Killed Women

INVISIBLE WOMEN "MADE VISIBLE"

Learning from the Femicides of Black, Minoritised and Migrant Women

A joint research report from the Invisible Women campaign (Killed Women), in partnership with Southall Black Sisters
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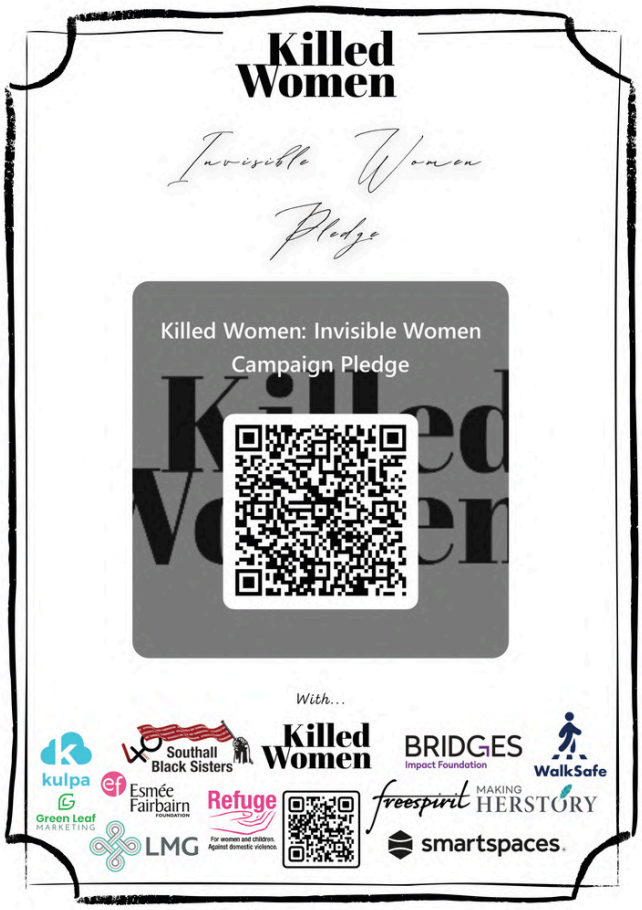
Most importantly, we want to express our heart-felt gratitude to all the families who so kindly and bravely agreed to be interviewed for the report. We do not underestimate how traumatic and painful such an involvement can be.

Thank you for sharing your experiences in order to help others.



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This research is dedicated to all Black, minoritised and migrant (BMM) women whose lives were taken by abuse, and to the bereaved families determined to secure justice and prevent further tragedy.

INVISIBLE WOMEN

Formed in 2023 by Killed Women (KW) Co-Founder Jhiselle Feanny with the support of Dr. Hannana Siddiqui of Southall Black Sisters, Invisible Women (IW) brings together KW bereaved families of BMM women who died as a result of domestic abuse and fatal male violence – whether in public spaces or within the home.

IW is a focused advocacy campaign led by KW bereaved families, demanding accountability, visibility, cultural competence within institutions, improved support and systemic reform. It confronts institutional racism and discrimination in policing and policy, dismantles intersectional barriers to safety and justice for BMM women, and challenges their erasure in media and public life through family-led testimony, research partnership and strategic public engagement.

It aims to:

- Hold government, police and other statutory agencies to account for failures to protect;
- Secure urgent procedural and policy reforms ensuring equal protection;
- Amplify the voices of affected women and families across media, public discourse and policymaking;
- Remove barriers to safety, justice and support;
- Build and apply an evidence- and research-based approach that drives lasting institutional change.

NB: Some families are named with consent; others are anonymised for safety. All testimonies are included with permission and have been reviewed by contributors.

KILLED WOMEN

Killed Women (KW) is a network of bereaved families whose daughters, mothers, sisters and loved ones have been killed by men. United by loss, they speak out so that these deaths are not dismissed as inevitable tragedies but recognised as preventable injustices. Members know first-hand the failures of courts, police, social services, media and government, and refuse to let these preventable injustices continue. The organisation campaigns to protect women from the most extreme violence, secure justice for those lost, and improve the rights and support of families left behind. Together, KW are building a movement that demands action beyond condolences – ensuring families have a seat at the table when making key decisions. They are a force determined to end violence against women and girls. Find out more about their work at https://www.killedwomen.org

SOUTHALL BLACK SISTERS

Southall Black Sisters (SBS) is a pioneering 'by and for' organisation, established in 1979 to challenge domestic abuse and all forms of gender-based violence against BMM women. At the heart of its work is a holistic women's resource centre offering a helpline, online advice, advocacy, counselling and peer support. SBS's frontline casework directly informs its campaigning, policy, research and strategic litigation work, enabling the organisation to drive national change in social, cultural and religious attitudes, as well as influence policy, practice and legal reform. Over the years, SBS has responded to cases of domestic homicides, so-called 'honour killings', suicides and women driven to kill violent partners in BMM communities. It has also contributed as an expert to Domestic Abuse Related Death Reviews (formerly Domestic Homicide Reviews) and conducted research into these issues. You can find out more about their work by visiting their website: https://southallblacksisters.org.uk

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EXECUTIVE SUMMARY

Invisible Women was formed in 2023 by Killed Women Co-Founder Jhiselle Feanny, with the support of Dr. Hannana Siddiqui OBE, of Southall Black Sisters. This campaign is in honour of all the BMM women who have died as a result of abuse; all those who were let down by the institutions that were supposed to protect them or deliver justice; and their bereaved families who have fought for change so that such tragedies will never happen again.

Invisible Women brings together the bereaved families of BMM women killed through domestic abuse and fatal male violence, both in public spaces and in the home. This includes bereaved families who believe that substandard police investigations have meant their loved ones have never had justice, with their cases not leading to a conviction.

The campaign demands accountability, visibility, cultural competence, improved support and systemic reform. It challenges institutional racism and discrimination in policing and policy, fights to dismantle barriers to safety and justice, and counters erasure in public and media narratives through family-led testimony, research partnerships and strategic engagement.

In the UK, a woman is killed roughly every three days; one in five homicides are domestic. Over the past decade, 78% of women killed in domestic homicides were murdered by a partner or ex-partner, and more than nine out of ten women killed were killed by men. For example, the disproportionality of the impact on BMM women is acute: all but two of the women killed by a man in London in 2023 were BMM women — this is evidence of systemic failure across agencies. BMM women face the hardest routes to safety because of No Recourse to Public Funds (NRPF), insecure status weaponised by perpetrators (and sometimes by men in authority), structural racism and poor cultural competence.

Over the past two years a Killed Women steering group of families have worked together to form the foundation of Invisible Women, drawing on their own experiences to pinpoint what needs to change. The families have identified both challenges and potential solutions that would address key failures and ensure accountability.

The research featured in this, the Invisible Women report, draws on in-depth interviews with seven bereaved families, and is supported by evidence from the Killed Women 'You Were Told' report and the 'Life or Death' report from Imkaan and the Centre for Women's Justice (both 2023). The findings reveal that families felt they were let down at every stage; experiencing failings in policing, inquests and court proceedings, and structural discrimination and prejudice. They make clear an urgent need for systemic reform, accountability, media regulation, specialist services and support, and better data collection.

We will be urging the system to take the testimonies of bereaved families seriously and act on their calls for change. Their loved ones' deaths were preventable, and their voices must drive reforms that confront institutional failings and discrimination. Our vision for Invisible Women is that BMM women are protected and believed, bereaved families are seen, heard and supported, and that institutions are held to account.

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INTRODUCTION

This report draws on the voices and lived experiences of bereaved families who have lost loved ones to violence against women and girls (VAWG). Their testimonies highlight the compounded risks BMM women face from both perpetrators and the state – risks rooted in structural inequalities and intersectional discrimination. They reveal deep systemic failings: BMM women treated as less credible and less deserving of protection; stereotyped along racial lines; denied the culturally appropriate support they urgently need; and rendered invisible even in death, as long-demanded reforms continue to be ignored. These lessons must be acted upon, so that their deaths are not in vain.

BACKGROUND

On average, a woman is killed in the UK every three days. One in five homicides are domestic, and over the past decade 78% of women killed in domestic homicides were murdered by a partner or ex-partner. More than nine in ten women killed were killed by a man. These figures should stop us in our tracks – because behind every number is the devastating loss of a loved one: a daughter, a mother, an aunt, a sister.

BMM women and girls are disproportionately affected. BMM women face the hardest barriers, and often experience challenges to access safety and support. This includes the NRPF condition on migrant women, which denies them access to most social security and housing benefits, and accommodation under the Homelessness Act. Research shows that women with NRPF are three times more likely to be subjected to VAWG than the wider female population. Perpetrators use insecure immigration status as a weapon of control, with over 60% of migrant women threatened with deportation. This weaponisation extends to abusers in positions of authority. David Carrick (a serving police officer), for instance, exploited a victim-survivor's immigration status to silence her, threatening deportation if she resisted – a chilling abuse of power that deepened her entrapment.

For BMM women, abuse is too often ignored or not taken seriously; investigations are slow or inadequate, and protection measures are inconsistently enforced. Safety and access to support are further constrained by institutional racism and misogyny, the criminalisation of victim-survivors, and insecure immigration status. Help remains uneven: culturally appropriate services are scarce due to poor funding, and providing interpreters and securing legal advice or mental health care is difficult. Community stigma and 'honour'-based control can silence victim-survivors and families.

Media coverage is often reduced or delayed, and treatment of BMM women and their bereaved families is often negative and minimalistic. The reporting on BMM women and their bereaved families is frequently framed in victim-blaming terms – fuelling online abuse and weakening public sympathy and support. Poor ethnicity data, limited independent scrutiny and poor follow-through on 'lessons learned' allow these failures to persist.

Of the 369 female domestic homicide victims recorded by the UK Government between 2020 and 2024, 88 (24%) were from BMM backgrounds (who formed 18% of the UK population in the 2021 census). This disparity is even more pronounced and appalling in London femicide patterns and data: 62% of femicide victims in 2023 were Black, despite Black women comprising only around 14% of the city's female population; and figures obtained from the Metropolitan Police reveal that all but two of the women killed by a man in London in that year were BMM women. This acute disproportionality indicates systemic failures in prevention and protection across agencies, including policing and social services, and aligns with the Casey Review, which found that the Metropolitan Police Service is institutionally both racist and misogynistic.

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QUALITATIVE RESEARCH: **BEREAVED FAMILY MEMBERS**

This research report draws on qualitative, narrative research, based on in-depth interviews with seven bereaved families, each lasting approximately 45 to 90 minutes. The aim was to capture their reflections on loss and their perspectives on what justice looks like, and the reforms urgently needed to prevent such deaths in the future.

The interviews were semi-structured, guided by a core set of questions, yet allowing participants the space to share their stories in their own words. Bereaved families' voices are presented throughout as anonymised quotes. While not every insight could be included, these testimonies will continue to shape and inform our work.

An intersectional feminist analysis frames this research report, highlighting the community and institutional failings revealed through the families' experiences and underpinning recommendations aimed at addressing the root causes of VAWG and its disproportionate impact on BMM women and girls.

A. FAILINGS OF THE POLICE

Families consistently identified the police as the statutory agency that failed them most profoundly.

All bereaved families we spoke to raised serious concerns about the police's response – both to their loved ones while alive and to them in the aftermath of their deaths. Families strongly believed these deaths could have been prevented had the police acted with urgency, professionalism and the seriousness their loved ones' lived experiences demanded.

As a result, the 'one chance rule', which was developed in forced marriage and 'honour'-based abuse (HBA) guidance, but which can also be applied to other forms of VAWG, and which required early intervention to prevent escalation of abuse, was rarely applied. Moreover, forced marriage and HBA were often missed or dismissed by police and other agencies; families also reported discrimination based on race, sex, age, religion and other protected characteristics, alongside a lack of understanding of HBA that shaped service responses (see further: 'You Were Told', p. 12; 'Life or Death?', p. 39–42, Annex 6 p. 109–119).

This section of the report outlines the failings of the police as reported by the BMM bereaved families interviewed. While some of the families' experiences – and those of their loved ones – reflect issues faced by the broader population of women subjected to VAWG, the section also highlights experiences that reveal the deeply entrenched intersectional discrimination particularly faced by BMM women and their bereaved families.

i. Failure to act on perpetrators' known histories

In several cases, police had prior knowledge of perpetrators' abusive histories and previous victims. Yet this information was not used to assess risk appropriately or to safeguard victims.

In one case, a missing woman was classified as 'medium risk' despite clear evidence of contact with a known perpetrator. Her vulnerabilities – including homelessness, substance use and being a mother – were not factored into the risk assessment. She had even been referred to a Multi-Agency Risk Assessment Conference (MARAC) due to her history of reported abuse, yet the police failed to recognise the urgency of her situation.

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In another case, sisters were subjected to HBA by their family. Despite a trajectory of reports across the system from childhood onwards, the police failed to intervene or appropriately support the victims, leading to the tragic loss of one of the sisters.

ii. Victim-blaming and dismissal of abuse reports

Families described how their loved ones were subjected to victim-blaming attitudes and dismissed when they reported abuse.

One family shared the heartbreaking experience of their loved one repeatedly trying to get the police to take her reports seriously, only to be disregarded each time. The family member questioned the entrenched culture of victim-blaming within policing and urged accountability for perpetrators and for the system that condones their actions.

"It's never the man's fault. *What did you do to initiate this divorce? Why did you run away? Why couldn't you make it work?* And I think that goes across all societies, all backgrounds, all races – women are always placed at the heart of the blame. So whether it's rape culture, or whether it's sexual harassment, it's always: *What were you wearing? What were you doing? Why did you go out there late [at] night? Do you really need to run on your own?* All of those things, that kind of blame culture."

Another family expressed deep dissatisfaction with the police's safeguarding response. Despite their loved one being at heightened risk after leaving her abusive partner and having an injunction in place, she did not receive adequate support.

"She was let down by lots of people. The police let her down. She'd gone to them so many times about the stalking, and they hadn't taken it seriously. [She had an] injunction, [which] I don't think was really taken seriously either. Sitting in the court, hearing evidence, [I felt] like, why didn't you do more? Why didn't you put something in place for her? Why didn't you try and keep her safe?."

Women's vulnerabilities, such as substance use, were often used to undermine their credibility and discount risk. One family recalled that, despite repeatedly insisting something was wrong, the police treated the missing person report lightly, suggesting their loved one would "come back when she's ready".

Another family shared that, despite the legal framework around domestic abuse and coercive control, police often dismissed reports as an argument between two people that would resolve itself. Before her homicide, their loved one had tried to report abuse to the police, only to be told they would not press charges against the perpetrator. The family explained that their loved one felt the police did not take her report seriously, describing their attitude as one of inaction that left her feeling told off. This emboldened the perpetrator to continue his actions with impunity.

Another family shared that despite their loved one's repeated attempts to "[cry] out for attention", she was never believed or taken seriously – an experience that is all too common, and particularly prevalent in cases of HBA, which are often overlooked or dismissed. Instead, she was victim-blamed – with references made to her alcohol intake (which the perpetrator had forced her to consume) – and even criminalised, having been charged with criminal damage during one desperate attempt to escape an attempt on her life.

"The barriers are being heard, seen, understood. Because, they will listen to you, and think, *'Oh, that's so far-fetched'*. And *'That could never happen in the UK'*. And they see you, and they think, *'Yeah, she just had a bit of a tumble with her partner'*. They don't look deeper into it. And they just don't take you seriously at all."

iii. Lack of adequate training and coordinated safeguarding

Families also highlighted failures to deliver a consistent, coordinated safeguarding response.

One family shared that, despite their loved one making multiple call-outs to the police asking for protection, these calls were never registered, linked or flagged as a safeguarding concern. The family member stressed that this failure – pointing to a lack of proper training – was compounded by the police classifying their loved one as 'low risk' simply because she had separated from the perpetrator. Together, these failings led to her devastating – and entirely preventable – loss. Another family later discovered that the perpetrator's known dangerous history was not shared with health services.

Another family described how their loved one was first assessed as 'medium risk' but later reclassified as 'high risk' – a change that was never communicated to her. When the family re-engaged with the police for advice about a trip the victim was due to take with the perpetrator, officers failed to recognise or disclose the heightened risks she faced, including her pregnancy and her decision to leave him. The only response given was that the officer would check with a supervisor about whether she could go on the trip. No follow-up ever came, leaving both the victim and her family – who had been actively supporting her attempts to report the abuse – without the information or safeguarding they desperately needed.

"They had no training, the system was failing, they had no idea what they were dealing with."

iv. Failure to collect evidence and investigate properly

Families described deep frustration at having to chase the police – even after the death of their loved one – just to have the case treated with the seriousness and urgency it required. In some instances, families felt compelled to carry out parts of the investigation themselves, despite the risks, because the police failed to act.

One family reported that officers neglected to interview potential witnesses, preserve the crime scene or examine electronic evidence. They explained that, although they repeatedly provided insights into their loved one's history of vulnerability and of being a 'high risk' domestic abuse victim raised at MARAC, the police disregarded them.

Notably, the family highlighted a clear lack of institutional will to progress the case – despite the extent of evidence available immediately after their loved one's death, it felt as though her experiences had been dismissed and leads were deliberately left unpursued. They lamented the absence of trauma-informed care and described the police's conduct as unprofessional, failing to carry out even the most basic investigative duties, including proper collection and examination of evidence.

"We felt really disappointed with their behaviour and lack of enthusiasm to investigate the case properly. It got to a point where we were just contacting them all the time and trying to get information. They didn't want to follow up the case properly or follow the leads. There was so much evidence they could have had."

This family's experience reflects a broader pattern of disengagement reported by others, where officers seemed more inclined to shield perpetrators than to work with victims' families – leaving families to constantly push for even the most basic updates.

v. Intersectional discrimination

Although some of their experiences mirrored those of women in other non-BMM communities, families also expressed deep concern that their loved ones were treated differently because of race, age, sex and class. They described how intersecting discrimination – particularly misogyny and racism – shaped the police's inadequate response. Families also noted that this was especially in relation to HBA, which they felt was neither understood nor taken seriously – even though these cases often involved multiple perpetrators and victims.

One family member explained that although overt discrimination was not visible, racial bias seemed to play a role in the dismissal of their reports. Their loved one spoke fluent English, but her name and appearance marked her as different, which they believed influenced the disparity in response compared to white neighbours whose reports were acted on immediately.

Families challenged the systemic de-prioritisation of violence against BMM women and girls, stressing the urgent need for equal treatment and respect.

"They took no notice of her because of her race. […] And I said, is it because she wasn't a doctor, or she wasn't blonde, or something like that? What did she need to be before you take her more seriously? […] Every case should be treated the same."
"I think race played a big role in that […]. And the fact that she was a female, I don't think they regarded her as being important."
"Are we talking about the way the police treat her? Are we talking about the way the judges look down on her? Are we talking about the racism and sexism that has been happening, all the way? It feels like it's a game rigged for men, and specifically white men as well, to ensure that those men will always be protected."

In one case of HBA, the family felt that the police were reluctant to intervene due to considerations of 'cultural sensitivity', despite incidents of rape, repeated threats to kill, and an attempted murder organised by several perpetrators, which were reported to the police on five occasions. They stated that their loved one had tried to provide the police with detailed accounts of her experiences of abuse, but was dismissed due to victim-blaming attitudes and, to a large extent, because of the officers' desire not to intervene in order to be 'culturally sensitive'. The family added that even after their loved one's death, the police were merely "pointing fingers" at one another rather than taking accountability for their failings – thus creating a further dishonour to their loved one's memory, as lessons must be learned and acted upon following such losses.

vi. Failure to provide culturally appropriate support

Families emphasised that their loved ones were often extremely vulnerable, repeatedly signalling their need for help, and would have benefitted from being truly seen, heard and understood. Instead, they were denied culturally appropriate support – both at the point of identification and in the response that followed.

One family shared that their loved one endured abuse perpetrated in the name of 'honour', yet professionals lacked the training to properly identify or assess it.

Another family described this same failure of recognition as a form of racism, raising concerns about how clear indicators of HBA from both the perpetrator and his parents were mishandled by police. The family explained that while it was evident their loved one needed to be spoken to in a safe and separate space to disclose her experiences, the police failed to recognise or provide this basic safeguard.

Similarly, another family recounted how the police followed up their loved one's reports of abuse by approaching her at the very house she shared with her abusive relatives – silencing her further and aggravating the risk of harm.

Several families also noted that, to their knowledge, their loved ones were never referred to specialist 'by and for' services for BMM women and girls, despite these services being recognised for their culturally specific, holistic and tailored support.

Families spoke too of the poor way they themselves were treated in the aftermath of their losses. One family acknowledged that while the police carried out some appropriate measures at the time, support remained extremely limited. Instead of being offered care, they were expected to actively assist the investigation immediately after losing their loved one – a stark reflection of the absence of a trauma-informed approach. They added that, although the resulting statement was certainly thorough, it was "a bit too late", given the systemic failings that had already cost their loved one's life.

Another family recalled their shock at the police's apathetic response after the loss. They felt they were treated differently, received no meaningful support, and were left entirely without a family liaison officer (FLO) at a time of profound trauma.

"The way [we] were being treated was like, *'oh, another one of their 'honour'-based abuse murders'*. It was shocking, absolutely shocking. […] Nobody to check in on us, left in limbo, you know. Something massive has happened. And you have got no support whatsoever from the police."

The family described an experience of being left entirely unsupported following the traumatic loss of their loved one, with no designated contact point to call in moments of distress, no one to accompany or drive them to identify the body, and no guidance to help them understand the process or next steps. They questioned the extent to which their race had influenced the treatment they received, perceiving it as a determining factor alongside the systemic de-prioritisation of VAWG across institutions.

Yet another family shared that they found there to be a "flux of guidance and help". They described the immediate period following the loss of their loved one as one of profound shock, during which they were simply trying to survive the repercussions of the loss. It was precisely during this time that support was being offered, but if families didn't "mobilise [...] to accept the help", it would fade away by the time they were in a position to be able to avail themselves of it. This highlights the need for support that is tailored and responsive, adapting to families' circumstances and readiness to engage.

Taken together, these accounts reveal systemic failings in policing that expose intersectional discrimination based on race and/or sex, resulting in delayed and inadequate responses to domestic abuse, including coercive control, sexual violence and HBA. Bereaved families frequently described poor safeguarding stemming from entrenched victim-blaming attitudes, insufficient training, limited understanding, a lack of culturally appropriate responses and services, inadequate supervision and failures in crime investigation. They also reported weak information-sharing with victims and families – both before and after a death – and the dismissal of forced marriage and HBA cases.

Families' testimonies make clear that these were not isolated occurrences, but recurring patterns that demand urgent reform – not only in relation to addressing abuse and preventing deaths of BMM women, but also in supporting bereaved families in their quest for information and justice.

B. FAILINGS OF OTHER STATUTORY AGENCIES

Beyond policing, families also described grave failings by statutory services – health, social care, and education – that should have identified risk and acted, but instead missed critical opportunities.

In 'You Were Told', among respondents who said there was a history of abuse, 78% reported that one or more services already knew about it and 69% said two or more services knew – including police, General Practitioners (GPs), schools, legal services, social services and the Crown Prosecution Service (CPS) – yet effective protection did not follow.

The families we engaged with reported that, despite victims seeking help from these services, they were rarely recognised as being at serious risk requiring urgent intervention. Responses, when offered, were fragmented, inconsistent and uncoordinated.

One family member recalled that when their loved one was in hospital, a woman in the bed next to her witnessed the perpetrator being abusive and reported it. A midwife began a risk assessment, but she then passed it to another member of staff, and from there it was never followed up or linked with the police. The family saw this as a critical missed opportunity to save their loved one.

Another family member described how their loved one was brutally failed by social services, who, rather than safeguarding her or offering support, threatened to take away her child.

"Social services. They failed big time. [Instead of] trying to look at the case and think: What's going on for this woman? Why is she calling the police? Is she under risk? Should we speak to the police? Can we do something with the police? Instead, they will actually make her feel scared."

A different family shared that despite multiple agencies having notice of the abuse their loved one endured from family members who perpetrated HBA, no-one intervened urgently or appropriately. This neglect stretched from childhood through to adulthood, when the abuse escalated and ultimately culminated in a tragic 'honour killing'.

"The system failed her.
Social services. NHS. Education services. Police.
Everybody let her down."

The family added that institutional racism was evident in the way the system responded. Because professionals failed to understand their loved one's minoritised culture, they overlooked serious risks and failed to provide a coordinated response. They further noted that the system shows resistance to learning from such experiences, which they saw as a form of entrenched institutional racism.

Another family echoed these concerns, describing how a range of stakeholders – including the police, the courts, health services and women's refuges – had notice of their loved one's abuse. Yet none of these agencies shared information with one another, resulting in a failure to deliver a joined-up response.

"The police had information. But there's also more information on the impact on [the kids] from the doctors. And, wait, the women's refuge, they've got a full report on her and what she'd been through. All of these arms that had somehow got involved, none of them had shared information with each other."

These failures underline the absence of a coordinated, trauma-informed and culturally appropriate statutory response. The testimonies of families make clear that opportunities to intervene were repeatedly squandered – with devastating and preventable consequences.

C. FAILINGS IN COURT PROCESSES, INQUESTS AND DOMESTIC ABUSE RELATED DEATH REVIEWS

Families' struggles did not end with the loss of their loved ones; many found that the very systems meant to deliver justice compounded their grief. Inquests, Domestic Abuse Related Death Reviews (DARDR) and court processes were described as opaque, neglectful and unjust.

i. Court systems that neglect victims and the bereaved

Bereaved families spoke of being neglected at every stage – both in the treatment of their loved ones while alive and in the aftermath of their deaths, where institutional failures compounded their grief. They shared their deep frustration at the failure of the police and judicial system to recognise the perpetrator's abuse and control. One family said their loved one "could have been saved a billion times", but her repeated attempts to seek help were ignored, despite the abuse following a pattern seen in many domestic abuse and coercive control cases.

Another family shared that their loved one was treated poorly by every authority she sought help from, including judges. They emphasised that she was particularly failed by the family courts. She had sought intervention to prevent the perpetrator from having contact with her children, but the courts consistently favoured the perpetrator, minimising her concerns and undermining her fight for safety. The family described the system as extremely "dupable", exploited by perpetrators who understood how the system diminishes the seriousness of VAWG, to the detriment of vulnerable victims.

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**"We heard how she was treated by judges, [...] and saw how she was left with absolutely nothing of value.
She [was] going to court, desperately trying to get his right to contact with the children completely stopped. So, she's going to court, she's being told that he's going to anger management classes, *he's so wonderful, the social workers think he's really good for the kids. Isn't he charismatic? Isn't he really caring? Isn't he so wonderful with the kids, bringing them presents? And, he just wants to make it up with [her]. [And that] he seems very gentlemanly. [That] he's been working really hard to get his lawyers.* And, she's having to hear this kind of reasoning as to why she should accept this man into her life when
she has been left with a broken rib.
She came out with all kinds of injuries that were both mental and physical. All of these things, she had stated time and again to the officers, time and again to judges. She was in court begging for people to understand that he wasn't everything that they were seeing."**

The family emphasised that it was a family court hearing that finally shattered their loved one's confidence in the system, due to victim-blaming and the failure to take her experiences seriously.

**"She came home [from court] in absolute floods of tears. In that court hearing, over the kids, the judge had said to her, *'now stop it, you're being very silly, you're a silly woman for thinking he's going to do any of this to you'*. And that's the day that broke her. That's the day she stopped the fight. And she said,
'I'm never going to win'."**

The family further highlighted that their loved one felt discriminated against by the court system because of her ethnicity, questioning whether she would have received better treatment had she not been from a minoritised culture or if her English had been better.

"She said, if I didn't wear those things, if I didn't have the skin colour, maybe the judges would treat me differently. [...] [She] felt the way that they would speak to her, as opposed to the way that she thought they would speak to everybody else in that courtroom was always a bit looked down upon, as if she was a bit stupid. One day, when she came back from court, she said 'they don't know that I can understand everything they're saying, and they don't know that even though I can't respond in the words that I want to in their language, if they knew what I was saying, they would think I was a scholar. And she got that sense of, the system isn't there to help, the system is to judge you before they judge whether they're going to help you or not. And she felt like she failed as soon as she walked into the room, and they saw who she was."

Another family described struggling to obtain basic information about their rights and options while pursuing justice, only to discover that their case – along with twenty others – had been "lost in the system" due to staff turnover. This bureaucratic failure robbed them of precious time to grieve.

Another family questioned the limited support available to families following such devastating loss, particularly after the trial – a period of heightened vulnerability for those who have provided evidence and been exposed to the horrors their loved one endured, as well as any failings that contributed to her death.

**"Leading up to the trial, I had this nervous energy, like I needed to survive, I needed to get through, I needed to be able
to do what I needed to do.
And then when the trial's over, it's just the biggest anticlimax. Like, what now? Why was there no follow-up support, or just a transition period [after] the trial's ended? Even if you start tapering it off ever so gently,
softer kind of support would have been really helpful to transition back."**

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This section highlights the systemic failings of the UK court system experienced by BMM bereaved families. Families reported being neglected at every stage, from authorities failing to recognise abuse to courts undermining victims' safety and concerns. Experiences of victim-blaming, discriminatory treatment and procedural barriers compounded their trauma, while limited post-trial support left families without guidance or care during a critical period of vulnerability.

ii. Marginalisation of grieving families within inquests

Families described how inquest proceedings often compounded their pain by rendering both them and their loved ones invisible. Rather than adopting a trauma-informed approach, coroners sometimes failed to investigate critical evidence, explore domestic abuse or HBA, or treat families and their lost loved ones' deaths with care or seriousness.

One family shared that pursuing justice through the findings of an inquest fell entirely on their own initiative, with no support provided by the system.

Another family shared that the inquest into their loved one's death was deeply inadequate: the coroner failed to properly examine the testimony of a witness who had overheard the domestic abuse on the night of the death, and even went so far as to minimise and discredit his account.

"There was no care and attention paid to the family, or even to the witness. We just want to know what happened. Why was my daughter not entitled to a fair investigation? That's the basics. That's the bare minimum."

iii. Inconsistent experiences of Domestic Abuse Related Death Reviews

In relation to DARDRs, formerly Domestic Homicide Reviews (DHR), families described a wide spectrum of experiences, ranging from concerns about aspects of the review process to appreciation of its findings.

Families expressed profound concern about delays in the commissioning of reviews and the gaps in communication and receipt of updates, with one describing it as a "long, painful, devastating process". Another family reported that they only became aware of the review in their loved one's case through reports in the media.

Highlighting the lack of cultural competence among review Chairs and panels, one family recounted that the review panel had focused on the police's compassion and empathy during their loved one's attempts to report abuse, rather than acknowledging their failings. The family explained that they had to actively challenge this framing to redirect attention to the police's shortcomings, emphasising that compassion alone could not have saved her and that concrete safeguarding measures were urgently needed.

Other families found the reviews valuable in revealing the full extent of the abuse, and emphasised that meaningful accountability and learning can only occur when the findings are acted upon.

iv. Inadequate and unjust sentences

Families voiced deep dissatisfaction with the leniency of sentences handed to perpetrators. Many expressed that, while no sentence could ever fully compensate for their loss, the punishments given were far too short considering the perpetrators had deprived someone of their entire life and all it could have encompassed.

"Life should mean life. They shouldn't be allowed out."
"The justice system does not give people justice. No amount of prison sentence is ever going to be enough for us, we know, [...] [but it was] nowhere close to what you would have wanted it."
"It's never going to be enough. He's destroyed us completely. You know this grief has brought us to our knees. No amount of sentence will ever be enough, but he still needs to face a harsher sentence."

One family member shared that they appreciated being kept informed of parole hearings in their loved one's perpetrator's case, which allowed them to advocate against early release out of fear for themselves and the children. They added, however, that this positive practice came "with a pinch of salt", as it likely would not have occurred had they not actively pushed the system to consider their family's interests. They highlighted that, in their experience, the system continues to fail victims and families – particularly those from BMM backgrounds.

"The agencies so many of us hope to be saved by, aren't working in that mode. They don't see a lot of women, especially, I think, of Black and Asian minority backgrounds, as figures who are abused in the same way as their white counterparts. It's almost as if [they're saying], this is our culture, it's your religion. I'm like, no, this isn't our culture, it's nothing to do with our religion. This is just a violent male, using anything he can to abuse another woman. So, there is the feeling that the systems in place don't view Asian and Black women the same. And that they can disparage that abuse by kind of aligning it with their perceptions."

One family highlighted that additional factors – such as the victim's pregnancy and her subjection to HBA – should have been considered as aggravating circumstances in sentencing. They explained that arguments regarding HBA had been advised against during trial in order to avoid confusing the jury and to increase the chance of a murder conviction. Nevertheless, the family emphasised that explicitly recognising HBA as an aggravating factor in sentencing would be highly valuable.

Another family member similarly stressed the importance of considering 'honour' in sentencing, noting that their own family had claimed to enact 'justice' in its name through the murder. They argued that laws recognising this would help effect change within communities, where surveillance of victims continued and resistance to holding perpetrators accountable persisted because some perceived the murder as having restored family 'honour'.

This family advocated a change in law to recognise HBA as an aggravating factor in criminal sentencing:

"[This] law would do so much more than what is happening at the moment. It's heart-numbing to see it sitting there for so long and collecting dust."

Some families explored the possibility of appealing sentences, only to discover – too late – that they had missed deadlines for appeal notifications, simply because the system had failed to inform them.

Families were also distressed by perpetrators being allowed to avoid attending sentencing hearings to avoid hearing their victim impact statements, calling for stricter laws, including additional prison time, for those attempting to evade accountability.

Taken together, these testimonies highlight enduring shortcomings within the justice system: victims were sometimes overlooked, grieving families felt marginalised, and sentences were widely perceived as inadequate. Far from providing truth, accountability or closure, DARDRs, inquests and court proceedings often compounded families' distress.

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D. FAILINGS OF NON-STATUTORY STAKEHOLDERS

A number of families also spoke of being let down by non-statutory stakeholders, particularly the media and, in some cases, religious or community leaders. While these actors fall outside formal statutory systems, their influence profoundly shaped how victims and families were treated.

Regarding religious and community leaders, one family member described how the perpetrator colluded with these figures to convince the victim that the abuse was her fault. Religion was manipulated as a tool to exert further control over her, reflecting a pattern that affects many women in similar situations.

The media was also cited as a source of harm. Rather than safeguarding privacy and dignity, early coverage often compounded families' trauma. While some families expressed gratitude for ethical reporting that amplified their voices, others highlighted the damage caused by sensationalist coverage, victim-blaming narratives and breaches of privacy that dehumanised their loved ones and retraumatised surviving children.

"So, at the beginning, they breached our privacy. In fact, we found out, in the newspaper, before we'd actually even heard properly. And, then, afterwards, after she died, the negative reports came out, just humiliating her. They kind of victim-blamed her. It was awful. The kids were traumatised, they were re-traumatised. The kids were bullied in school."

Another family questioned the disparity in media attention their loved one's case received, suggesting it may have been because of the perception that "it's just another Asian woman who's been killed by another Asian man. And, whoopsie-daisy, isn't that part of the culture anyway?". They emphasised that such reporting silences the voices of BMM women and girls, and called on the media to report on VAWG in a trauma-informed manner that centres victims' experiences.

Another family echoed these concerns, highlighting the lack of attention to VAWG and the way victims' lives – particularly those of BMM women – are de-centred and depersonalised in the limited coverage they receive.

"I have a real issue with the way women's lives are reported on. When a woman is killed, especially by an abusive partner, or an ex-partner, the perpetrator gets the attention, but the woman's life and the woman's voice just gets faded away. She's literally now just a statistic."

These testimonies underline the powerful role that media and community actors play in either amplifying harm or denying support. For many families, sensationalist or judgmental responses not only compounded trauma but also reinforced the failures of statutory agencies.

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RECOMMENDATIONS

The failings identified across policing, statutory services, DARDRs, coroners' courts, the justice system and non-statutory actors are interconnected and enduring.

Families' testimonies expose patterns of neglect, discrimination and institutional apathy that cannot be fixed by piecemeal measures. To prevent further lives being lost – and to stop families being failed – decisive, structural change is required.

The following recommendations require **three pillars** arising from key themes within the research: ***accountability, visibility*** and ***systemic reform***.

A. A WHOLE-SYSTEM APPROACH TO VAWG

Families' testimonies reveal a stark picture of the failures of statutory agencies – and policing in particular – in understanding VAWG.

Victims and their families were consistently failed in their efforts to have BMM women and girls' experiences of violence treated with the seriousness they deserved. Families reported entrenched victim-blaming attitudes, and it is evident that, beyond sex, discrimination based on race further eroded recognition of their loved ones' experiences. The barriers many women encountered – fear and mistrust of the police, fear of losing their children, perpetrator-favouring attitudes and disbelief of victims, lack of cultural competence, and racial stereotyping – underscore the urgent need for change.

There was also a glaring lack of a coordinated, whole-system response, with significant safeguarding gaps.

"They need to liaise more together. [...] They need to communicate."

As 'You Were Told' highlighted, **prevention must be the organising principle**. With the government's pledge to halve VAWG within a decade, a whole-system approach must prioritise prevention by tackling root causes.

Government should embed a cross-government BMM strategy within the national VAWG framework to uproot entrenched misogyny and racism within statutory and non-statutory agencies and guarantee access to specialist, community-based 'by and for' support. Reform must be comprehensive across the whole spectrum of policing, health, social care, education, DARDRs, the CPS, the courts and sentencing.

It must include concrete measures to equalise rights and protections for all victim-survivors, supported by practice standards, sustained training led by specialist community organisations, and meaningful community awareness work that challenges harmful attitudes, including those amplified online.

Migrant women are among the most marginalised, with the fewest protections. Research shows that migrant women with NRPF are three times more likely to experience VAWG. Any effort to equalise rights and protections for all victim-survivors must recognise this reality and work to close the gap.

Organisations with decades of frontline experience, such as SBS and the Latin American Women's Rights Service, have long called for **urgent reforms: a full firewall between the police, other statutory agencies and Immigration Enforcement** to prevent data-sharing and the weaponised use of deportation and detention, and a combined model of protections – the Migrant Victims of Domestic Abuse Concession and the Domestic Violence Indefinite Leave to Remain rule – enabling victim-survivors with NRPF to access public funds while regularising their stay regardless of immigration status.

Together, these measures would significantly reduce dual perpetration against migrant women by the state, both ensuring their safety and encouraging the reporting of abuse.

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"I would like to see women being heard. And being listened to. And being safeguarded. At the best interests of them and their kids."
"We just need to eradicate violence against women. This is something that has happened not once, but many times. And it needs to stop. It appears there's a loophole in the system, and I think that people who are vulnerable, who suffer from domestic violence, and because of their race and ethnicity, aren't always given the immediate actions as someone who might be white or of a different ethnicity background. However, the message is that we're all in this together, we're all women, and we need to be treated with respect."

B. REFORMS IN POLICING AND THE JUSTICE SYSTEM

Families identified the **police's response to VAWG as a primary area in need of change.** They expressed concern that, despite longstanding and mounting evidence of police failures to safeguard women – particularly BMM women affected by intersectional discrimination – lessons continue to go unheeded, with families noting that "they're making the same mistakes all the time".

"In terms of justice, I would like for cases to be investigated properly. Also, for the police and other officials to look at domestic violence and the impact it has on individuals, and why it may be difficult for them to come forward to get help."

There is undoubtedly an **urgent need to strengthen police accountability** through independent review of domestic abuse and HBA case handling, with clear escalation routes, supervisory sign-off on high-risk decisions, and published rationales for screen-outs/No Further Actions (NFAs).

Investigations **must improve from first contact:** mandatory BMM domestic abuse/HBA flags (including forced marriage), early assignment of specialist leads, standardised risk tools and early-evidence kits, coordinated safety planning with health and social care, and clear duties to share information with victims and bereaved families before and after a death.

Families also urged that misogyny and racism within policing be actively tackled and stamped out; along with improving the response to victim-survivors in 999 control rooms to align with the safeguarding intent of 'Raneem's Law,' and providing targeted training – especially on HBA. Families highlighted statutory agencies' repeated failures to identify or respond appropriately, suggesting the **critical need for the 'one chance' rule** and culturally appropriate approaches that address institutional racism and non-intervention on cultural and religious grounds.

The need for reform on HBA was also raised in relation to establishing a statutory definition and sentencing considerations. The statutory framework **should include a legal definition of HBA, accompanied by linked duties on identification, investigation, protection and safeguarding,** developed through a comprehensive consultation with all relevant stakeholders, including specialist 'by and for' service providers. Sentencing should better reflect the gravity of domestic abuse and HBA. Killed Women has formally requested that government explicitly recognise 'honour' as an aggravating factor in sentencing; this sits within ongoing sentencing reform/review work and would strengthen the case for Banaz's Law. Families repeatedly expressed concern that current sentences often fail to reflect the severity of domestic homicides, leaving victims and their families underserved.

Specifically, families advocated for **recognising 'honour' as an aggravating factor in sentencing** to improve responses to BMM victim-survivors and to foster normative change within communities. Known as 'Banaz's Law' and tabled in the House of Commons under the Criminal Justice and Crime and Policing Bills, this reform has garnered support from over 50 MPs and the Women and Equalities Committee, which stated: "Explicitly recognising so-called honour in sentencing guidelines [...] would strengthen the understanding that honour-based abuse is taken seriously by the criminal justice system and only ever as an aggravating factor."

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The proposed reform is intended to be accompanied by extended statutory guidance to ensure that HBA is neither missed nor dismissed by statutory agencies, and cannot be leveraged by perpetrators as a defence in homicide or other crimes.

Families also called for additional sentencing reforms, such as extending prison time for perpetrators who attempt to avoid consequences by refusing to attend sentencing. This reform, proposed under the Victims and Courts Bill currently in Parliament, is intended to give judges greater powers to hold perpetrators accountable.

Beyond sentencing, families emphasised the need for improved support throughout the justice process – from the initial notification of a loved one's death and the subsequent investigation to post-trial support.

C. IMPACTS ON CHILDREN AND THE REFORMS NEEDED

Families shared that their loved ones, while still alive and attempting to secure help from statutory agencies, were profoundly failed. This was compounded by the weaponised fear of losing their children and by entrenched system-wide narratives that consistently portrayed perpetrators as 'good fathers'. Families also expressed profound concerns about the conduct of non-statutory agencies, particularly the media, which often retraumatised children through harmful and insensitive coverage. In these situations, the needs of women and children were rarely centred, with priority instead given to the rights of perpetrators.

"And one woman murdered not only ends her life, but destroys the lives of her loved ones, leaving them with a lifetime of grief and pain. And it's a massive ripple effect for many generations to come. You've got parents without their daughters. You've got children without their mothers."

"It's just the rights of the man, again, always central. And the voice of the children, the women, completely decimated. How [are] children not taken into account, their experiences [...] not heard?."

Even after the deaths of their loved ones, women and children continue to be invisibilised by the system. One family shared that their loved one's children, who had been at their home almost every other day, were taken away by social services, and that they were prevented from having any contact with them while the trial was ongoing. The family expressed deep concern about the impact of this decision on both the children and the grieving relatives, describing how it may have felt to the children as if their family had disappeared from their lives and "weren't there for them in that most crucial time, when they were screaming for their mum".

They added that, in their time of grief, this "fed [their] devastation", as not only had they lost their loved one, but her children were also taken from them, with all contact completely cut off. They described this as the "cruelty of the system", which exposed both the children and the grieving family to further harm during an already unbearable period.

Another family shared that, following the loss of their loved one, the children had to be moved out of the borough and sent to a new school. Yet another family described how media coverage led to their loved one's children being bullied at school, creating a continuing "domino effect on the family".

A different family explained that agencies had also failed to protect not only their loved one but their own children. While providing evidence, they were intimidated through lines of questioning that threatened to reveal their children's identities and put them in danger, particularly in a case involving multiple abusers perpetuating HBA.

Families highlighted the urgent need for stronger responses to children as victim-survivors and witnesses whose testimonies must be recognised and respected. They called for reform of the family court system, which they felt too often favours perpetrators – predominantly men – at the expense of women and children, creating a forum for post-separation abuse.

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Families also advocated that **perpetrators who have murdered the other parent should be denied contact** with their children. They further urged that bereaved families be given the authority to decide whether DARDR reports are published in the public domain, noting that there may be concerns about children discovering the details of their mothers' experiences before their families feel they are ready to know and have that conversation.

D. QUALITY ASSURANCE AND SCRUTINY: DOMESTIC ABUSE RELATED DEATH REVIEWS AND INQUESTS

"[Domestic] Homicide Review, it's a document that should be like a booklet for all your agencies to go back to and look into."

Families emphasised that the **recommendations arising from DARDRs must be implemented** if meaningful learning is to be achieved.

The government should act on the Domestic Abuse Commissioner's (DAC) proposals regarding the Domestic Abuse Related Deaths Accountability and Oversight Mechanism. It should strengthen its response to, and implementation of, review recommendations, and improve capacity and resourcing to deliver these reviews locally.

In particular, **a DHR Scrutiny Panel for ethnic minority deaths should be established, with bereaved-family participation and 'by and for' expertise,** publishing time-bound action plans and tracking implementation. 'By and for' services must be mandatorily engaged even if the victim had no prior contact with such organisations so that the intersectional nature of abuse and discrimination is fully understood. Given their specialist expertise, these organisations must be compensated for their time, especially where they contribute regularly to review panels.

Families reported mixed experiences with inquests. One described their loved one's death as not having been investigated fairly or sensitively by either the police or the inquest process, while another acknowledged the significance of their inquest outcome but stressed that it was achieved only after extensive family advocacy. These experiences highlight **the need for stronger oversight and accountability within the inquest system.**

Coroner scrutiny should be strengthened: coroners should interrogate institutional decision-making (police, CPS, health, social care), invite expert HBA/forced-marriage evidence and specialists, flag systemic failings in narrative conclusions, issuing formal notifications to oversight bodies.

Ideally, **DARDRs should precede inquests, enabling coroners to draw on their findings to fulfil their duty of establishing the facts of a death** in the public interest and considering whether statutory failings contributed. As recommended in earlier research, where an inquest occurs first, and a subsequent review identifies state failings that contributed to the death, the chair of the review panel should share the report with the relevant coroner. This would allow the coroner to consider resuming or reopening the inquest. Bereaved families must be informed of this process and advised that they may wish to seek independent legal advice for the inquest. Families should also be entitled to full legal aid regardless of income.

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E. FAIR REPORTING AND VISIBILITY STANDARDS FOR BMM GROUPS

Families reported that media coverage often compounded their trauma, with breaches of privacy, victim-blaming narratives and sensationalism harming the memory of their loved ones and retraumatising surviving children, while ethical reporting that amplified victims' voices was rare and inconsistently applied.

Media and public communications **should meet clear standards** that prohibit victim-blaming or shaming rooted in racism or misogyny, mandate accurate domestic abuse/HBA terminology, and ensure timely, balanced coverage. Newsrooms and public bodies (including police and local authority press offices) should adopt style guides and pre-publication checks to avoid stereotypes, provide context on institutional failings, and centre victims' dignity. Bereaved families should be offered a meaningful right of reply and safe, trauma-informed engagement. Independent regulators (e.g., Independent Press Standards Organisation, Ofcom) should monitor compliance and publish periodic audits, with corrective notices where standards are breached.

This approach advances visibility with accuracy and respect, strengthens accountability through oversight, and supports systemic reform in how reported cases are communicated to the public.

F. CULTURALLY COMPETENT SUPPORT AND SPECIALIST SERVICES

Families reported that their loved ones – often extremely vulnerable and repeatedly seeking help – were systematically failed by statutory agencies, who denied culturally appropriate support, mismanaged clear indicators of abuse, exhibited victim-blaming and racialised responses, provided inadequate safeguarding and investigation, and left both victims and bereaved families without trauma-informed care or meaningful engagement. They highlighted recurring, intersectional failings in policing and service provision that demand urgent reform.

All statutory agencies should meet standards for cultural competence, including anti-racist practice standards. Workforce standards should mandate annual training, supervision on bias, HBA/forced-marriage practice, and trauma-informed approaches, co-designed and delivered with specialist community organisations. Government should embed certified interpreters (no family/community substitutes), and guarantee safe-reporting routes for women with insecure status.

Families also highlighted the vital role played by specialist, community-based 'by and for' services for BMM women and girls, stressing the urgent need for sustainable funding as part of a whole-system response to tackling VAWG.

> **"Funding is so important. [Services] need support, they need funding to be able to continue to make changes for women."**

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Families warned that without proper investment, it is difficult to see how these services can continue delivering life-saving support or leading campaigns grounded in lived experience that drive essential changes in law, policy and practice.

Government must ensure that every BMM woman can access timely, trusted and culturally competent support – regardless of immigration status – that prevents abuse from escalating, reduces risk, and reduces domestic homicide through evidence-based, community-led services integrated across policing, health, social care and justice.

Commissioning must shift from short-term pilot schemes to multi-year core funding for specialist 'by and for' BMM domestic-abuse services – covering refuge spaces, immigration-informed advocacy and access to legal aid – so that support is reliable, trauma-informed and accessible.

Evidence shows that despite being proven "extremely effective," 'by and for' services face a 39% funding shortfall and are six times less likely to receive statutory funding than other providers. This is in spite of evidence showing that investment in these services generates significant returns, with an estimated £127 million in national savings through their holistic, wraparound and culturally competent support.

Reform must therefore include a clear government commitment to close the funding gap and resource 'by and for' services at a level commensurate with need. This requires a sustainable, long-term, ring-fenced allocation dedicated to BMM victim-survivors. In her February 2025 submission to the Spending Review, the DAC called for £158.3 million to be ring-fenced for 'by and for' services, alongside £63.5 million in dedicated funding for victim-survivors with NRPF.

G. DATA AND TRANSPARENCY

Families have consistently called for greater transparency and access to information about how cases are handled and decisions made.

To anchor accountability, **BMM VAWG ethnicity data must** be mandated across police, CPS, courts, health and social care – including HBA/forced-marriage flags – with quarterly public reporting. A single cross-agency dashboard should track risk, key decisions, outcomes and compliance, enabling independent scrutiny and continuous learning.

These measures – taken together – move beyond isolated fixes. They create a coherent framework in which BMM women and girls are protected and believed, bereaved families are informed and supported, institutions are answerable for their decisions, and progress is visible in the data as well as in people's lives.

CONCLUSION

We urge the system to take the testimonies of bereaved families seriously and act on their calls for change. Their loved ones' deaths were preventable, and their voices must drive reforms that confront institutional failings and discrimination. Only through meaningful, systemic transformation can we honour their loss and ensure that no more women and girls' lives are needlessly taken by violence.

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