomes**
   - What are the key outcomes of Homicide Service, for:
     i. Service users
     ii. Staff
     iii. Victim Support service delivery more broadly
     iv. Partnership working
     v. Wider community
   - Any early outcomes to report
   - What would help realise impacts

6. **Reflections and lessons learned**
   - General reflections about Homicide Service
   - Perceived successes and challenges
   - Key lessons learnt
   - Suggestions for improvements

7. **Next steps**
   - Any other areas of importance to cover
   - Reassure regarding confidentiality
   - Discuss ongoing recruitment of service users
   - Thank for their time

Topic guide for service users

The main headings and sub-headings of the topic guide used for the interviews with service users are provided below.

1. **Introduction**
   - Introduce self and NatCen
   - Reiterate study aims
   - Review topics to be covered

- Voluntary nature of participation
- Explain confidentiality and anonymity, and potential caveats
- Interview practicalities
- Remit of discussion; will not impact on case
- Questions

2. Background

- Who they are, where they live and who with
- Researcher to briefly outline what is known about the case from detail given by case worker on the completed consent form
    - i. Check correct and whether anything they want to add to this

3. Introduction/referral to the Homicide Service

- When first introduced to Homicide Service; who, how, timing, what discussed, understanding of Homicide Service aims/role
- Initial reaction to Homicide Service at this stage
- Decision-making around take up
- Who else supported

4. Support received from the Homicide Service

- First meeting/needs assessment (if not covered above)
- Nature of support received
    - ii. Practical support
    - iii. Emotional support
    - iv. Financial support
    - v. Information provision
    - vi. Advocacy
- Nature and timing of ongoing meetings/needs assessments
- End of service
- Nature of relationship with staff providing support
- Nature of communication with staff
- Successful aspects of relationship
- Less successful aspects of relationship

5. **Service impact/outcomes and overall reflections**
    - General reflections about Homicide Service
    - What have been the key outcomes of Homicide Service
    - Impact of outcomes
    - Envisaged outcomes/impacts where support still being received
    - Facilitators/barriers to impacts being realised
    - Suggestions for improvements

6. **Next steps**
    - Any other areas of importance to cover/questions for researcher
    - Reassure regarding confidentiality
    - Thank for their time

Qualitative analysis

All interviews were digitally recorded and transcribed verbatim. The interview data were managed and analysed using the Framework approach developed by NatCen (Ritchie and Lewis, 2003). Key topics which emerged from the interviews were identified through familiarisation with the transcripts. Analytical frameworks were then drawn up (one for staff; one for service users) and a series of charts or matrices were set up, each relating to a different thematic issue. The columns in each matrix represented the key sub-themes or topics and the rows represented individual strategic or delivery staff, or service users.

Data from each transcript were then summarised into the appropriate cells. Bespoke FrameWork software, also developed by NatCen, enabled the summarised data to be hyperlinked to the verbatim transcript text. This approach meant that each part of every transcript that was relevant to a particular theme was noted, ordered and accessible. The final analytic stage involved working through the charted data, drawing out the range of experiences and views, identifying similarities and differences and interrogating the data to seek to explain emergent patterns and findings. Verbatim interview quotations are provided in this report to highlight themes and findings where appropriate.

Appendix B
Performance management data

This appendix provides summary tables from the analysis of the performance management data.

Table B1 Notifications and referrals (March 2010 to May 2011)[62]

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Total number of notifications from the police	155	152	156	117	177	**757**
Total number of notifications from FCO	3	0	5	7	11	**26**
Total number of bereaved self-referrals	10	21	24	8	11	**74**
Total number of consent referrals	131	135	141	108	148	**663**

Table B2 Number of people referred per homicide (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Number of bereaved adults referred	212	232	255	243	260	**1,202**
Number of bereaved children referred	11	22	18	16	18	**85**
Total number of people supported	**223**	**254**	**273**	**259**	**278**	**1,287**
Average number of adults referred per homicide	2	2	2	2	2	**2**
Average number of children referred per homicide	0	0	0	0	0	**0**
Average number of people referred per homicide	**2**	**2**	**2**	**2**	**2**	**2**

[62] The number of notifications does not equal the number of referrals because a homicide notification does not always lead to people being referred to the Homicide Service (see Figure 3.1 for further details as to why some people are not referred).

Table B3 Reasons for homicide not being referred (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
SIO determines no engagement	2	4	0	0	3	**9**
Family decline VS services	10	9	10	9	9	**47**
No next of kin	5	0	1	0	8	**14**
Deceased not identified	1	0	0	0	0	**1**
Unknown	3	0	0	0	9	**12**
Total number of homicides not referred	**21**	**13**	**11**	**9**	**29**	**83**

Table B4 Needs assessments (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Number of needs assessments carried out	1,079	2,086	1,719	1,833	1,947	**8,664**
Number of positive needs assessments	903	1,482	1,096	1,301	1,101	**5,883**
Average number of needs assessments per person supported	5	8	6	7	7	**7**
Average number of needs assessments per homicide referred	8	15	12	17	13	**13**
Average number of needs assessments per case worker	270	348	344	367	389	**347**

Table B5 Non-commissioned support provision (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Financial assistance	59	89	74	84	41	**347**
Burglar alarms	1	0	1	0	0	**2**
Personal alarms	3	1	2	3	2	**11**
Emotional support	388	515	489	418	413	**2,223**
Advocacy	208	253	170	326	182	**1,139**
Crime prevention	0	0	0	1	1	**2**
Information provision	47	125	88	60	89	**409**
Practical support	81	113	72	157	172	**595**
Other support	31	5	11	18	39	**104**
Witness Service	52	72	12	43	62	**241**
Total	**870**	**1,173**	**919**	**1,110**	**1,001**	**5,073**
Average amount of support provided per person supported	4	6	4	5	4	5
Average amount of support provided per homicide referred	7	10	8	12	8	9

Table B6 Commissioned support provision (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Security locks	11	0	6	7	4	**28**
Childcare	11	25	12	3	14	**65**
Interpreting and translating	1	1	3	3	8	**16**
Counselling	32	92	23	47	25	**219**
Repairs and cleaning	2	0	1	2	0	**5**
Specialist support	11	38	7	30	32	**118**
Transport	12	2	6	37	2	**59**
Removals	5	3	4	6	4	**22**
Glazing	1	0	0	0	0	**1**
Total	**86**	**161**	**62**	**135**	**89**	**533**
Average amount of support provided per person supported	0	1	0	1	0	0
Average amount of support provided per homicide referred	1	1	0	1	1	1

Table B7 Exiting the Homicide Service (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Total number of client cases closed	37	84	19	46	28	**214**
Average number of client cases closed referred per case worker	9	14	4	9	6	**9**
Range of number of client cases closed per case worker	5 to 18	0 to 24	3 to 7	0 to 24	3 to 10	**0 to 24**

Table B8 Case worker caseload (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Total number of consent referrals	131	135	141	108	148	**663**
Average number of homicides referred per case worker	33	23	28	22	30	**27**
Range of number of homicides allocated per case worker	31 to 35	5 to 31	4 to 49	10 to 35	23 to 39	**4 to 49**
Total number of people supported	223	254	273	259	278	**1287**
Average number of people supported per case worker	56	42	55	52	56	**51**
Range of number of people supported per case worker	50 to 61	18 to 57	12 to 84	28 to 73	39 to 71	**12 to 84**

Table B9 Case worker workload (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Total number of staff visits	543	873	900	878	603	**3,797**
Average number of visits to service users per person supported	2	3	3	3	2	**3**
Average number of visits to service users per homicide referred	4	6	6	8	4	**6**
Average number of visits to service users per case worker	136	146	180	176	121	**152**
Total number of volunteer visits	38	210	104	26	59	**437**
Average number of volunteer visits per person supported	0	2	1	0	0	**1**
Average number of volunteer visits per homicide referred	0	2	1	0	0	**1**
Total number of staff calls to service users	1,559	2,025	1,576	1,428	1,792	**8,380**
Average number of calls to service users per person supported	7	8	6	6	6	**7**
Average number of calls to service users per homicide referred	12	15	11	13	12	**13**
Average number of calls to service users per case worker	390	338	315	286	358	**335**
Total number of calls on behalf of service users	681	1,205	609	708	1,040	**4,243**
Average number of calls on behalf of service users per person supported	3	5	2	3	4	**3**
Average number of calls on behalf of service users per homicide referred	5	9	4	7	7	**6**
Average number of calls on behalf of service users per case worker	170	201	122	142	208	**170**

Table B10 CICA applications (March 2010 to May 2011)

	London	North West and Wales	North East and Yorkshire and the Humber	South West and West Midlands	South East and East England	**Total**
Total number of CICA applications	47	125	114	100	66	**452**
Average number of CICA applications per homicide referred	0	1	1	1	0	**1**
Average number of CICA applications per case worker	12	21	23	20	13	**18**

Ministry of Justice Research Series 2/12

Early learning from Victim Support's Homicide Service

This research assessed the implementation, delivery and effect of Victim Support's Homicide Service during its first 14 months of operation. Qualitative research was conducted involving Homicide Service staff, the police, other organisations involved in service delivery, and bereaved families. Performance management data was also analysed. The research found that the Homicide Service had a positive effect on bereaved service users; however, there was considerable pressure on resources to deliver the service. This could be alleviated through more effective use of volunteers, and improvements to technology and training. The performance management data could also be improved to better monitor service delivery.

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