POLICING HONOUR-BASED VIOLENCE WITHIN THE UK: THE IMPORTANCE OF AN HONOUR-BASED VIOLENCE RISK ASSESSMENT TOOL AND THE VALIDITY OF ‘DASH’

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This dissertation is submitted in fulfilment of the requirements of Level 6 of the BSc (Hons) Policing

June 2015
ABSTRACT

Although practised in some parts of the world for centuries, honour-based violence is a relatively new and unfamiliar concept for Western law enforcement. This unfamiliarity has hampered the UK police’s ability to effectively protect honour-based violence victims. This paper contextualises this unfamiliarity by describing the origins, behaviours and characteristics of honour-based violence, and the impact this has had on UK policing, in order to argue that a competent honour-based violence risk assessment tool is fundamental to the effective policing of this crime. Drawing on evidence within academic literature, the current tool, known as ‘DASH’ (Richards, 2009), which is endorsed by the National Police Chiefs’ Council and used by UK police forces to risk assess honour-based violence victims, is then critically analysed within this paper to ascertain whether it is fit to assess honour-based violence risk. The analysis reaches the conclusion that DASH is, in fact, not fit for this purpose and recommendations will be made to remedy this deficiency, along with wider suggestions for improving the UK police’s ability to effectively protect honour-based violence victims.
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INTRODUCTION

The National Police Chiefs’ Council (NPCC), formerly the Association of Chief Police Officers (ACPO), defines honour-based violence (HBV) as “a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community” (ACPO, 2008, p. 5). HBV is prevalent amongst some Black Minority Ethnic (BME) communities in various parts of the world and is also committed on UK soil (Gill 2005a, 2008b, 2010; The Job, 2006; Keyhani, 2013; Payton, 2014; Atherley, 2007; Belfrage et al, 2012; Siddiqui, 2005; Pertile, 2008; Roberts et al, 2014; Salter, 2013; Dean 2008).


There are wider aspects to HBV that were considered in the research for this paper, such as the practice of Female Genital Mutilation (FGM) (FCO and Home Office, 2014b; Roberts et al, 2014); the presence of male victims (Atherley, 2007; Roberts et al, 2014; Dogan, 2014; Asif, 2005a and Kvinnoforum, 2004, cited in Atherley, 2007, p. 34; Siddiqui, 2005; Shah Kakakhel, 2004); and honour-related violence within gang cultures (Salter, 2013). However, they fall outside the tighter scope of this work as this paper focuses on the UK police response to living female victims/potential victims who have come to the attention of the police because they are currently subject to, or suspect that they will be subject to, HBV in response to a perception that they have dishonoured their family.

Despite its presence, HBV is a relatively unfamiliar concept for Western law enforcement agencies, and the public alike (Gill, 2005b, 2008; Reddy, 2008; Dustin and Phillips, 2008; Siddiqui, 2005; Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006; Pertile, 2008; Brandon and Hafez, 2008; Olwan, 2014). It is estimated that at least five thousand honour killings occur worldwide each year (United Nations, 2000, cited in Roberts et al, 2014, p. 9). In the UK, the Crown Prosecution
Service (CPS) estimated that the police dealt annually with approximately twelve honour killings in the last decade (Gill, 2010; ACPO, 2008) and, although the literature does not present more recent UK statistics for honour killings specifically, the Metropolitan Police Service (MPS) in 2010 (Payton, 2014) estimated that it had dealt with almost three thousand HBV-related crimes that year, in comparison to five hundred incidents in the mid-2000s (The Job, 2006; ACPO, 2008; Belfrage et al, 2012). However, growing police awareness of honour-related crimes, and victims’ realisation that they have recourse to justice, may account for this increase, rather than a rise in perpetration, per se (Payton, 2014).

HBV only began to grab the UK police and public’s attention during the early 2000s thanks to the high-profile media coverage of honour killing victims such as Heshu Yones (Dustin and Phillips, 2008; Siddiqui, 2005). This previous lack of awareness has had a negative impact on the effective policing and risk assessment of HBV within the UK (Roberts et al, 2014; Payton, 2011, cited in Salter, 2013, p. 108; Home Affairs Committee, 2008; Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006; Pertile, 2008; Brandon and Hafez, 2008). Victims have had difficulty reaching out for help, getting police attention, being believed and receiving effective protection (Dean, 2008; CRASAC, 2014; Payton, 2014; Belur, 2008; Gill, 2008a). However, over the past decade, there has been an increase in awareness amongst the police, government and other agencies in the UK (ACPO, 2008; Gill, 2008b) in terms of understanding HBV as a subject matter and striving to find better ways to police it. This has led to the creation of a risk assessment tool which accommodates risk factors for HBV (Home Affairs Committee, 2008; Home Department, 2008), namely the ‘Domestic Abuse, Stalking, Harassment and Honour-based Violence’ (DASH) risk assessment checklist (see www.dashriskchecklist.co.uk; Richards, 2009, 2015).
which is used by police and other agencies in the UK (Roberts et al, 2014; Payton, 2014; Robinson, 2010; FCO and Home Office, 2014a).

DASH is predominantly a risk assessment tool for conventional domestic violence (DV), but incorporates risk factors for HBV, stalking and harassment. HBV has been linked with DV as the two forms of familial violence share many characteristics (Payton, 2014; Keyhani, 2013; Gill, 2004, 2008b; Baker et al, 1999; Belur, 2008; Burman and Chantler, 2005; Podaná, 2010; FCO and Home Office, 2014b; ACPO, 2008; Meyer, 2011; Baker et al, 1999; Domestic Abuse: Caught on Camera – Panorama, 2014; Dogan, 2014). In some ways, this, arguably, provides useful contextualisation which can help the police deal with this ‘alien’ crime. In other ways, this can be counter-productive as, firstly, the policing of DV is not without its own issues (Home Affairs Committee, 2008; Hoyle, 2008; Dichter and Gelles, 2012; Grauwiler, 2008; Meyer, 2011; Felson and Pare, 2008; HMIC, 2014; The Police Foundation, 2014), and, secondly, as well as similarities, HBV has significant differences from DV which require alternative policing techniques (ACPO, 2008; Papp, 2014; Araji, 2000; Gill, 2004, 2009; Belfrage et al, 2012; Roberts et al, 2014; Dustin and Phillips, 2008; Salter, 2013; Cooney, 2014; Brandon and Hafez, 2008; Baker et al, 1999; Dogan, 2014; Siddiqui, 2005; FCO and Home Office, 2014b; Pertile, 2010).

The discussion on effective UK policing of HBV is very relevant within today’s climate as Her Majesty’s Inspectorate of Constabulary (HMIC) is currently undertaking an inspection of this matter (HMIC, 2015). This follows its identification that HBV still appears to be overlooked by police and, to date, forces have never been independently scrutinised by any inspectorate on this matter. This is a timely
inspection as media reports continue to highlight HBV-related incidents – see last
month’s Rethishkumar case – where the UK police response could be considered
deficient (Halliday, 2015). The consequence of deficient policing can not only put
individuals in danger, but can negatively impact on the police’s reputation, resulting
in loss of public confidence (Kropp, 2004, 2008; Nicholls et al, 2013; Robinson,
2010; Bennett Cattaneo and Goodman, 2007; Kercher et al, 2010; Walklate and
Mythen, 2011; Roberts et al, 2014; Home Affairs Committee, 2008; Grant and Rowe,
2011).

Arguably, correct risk assessment of victims is one of the most important first steps
to effectively policing HBV (Home Affairs Committee, 2008; Roberts et al, 2014;
Bennett Cattaneo and Goodman, 2007; Robinson, 2010; Nicholls et al, 2013; Kropp,
2004; Robinson, 2010). Therefore, drawing on academic literature, this paper will
argue that an HBV-competent risk assessment tool is essential in the effective
policing of HBV. As DASH is the only HBV risk assessment tool endorsed by NCPP
and used by forces across the UK (Robinson, 2010; HMIC, 2014; The Police
Foundation, 2014), this paper will then undertake a critical analysis of DASH using
evidence extracted from the literature to establish whether it is fit to assess HBV risk.
To achieve these aims, this paper consists of three chapters.

Chapter one discusses the definition of HBV, and the honour mind-set behind it, to
illustrate how much it contrasts with Western thinking. This will help lay the
foundation of understanding as to why UK law enforcement has struggled over the
last ten to fifteen years to correctly assess the level of risk HBV poses to its victims
Committee, 2008; Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006;
Pertile, 2008; Brandon and Hafez, 2008). It is divided into sub-sections which discuss:  
a) the definition and origins of the honour mind-set; b) the consequences of losing honour and the means by which to restore it, emphasising the perceived necessity for violence; c) who subscribes to this mind-set; and d) how this mind-set has led to the increased subordination and victimisation of women. The impact of these factors on the UK police’s ability to assess victim risk of HBV is highlighted throughout, and, as HBV shares similarities to DV, it is argued why simply relying on DV policing techniques can be harmful.

Chapter two sets the scene for the policing experience of HBV in the UK, from the early to late 2000s, which emphasises the importance of an HBV-competent risk assessment tool. It is divided into sub-sections which discuss:  
a) how the police became aware of HBV; b) the policing relationship between HBV and DV; c) developments and set backs in the policing of HBV, which includes a case study; and d) how the police applied learning from this case study to improve its response to HBV incidents, which resulted in the conception of DASH.

Chapter three contains the critical analysis of DASH. Its initial three sub-sections lay the foundation for the analysis by discussing:  
a) the extent to which DASH features in the literature, noting its lack of empirical testing to date, thus emphasising the importance of the analysis within this paper; b) the background of risk assessment within law enforcement, and the methods used, to contextualise the format of DASH; and c) how DASH was created. The final sub-section contains the analysis itself which uses academic evidence presented in chapters one and two that has been drawn from the literature, to evaluate DASH’s predictive validity for HBV victims. In terms of risk, this paper concentrates on police assessment only. Wider elements
such as risk management, Multi-Agency Risk Assessment Conferences (MARACs) and Independent Domestic Violence Advisers (IDVAs) were considered in the research for this paper, but fall outside the tighter scope of this work (Roberts et al, 2014; Kropp, 2004; Robinson, 2010; Salter, 2013; Walkate and Mythen, 2011; Campbell, 2004; Gill and Baljit, 2008; Robinson and Howarth, 2012).

The concluding remarks of this paper will support the argument that a competent HBV risk assessment tool is fundamental to the effective policing of this crime. It will assert that, as a result of the critical analysis in chapter three, DASH is not fit to assess HBV risk, and will make recommendations for its improvement, along with wider recommendations for initiatives to assist further with the effective policing of HBV.
1. THE DEFINITION OF HBV AND THE IMPACT THIS HAS ON POLICE ASSESSMENT OF HBV RISK

In traditional Western understanding, honour is perceived as a positive character trait whereby an individual who has honour is considered virtuous, altruistic, who inspires the respect and trust of others, and who is of “good moral character” (Gill, 2004, p. 475; Gill et al, 2012; Vandello and Cohen, 2003, cited in Roberts et al, 2014, p. 1).

Another definition of honour – the definition that relates to HBV and that will be used throughout this paper – is similar in some ways to the Western understanding, in that this version of honour also indicates the presence of positive character traits, such as fidelity, loyalty and “good moral character” (Gill, 2004, p. 475, Gill, 2008; Siddiqui, 2005; Roberts et al, 2014).

However, there are two main differences associated with this version of honour. Firstly, it is understood as a form of “symbolic capital” (Bourdieu, 1977, quoted in Knudsen, 2003, p. 109). By this, it is meant that the presence or absence of honour is indicative of the level of status and reputation held, thus honour is power (Pitt-Rivers, 1966, cited in Roberts et al, 2014, p. 1; Payton, 2014; Gill, 2010; Baker et al, 1999; Sen, 2005, cited in Keyhani, 2013, p. 260; Brandon and Hafez, 2008). And secondly, rather than an individual having and being responsible for honour in their own right, exclusive of the behaviour of others, honour, in this respect, is intrinsically linked to family and the community (Gill, 2003, 2008b, 2009, 2010; Payton, 2014; McVeigh, 2013; Siddiqui, 2005; Brandon and Hafez, 2008; Stewart, 1994, cited in Knudsen, 2003, p. 110; Akpınar, 2003).

1.1 Origins of the Honour Mind-set

The origins of this honour mind-set are not entirely known (Dogan, 2014). However, it is speculated in the literature that it was first practiced centuries ago in tribal areas of both Afghanistan and what is now Pakistan (Atherley, 2007; Amnesty International, cited in Knudsen, 2003, pp. 115-6). Typical of frontier lands and wild terrains, it is theorised that these primitive societies needed to work together when resources were scarce and official law enforcement was not yet established, in order to survive (Roberts et al, 2014). In this regard, it was important to have loyalty amongst the group and a formidable reputation to discourage threats to the stability and survival of that group. Additionally, it is posited that the hunters of the group, typically men, often felt the need to control the sexual behaviour of their female partners in order to ensure that the food they risked their lives to obtain was utilised for the feeding of their own offspring and not that of another man (Brandon and Hafez, 2008). To this end, the sexual control of their partner would occur before,
during and after childbirth in order to secure the continuation of the man’s seed. Evolving from this was the notion that women were a form of property or capital to be guarded. The whole family stood to benefit from this capital and, gradually, this idea became ingrained and extreme over the centuries, cementing the subordination and de-humanisation of the female members of honour-based communities, resulting in the social norms experienced in this culture today (Brandon and Hafez, 2008; Reddy, 2008). As Roberts et al (2014, p. 409) neatly summarises “even though the social conditions that helped to frame those ideas in the past have totally disappeared, the ideas endure with a new mentality or rationale, and are transmitted from generation to generation”.

1.2 Consequences of Losing Honour

If family honour is stained, the consequences can be dire. The individual and their family are so closely interconnected with the community, that if the community bears witness to, hears of, or suspects an honour transgression has taken place, whether it is true or not, this will likely result in complete shaming and ostracism of the family concerned (Akpinar, 2003; Siddiqui, 2005; Atherley, 2007; Dogan, 2013; Cooney, 2014; Onal, 2008; USA: Department of State, 2006, cited in Nasrullah et al, 2009, p. 1). They will be socially outcast from their community, losing business and being unable to arrange marriages for their daughters, all of which threatens their ability to survive. They may also be subject to community gossip, harassment, stigmatisation and ridicule (Pope, 2012 and Goffman, 1963, cited in Payton, 2014, p. 2865; Cooney, 2014; Knudsen, 2003; Keyhani, 2013).
1.3 Restoring Honour – Committing HBV

If a woman damages her family’s honour, the only remedy to restore their honour is to punish the woman, usually with violence or murder, which is generally carried out by a male member of her natal family, or her husband if she is married (Atherley, 2007; Nasrullah et al, 2009; Belfrage et al, 2012; Payton, 2014). Whether the male wants to be the perpetrator of violence or not, his conscious or unconscious investment in the notion of ‘hegemonic masculinity’ (Connell and Messerschmidt, 2005; Durfee, 2011; Connell, 1987, cited in Hester, 2012, p. 1068) within what Sharabi (1988, quoted in Araji, 2000, p. 3) describes as a “neo-patriarchal” culture means that, as a man, he feels under immense pressure by his family and/or community to carry out the violent act. If he does not, he is likely to be subject to ridicule and further shame for being ‘unmanly’, which, again, affects not only him, but his entire family (Gill, 2004; CIMEL and INTERIGHTS, 2001; Akpinar, 2003; Gilmore, 1987, and Abu-Odeh, 1996, cited in Reddy, 2008, p. 307; Belfrage et al, 2012; Dogan, 2013; Campbell, 1964, cited in Baker et al, 1999, p. 169).

The violence, particularly killings, tend to be decreed in advance by the family head, usually the father, at specially arranged family meetings, in the absence of the intended victim, where several members of the family, including females, collude in the punishment (Roberts et al, 2014; Salter, 2013; Chesler, 2009, cited in Papp, 2014, p. 116; Dustin and Phillips, 2008; Gill, 2009; Khafagy, 2005; Cooney, 2014; Dogan, 2014). Female colluders may feel pressured into participation due to their conscious or unconscious investment in their own survival, which depends on their family’s collective ability to earn money and produce marriageable women (Pope, 2012 and Goffman, 1963, cited in Payton, 2014, p. 2865; Cooney, 2014; Knudsen, 2003; Keyhani, 2013; Roberts et al, 2014; Gill, 2010; Gill et al, 2012; Khafagy, 2005;
Kressel, 1981, cited in Baker et al, 1999, p. 172). Conversely, although less frequent, women may be the driving force behind the violence, but this usually occurs if, for example, the senior male appears too weak to orchestrate the punishment or his investment in symbolic capital is less than the senior female of the family (McVeigh, 2007; Roberts et al, 2014; Mora, 2009, cited in Keyhani, 2013, p. 263; Papp, 2014).

It is pertinent to pause for a moment and consider the impact that the meaning of honour, and its relationship with violence, has on the policing of this crime. The two aspects of this interpretation of honour: a) its value as symbolic capital; and b) its shared ownership within the group, mean that when HBV takes place there is often widespread collusion within the family and community to ensure that the act is carried out and kept hidden from any opposing force (Roberts et al, 2014; Salter, 2013; Chesler, 2009, cited in Papp, 2014, p. 116; Dustin and Phillips, 2008; Gill, 2005a, 2008b, 2009, 2010; Gill et al, 2012; Khafagy, 2005; Cooney, 2014; Dogan, 2014; IKWRO, 2014; Siddiqui, 2005; ACPO, 2008; Smartt, 2006, cited in Keyhani, 2013, p. 259). As a result of this collusion, police responders and investigators are dealing with multiple perpetrators and are met with a conspiracy of silence within the community, which is immensely difficult to penetrate (Gill 2005a, 2008b; Gill et al, 2012; Siddiqui, 2005; Smartt, 2006, cited in Keyhani, 2013, p. 259).

This highlights a fundamental difference between HBV and DV: within DV the perpetrator is usually an intimate partner, who acts alone, and their behaviour is seen as abhorrent by their family and/or community (Roberts et al, 2014; Dustin and Phillips, 2008; Salter, 2013; Gill 2009; ACPO, 2008; Chesler, 2009; Pimentel et al, 2005, cited in Cooney, 2014, p. 409; Brandon and Hafez, 2008; Baker et al, 1999;
Araji, 2000). However, within HBV the collusion of the honour group is akin to the conspiratorial nature of organised crime (Roberts et al, 2014; CPS, 2010, cited in Salter 2013, p. 108; Brandon and Hafez, 2008; Reddy, 2014; Home Affairs Committee, 2008; Home Department, 2008). Therefore, the application of DV policing techniques and DV-specific risk assessment tools, within an HBV context, can prove extremely counter-productive (Roberts et al, 2014; FCO and Home Office, 2014b; Burman and Chantler, 2005). For example, where there are disputes/issues within families, a popular DV policing technique is to instigate family mediation to help the family reconcile their differences (Siddiqui, 2005; Pertile, 2010). Within an HBV context, the only reconciliation comprehensible to the family is when the honour transgressor has been punished (Brandon and Hafez, 2008; Gill, 2004; CIMEL and INTERIGHTS, 2001; Akpinar, 2003; Gilmore, 1987, and Abu-Odeh, 1996, cited in Reddy, 2008, p. 307; Belfrage et al, 2012; Dogan, 2013; Campbell, 1964, cited in Baker et al, 1999, p. 169; FCO and Home Office, 2014b). Mediation gives the family an opportunity to strike by providing access to the victim and has, therefore, been condemned as “potentially dangerous” (FCO, 2004, 2005, cited in Meetoo and Mirza, 2007, p. 193).

The members of this conspiracy are a mixture of those who approve of the violence and those who do not, but are compelled to support these criminal activities for fear of reducing their group’s symbolic capital by invoking further shame due to their contact with the police (CRASAC, 2014; Siddiqui, 2005; CIMEL and INTERIGHTS, 2001; FCO and Home Office, 2014b; Menjivar and Salcido, 2002, cited in Salter, 2013, p. 106; McVeigh, 2013). A potential or actual victim or witness of HBV faces a huge risk of complete social ostracism of themselves, and/or their family, or extreme harm/death if they approach the police for help (CRASAC, 2014; Siddiqui, 2005;
CIMEL and INTERIGHTS, 2001; FCO and Home Office, 2014b; Roberts et al, 2014; Payton, 2014; Gill, 2014). They may be heavily supervised by their family, possibly under house arrest or, if allowed out, will be under close surveillance by the wider community who will report their movements back to the family (Atherley, 2007; Salter, 2013; Gill, 2008b, 2009, 2010; IKWRO, 2014; Siddiqui, 2005; ACPO, 2008; Payton, 2014; Brandon and Hafez, 2008; FCO and Home Office, 2014b; Belfrage et al, 2012). Therefore, the police need to be acutely aware of these complexities when conducting risk assessments. For example, it may be very difficult to get a witness within the family or community to support the victim’s complaint, either because they support the need for HBV towards the victim or they are afraid of putting themselves in danger by speaking up (Roberts et al, 2014; Payton, 2014). Alternatively, the victim herself may try to withdraw from police contact or pretend everything is fine. Perhaps this is due to family pressure or because she fears the police are not being discrete enough, or simply because she still loves or depends on her family and does not want to bring further shame on them or get them into trouble with the police (ACPO, 2008; Salter, 2013; Dean, 2008; CRASAC, 2014; Siddiqui, 2005; FCO and Home Office, 2014b; Belur, 2008; Burman and Chantler, 2005; Murray, 2008). All these factors make HBV victims highly vulnerable (Gill, 2004; Belfrage et al, 2012), and the police must never assume that the risk of harm has suddenly gone away, reduced, or that there was never any risk in the first place (Gill, 2008b, 2009, 2010; IPCC, 2008; Belur, 2008).

1.4 Subscribers of the Honour Mind-set

A family that is considered to have honour is afforded a good reputation and status within their community. This translates to better security and opportunities, both socially and in business (Brandon and Hafez, 2008), and the ability to wield influence
over others and the community (Nisbett and Cohen, 1996, cited in Salter, 2013, p. 107). Echoing conditions from the past, this type of honour culture thrives in societies “where state authority is weak [therefore] family status becomes all important, and in this context honour becomes a vital key to accessing societal resources” (Atherley, 2007, p. 27).

There is no consensus in the literature as to which socio-demographic group the honour mind-set belongs to. A popular belief is that it is a religious tradition, specifically Islamic (Kulwicki, 2002, cited in Nasrullah et al, 2009, p. 3; Gill, 2010), however there is evidence of HBV affecting Sikh, Hindu and Christian families as well as other religions (McVeigh, 2013; Papp, 2014; CRASAC, 2014). Equally, some argue that HBV is either an issue of culture (Pertile, 2008; Tripathi and Yadav, 2004; ACPO, 2008 or gender, as victims are mainly women (Gill, 2010; Reddy, 2008; Shah Kakakhel, 2004).

The literature revealed that Gill (2003, 2004, 2005a,b, 2006, 2008a,b, 2009, 2010, 2014; Gill and Baljit, 2008; Gill et al, 2012) is by far the most prolific academic author of the UK criminal justice response to honour crime. She positions HBV as a gendered crime against women and is very critical of UK law enforcement and the government’s approach to dealing with HBV. Although Siddiqui (2005), who shares similar views to Gill, appears to have produced less in terms of volume of work, she is well referenced amongst the literature (Keyhani, 2013; Dustin and Phillips, 2008; Salter, 2013; Meetoo and Mirza, 2007; Atherley, 2007; Yurdakul and Korteweg, 2013) as is Welchman and Hossain’s (2005) book “Honour: Crimes, Paradigms, and Violence Against Women” (Belfrage et al, 2012; Roberts et al, 2014; Salter, 2013; Reddy, 2008; Gill et al, 2012; Keyhani, 2013; Gill, 2010, 2009; Papp, 2014). Others
explain that psychological factors, rather than religious, cultural or gender aspects, influence an individual’s propensity to commit HBV (Roberts, 2014; Roberts et al, 2014; Dogan, 2013).

There does, however, seem to be consensus on where, around the globe, the honour mind-set is most predominantly present. This tends to be within communities from developing countries, for instance, within South East Asia, the Middle East, parts of Africa, some Latin and South American Countries, and parts of Europe (Atherley, 2007; Gill, 2008b, 2010; Belfrage et al, 2012; Johnson and Lipsett-Riverra, 1998, cited in Roberts et al, 2014, p. 18; Dean, 2008; Safilios-Rothschild, 1969). Recent migration has resulted in first, second and third generation immigrants from these regions settling in Western countries, such as the UK. However, some of these settlers still commit acts of HBV (Atherley, 2007; Roberts et al, 2014; Belfrage et al, 2012; Brandon and Hafez, 2008; The Job, 2006; Reddy, 2008; Meetoo and Mirza, 2007). Although, it must be noted that not all members of these immigrant communities can be stereotyped as condoning HBV (Atherley, 2007; Papp, 2014; Roberts et al, 2014).

Despite the threat of basic survival now removed as a result of living in a developed country where health, education, financial and law enforcement infrastructures are more advanced, one might assume that living by these honour principles is redundant and can be abandoned. However, the importance of honour as symbolic capital is still very much ingrained in the hearts and minds of these individuals and are also socialised, to a greater or lesser extent, into their children, despite being born and raised in a Western country (Brandon and Hafez, 2008). This is perpetuated by the close-knit dynamics of these communities and their tendency to
deal with matters internally to reduce reputational damage (Atherley, 2007; Ginat, 1979, and Kressel, 1981, cited in Baker et al, 1999, p. 171; Payton, 2014). This lies in contrast to the modern Western trend to function as an isolated, nuclear family (Araji, 2000). In this way, it is easier to keep HBV out of the consciousness of the majority Western population.

This presents a huge challenge for the policing of HBV as these communities regard the committing of violence in the name of honour as just (Hussein, 2010, cited in Gill et al, 2012, p. 76; Cooney, 2014; Gill, 2010; Knudsen, 2003; Belfrage et al, 2012), yet understand the laws of the land in which they dwell do not permit this behaviour. They will, therefore, go to great lengths to keep HBV hidden from outsiders (Gill, 2005a, 2008b; Gill et al, 2012; Siddiqui, 2005; Smartt, 2006, cited in Keyhani, 2013, p. 259). This is one of the main reasons why UK police are so unfamiliar with HBV – they are rarely exposed to the presence of HBV and do not understand it as the majority of officers have no personal or observational experience of this mind-set (Atherley, 2007; IKWRO, 2014; Pertile, 2008; Brandon and Hafez, 2008; Belur, 2008). They, arguably, believe it to be so implausible, from their Western perspective, that it could not possibly be real (Gill, 2008a,b, 2010; Roberts et al, 2014; Salter, 2013; CRASAC, 2014). In parallel, academic literature and research on HBV is noticeably sparse (Gill, 2010, 2008b) with studies tending to rely on media reports as the source of their data (Chesler, 2010, Hussein, 2009, Kressel, 1981, and Sliman 2005, cited in Dogan, 2014, p. 390; Khafagy, 2005; Safilios-Rothschild, 1969). Added to this, the majority of DV studies concentrate on single, intimate partner perpetrators as well as insufficiently differentiating between the experience of white and BME victims (Salter, 2013; Smith 1989, cited in Belur, 2008, p. 429).
This lack of exposure and understanding increases the likelihood of the police to underestimate the risk of harm to victims or apply inappropriate policing techniques, as mentioned above (Siddiqui, 2005; CRASAC, 2014; Payton, 2014; IPCC, 2008). Arguably, therefore, a suitable risk assessment tool which guides and enhances first responding officers’ professional judgement in evaluating HBV risk is fundamental (Home Affairs Committee, 2008; Bennett Cattaneo and Goodman, 2007; Robinson, 2010; Nicholls et al, 2013).

1.5 Women’s Subordination and Tell-Tale Signs of Risk

As established many centuries ago, today’s communities who subscribe to this honour mind-set still view their women as subordinate property under the control of men within the family (Bond, 2014; Keyhani, 2013; Gill, 2008b; Baker et al, 1999; Payton, 2014; Pertile, 2010; Roberts et al, 2014). As such, women are held back from educational and employment opportunities, and denied inheritance (Awwad, 2004 and Goodwin, 1995, cited in Atherley, 2007, p. 27; Roberts et al, 2014; Gill, 2005a; CRASAC, 2014). These characteristics can be tell-tale signs to the police of heightened victim risk, as withdrawal from education and employment are highlighted in the literature as risk factors indicating the likely onset of HBV (Gill, 2005a; CRASAC, 2014; Atherley, 2007). However, these are not empirically validated risk factors for DV (ACPO, 2008; Papp, 2014), and, therefore, highlights another difference in characteristics between the two forms of familial violence.

The men, within these families, are held in high esteem as they financially support the family and continue its lineage (Roberts et al, 2014). In contrast, the women are seen as a burden and are often neglected or mistreated during childhood (Roberts et al, 2014; ACPO, 2008), and then married off at an early age to begin, arguably, their
sole reason for existence – that of child bearer and house keeper (FCO and Home Office, 2014b; Atherley, 2007; Roberts et al, 2014; The Job, 2006). This may bring with it the benefit of a ‘bride price’ (Agosin, 2001, cited in Atherley, 2007, p. 27; Roberts et al, 2014) where the bride’s family receives payment from the husband’s family to facilitate the exchange of property – the bride. However, and more commonly, it is the bride’s family who must pay the husband’s family, known as a ‘dowry’, to compensate for the transfer of burden (Samad and Eade, 2001, cited in Atherley, 2007, p. 28; Roberts et al, 2014). The value of the dowry is linked to honour which can be a source of shame for the bride’s family if the dowry is perceived by the husband’s family as insufficient (Tripathi and Yadav, 2004). This puts the bride at risk of harm from both her natal and husband’s family.

These communities value inter-familial marriages, in other words, the bride and groom may be as closely related as first cousins, which is common practice, and may be betrothed to one another from birth (FCO and Home Office, 2014b; Atherley, 2007). Families arrange such marriages in order to hold on to their wealth (Roberts et al, 2014) and to “uphold social structures and the alliances between families and clans” (Gill et al, 2012, p. 76). In this way, love and romance are not viewed as important and often the bride and, sometimes, the groom, have no say in their pairing (Samad and Eade, 2002, cited in Atherley, 2007, p. 31; Gill et al 2012; Knudsen, 2003). The rights of the family supersede the rights of the individual (McVeigh, 2013; Gill, 2008b, 2009).

The literature indicates that recent marriage can be a strong risk factor for the onset or presence of HBV, both in the context of insufficient dowry or the fact that the marriage itself may have been forced (Tripathi and Yadav, 2004; Dean, 2008;
Atherley, 2007; Roberts et al, 2014; Reddy, 2008; IKWRO, 2014; Gill 2008b; Dustin and Phillips, 2008; Belfrage et al, 2012; Siddiqui, 2005). This is contrary to the literature on DV where recent marriage is not present as a risk factor. Herein lies another example of how women’s subordination relates to risk and the need for officers to understand the complexities of HBV and to look beyond the context of DV so they are aware of the wider questions they need to ask the victim in order to build up a comprehensive picture of her exposure to threat when forming a risk assessment (Roberts et al, 2014; Payton, 2014).

Paradoxically, the women’s subordination does not relieve them of responsibility. The “custodian” of honour is the man (Gill, 2003, p. 18), however, the onus is predominantly on the woman to maintain it (Gill, 2005a, 2009). Whilst men are able to attain and increase honour through their “overt masculinity” (Atherley, 2007, p. 27), women are predominantly fuelled with what Kandiyoti (1988, cited in Gill, 2009, p. 479) describes as “negative power”, whereby they can either maintain their family’s honour, through their submissive and virtuous behaviour (Atherley, 2007) or lose it by behaving in a way that transgresses the behavioural expectations that require a female to be modest, submissive and sexually pure (Gill, 2003; Atherley, 2007; Roberts et al, 2014; Keyhani, 2013; Gill et al, 2012; Siddiqui, 2005).

Recalling the origins theory above, and noting how the notion of controlling women from those primitive societies became more extreme over time, today’s behavioural expectations saturate a woman’s existence, affecting not only her overt sexual conduct and relationship to others, but trivial aspects such as her choice of clothing, physical posture and speech (Roberts et al, 2014; Gill, 2003; Atherley, 2007; Belfrage et al, 2012; CIMEL and INTERIGHTS, 2001; ACPO, 2008).
Any one of the following behaviours, conducted by the woman, could result in the loss of her, and her family’s, honour: sexual relations before marriage; courtship or marriage to a man unapproved of by the family; association with an individual considered of ‘inferior’ racial/ethnic/caste/class; rejecting a marriage arrangement made by the family; an extra-marital affair; seeking a divorce or separation; homosexual behaviour; pregnancy outside marriage; being the victim of rape; intimacy in public such as kissing; answering back/rejecting orders; being too loud; behaving in a masculine way; being proud and confident; running away and truanting; being too ‘Westernised’ which can include dressing inappropriately, wearing inappropriate make up and using or owning a mobile phone; or consuming drugs or alcohol (Brandon and Hafez, 2008; The Job, 2006; Keyhani, 2013; Roberts et al, 2014; Meetoo and Mirza, 2007; ACPO, 2008; Atherley, 2007; Safilios-Rothschild, 1969; Baker et al, 1999; Amnesty International, undated, cited in Pertile, 2008, p. 34; CRASAC, 2014; Chesler, 2009, cited in Belfrage et al, 2012, p. 20; CIMEL and INTERIGHTS, 2001; Salter, 2013; Gill, 2005a; Singh, 2015). All these behaviours are considered to bring a stain on the family honour, thus illustrating the fragility of this symbolic capital, housed within the female (Keyhani, 2013; Gill, 2009; Maris and Saharso, 2001, and Stewart, 1994, cited in Gill et al, 2012, p. 76; Bond, 2014).

In line with the process of honour restoration previously described, these behaviours may evoke extreme violence towards the victim. Therefore, from a policing perspective, these behaviours need to be considered as risk factors. Some of these behaviours, for example, the victim seeking a divorce or separation, are risk factors for DV as well as HBV (Hoyle, 2008; Dichter and Gelles, 2012; Walklate and Mythen, 2011; Kropp, 2004; Robinson, 2010; Atherley, 2007; The Job, 2006; Roberts et al, 2014).
2014; Salter, 2013; Belfrage et al, 2012; CIMEL and INTERIGHTS, 2001; ACPO, 2008), but the majority are typical of HBV only. The idea that the behaviours listed above can be triggers for extreme violence or death may, arguably, be described from a Western cultural understanding as too far-fetched to be believed (Gill, 2008a, 2008b, 2010; Roberts et al, 2014; Salter, 2013; CRASAC, 2014). Therefore, they lend credit to the argument made earlier that the majority of Western officers may find the concept of HBV too implausible.

There are occasions where lighter punishments are administered which negate the need for violence, such as undergoing an abortion or a quickly arranged marriage to the man connected to the transgression, only if the community is unaware of the transgression (Atherley, 2007; Baker et al, 1999; Payton, 2014; Roberts et al, 2014; The Job, 2006; IKWRO, 2014; Gill, 2008b; ACPO, 2008; CIMEL and INTERIGHTS, 2001). In this way, there is a chance that the matter can be covered up, the family’s honour remains intact and the community are none the wiser. However, once a transgression becomes public knowledge, the risk of harm to the woman becomes severe (Brandon and Hafez, 2008). This illustrates how victim risk of HBV is unstable as it is dependent on the level of exposure of the transgression to the wider community, which could change at any moment. This highlights how risk assessment needs to be a continual, ongoing process in order to take into account dynamic risk factors and the potential for immediate changes in threat level (Roberts et al, 2014; Hoyle, 2008; Kropp, 2004; Robinson, 2010; Messing et al, 2013; The Police Foundation, 2014).

In summary, this chapter discussed the definition of HBV, and the honour mind-set behind it, to illustrate how much it contrasts with Western thinking, and related it
throughout to an operational policing context. This was to help lay the foundation of understanding as to why UK law enforcement has struggled over the last ten to fifteen years to correctly assess the level of risk HBV poses to its victims (Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006; Pertile, 2008; Brandon and Hafez, 2008), thus supporting the need for an HBV-competent risk assessment tool. The following chapter now sets the scene for the policing experience of HBV in the UK, from the early to late 2000s, which further emphasises the importance of an HBV-competent risk assessment tool and how the idea for DASH was conceived.
2. THE POLICING OF HBV IN THE UK

HBV was relatively unheard of in the UK until the early 2000s (Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006; Pertile, 2008; Brandon and Hafez, 2008; Olwan, 2014; Gill, 2005b, 2008; Reddy, 2008; Dustin and Phillips, 2008; Siddiqui, 2005). Rukhsana Naz is one of the earliest cases mentioned in the literature, a girl from Derby who was forced into marriage at the age of sixteen. She brought shame on her family for becoming pregnant, which was suspected to be the result of an extra-marital affair. She was subsequently strangled with a cord in 1998 by her brother whilst her mother held her down. The perpetrators were successfully prosecuted in 2000 (R v Shakeela Naz, 2000, cited in Keyhani, 2013, pp. 263, 267; Meetoo and Mirza, 2007; Gill, 2008b, 2010).

In the meantime, a BME women’s rights group, the Southall Black Sisters, of which Siddiqui (2005) is a member, campaigned for an inquiry into her case as they considered the government to be ‘racist’ for neglecting to deal with the issue of forced marriage (Independent, 1998, cited in Dustin and Phillips, 2008, p. 408; Siddiqui, 2005). In response to this, the government set up a forced marriage working group in 1999, attended by representatives from non-governmental organisations (NGOs), which framed “the discussion of honor killing and honor-based violence through the lens of forced marriage” (Home Office, 2000, cited in Yurdakul and Korteweg, 2013, p. 210). As a result, a report entitled ‘A Choice By Right’ was published in 2000 (ACPO, 2008). The report prompted the creation of the Community Liaison Unit within the Foreign and Commonwealth Office, which later became the Forced Marriage Unit in 2005 (Dustin and Phillips, 2008; FCO and Home Office, 2014b; Meetoo and Mirza, 2007). This was designed to assist British
victims who had been taken abroad and forced into marriage (Yurdakul and Korteweg, 2013). This unit developed links with British and foreign police which prompted ACPO to form the Forced Marriage Working Group (ACPO, 2008).

2.1 Police Recognition of HBV

Chapter one of this paper made several comparisons between HBV and DV, highlighting both their similarities and differences. Additionally, the above paragraph suggests that the police attitude towards HBV appears to have been following the same path as DV. It is not within the scope of this paper to discuss UK policing of DV in any detail. However, the following sub-section provides some background to elaborate on the relationship between HBV and DV. This will help contextualise the gap that DASH purports to fill as a combination risk assessment tool and further supports the argument to not rely on DV policing techniques in HBV cases.

2.2 Policing of DV and its Relationship with HBV

The Home Office definition of DV is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass psychological, physical, sexual, financial or emotional abuse (Home Office, 2013b, quoted in The Police Foundation, 2014, p. 2).

Although the UK policing response to DV has been improving since it first appeared on the policing agenda from the 1970s, with increased awareness programmes and legislation (Grant and Rowe, 2011; Sims Blackwell and Vaughn, 2003; Grauwiler, 2008; Robinson, 2010; Bowen, 2011; Felson and Pare, 2008; The Police Foundation, 2014; Roberts et al, 2014; Gill, 2004, 2008b, 2009; Burman and Chantler, 2005; Siddiqui, 2005; ACPO, 2008; Dustin and Phillips, 2008; Hoyle, 2008; Dogan, 2013; Yurdakul and Korteweg, 2013; Roehl et al, 2005; Bowen, 2011), it is arguably, like HBV, still “not good enough… [and] too often remains a poor relation to acquisitive crime and serious organised crime” (HMIC, 2014, p. 6). In this way, as with HBV, victims have encountered apathetic responses from police officers, such
as disbelief, trivialisation and victim-blaming, and have suffered an inadequate level of support due to the prioritisation of resources to ‘real’ police work (Home Affairs Committee, 2008; Hoyle, 1998, cited in Hoyle, 2008, p. 333; Dichter and Gelles, 2012; Stanko, 1985, Erez, 2002, Belknap, 2001, and Koss, 2000, cited in Felson and Pare, 2008, p. 202; The Police Foundation, 2014; HMIC, 2014). Although the HMIC (2014), in its recent inspection of the UK policing approach to DV, generally concluded that the policing response was inadequate, it did note that some positive changes had taken place, one of which was the introduction of DASH.

As mentioned, DASH is a combination risk assessment tool accommodating both HBV and DV (Richards, 2009, 2015; Roberts et al, 2014; Robinson, 2010), and this is because they share many characteristics. HBV and DV involve abuse that occurs within the domestic setting and are perpetrated by intimate partners/family members; victims are usually female and are abused for challenging patriarchal control; victims feel isolated and often endure abuse in silence, although in an HBV context this isolation is usually from outsiders rather than family; additionally, victims are reluctant to report abuse to the police or sustain their complaint for fear of reprisals, and/or because they are so intertwined with their family/intimate partner financially and/or emotionally, that it makes it difficult to escape (Payton, 2014; Gill, 2004, 2008b; Messing and Thaller, 2013; Sartin et al, 2006; FCO and Home Office, 2014b; ACPO, 2008; Meyer, 2011; Podaná, 2010; Baker et al, 1999; Smartt, 2006, cited in Keyhani, 2013, p. 263; Belfrage et al, 2012; Belur, 2008; Burman and Chantler, 2005). However, as described in chapter one, HBV has significant differences from DV, such as well-planned, premeditated attacks involving wide collusion and collective perpetration (Araji, 2000; Belfrage et al, 2012; Roberts et al, 2014; Dustin and Phillips, 2008; Salter, 2013; Gill, 2009; ACPO, 2008; Cooney, 2014; Brandon
and Hafez, 2008; Baker et al, 1999; Papp, 2014; Dogan, 2014). Therefore, any HBV risk assessment based purely on DV-specific risk factors is likely to produce an erroneous risk prediction (Hoyle, 2008; Robinson, 2010; Payton, 2014; Roberts et al, 2014; IPCC, 2008).

Arguably, DASH is a design that attempts to capitalise on these similarities and differences by combining HBV and DV in the one tool, yet separating HBV-specific risk factors into their own sub-section. DASH’s effectiveness in terms of predicting HBV risk will be analysed in chapter three, and this will include whether it is appropriate to incorporate both HBV and DV risk assessment in the one tool.

The above draws attention to the fact that, almost half a century of experience in policing DV does not constitute a good policing response to HBV, firstly because UK police are still failing to police DV adequately and, secondly, because HBV has distinctive characteristics which deviate from those of DV (Araji, 2000; Belfrage et al, 2012; Roberts et al, 2014; Dustin and Phillips, 2008; Salter, 2013; Gill, 2009; ACPO, 2008; Cooney, 2014; Brandon and Hafez, 2008; Baker et al, 1999; Papp, 2014; Dogan, 2014).

2.3 Positive Developments in the Policing of HBV

Prompted by Heshu’s case, the MPS took the lead in the prevention of HBV in the UK (Gill, 2010). The Strategic Homicide Prevention Working Group on Honour Killings was set up in January 2003 (The Job, 2006; Gill, 2008b), which included consultation with community leaders and women’s groups (Siddiqui, 2005). This resulted in the creation of the Homicide Prevention Unit in 2004, led by Laura Richards (The Job, 2006), who would later become the author of DASH (Richards,
2015), who teamed up with the Racial and Violent Crime Taskforce unit to improve media coverage and education, and raise confidence in the police amongst minority communities. This resulted in an increase in reporting of HBV crimes (The Job, 2006).

General developments were made by the MPS between 2003 and 2006, including the setting up of an Honour Killing Gold Group (ACPO, 2008); the organisation of an international conference on HBV with the Home Office (Gill, 2005b; Siddiqui, 2005); a strategy to deliver HBV training to frontline officers (Dustin and Phillips, 2008); and the creation of a project to educate communities about the legal and health implications of FGM, in line with the introduction of the Female Genital Mutilation Act 2003 (ACPO, 2008). Additionally, the Homicide Prevention Unit undertook a review of cases where Asian women had been reported missing. This led to approximately one hundred cases being linked to HBV, approximately fifteen of which were confirmed as HBV likely. These were then analysed to identify common risk factors, which were later incorporated into DASH (Gill, 2005a, 2009; Asif, 2005, cited in Atherley, 2007, p. 37; The Job, 2006; Richards, 2015; Robinson, 2010). These will be discussed in chapter three.

2.4 Set Backs and the Case of Banaz Mahmod

Despite these positive developments, the literature highlights several drawbacks to policing procedures during this time. Key evidence was either not gathered, not shared, or destroyed, as well as inaccurately recorded and misinterpreted, and there were inconsistencies in evidence management between UK forces (Gill, 2008a, 2005; Belur, 2008). Additionally, in an effort to balance robust policing with cultural sensitivity, the police over-relied on consultation with ‘community leaders’ to guide
their practices. These self-appointed leaders were always male and often subscribed to the honour mind-set. The voices of vulnerable women were seldom heard, as some of these leaders presented a biased view of their community (Belur, 2008; King, 2009; Johal, 2003 and Siddiqui, 2003, cited in Meetoo and Mirza, 2007, pp. 192-3; Papp, 2014; Siddiqui, 2005; Gill, 2004; Brandon and Hafez, 2008; Welchman and Hossain, 2005, cited in Papp, 2014, p. 115; Wilson, 2007).

The accumulation of these faults climaxed in 2006 when progress achieved thus far was eclipsed by the police’s failure to appropriately risk assess one particular victim, Banaz Mahmod, whose murder would likely have been prevented had appropriate steps been taken to manage her safety (Gill, 2008a,b, 2010; Dustin and Phillips, 2008; Yurdakul and Korteweg, 2013). Banaz contacted the police on five separate occasions between September 2005 and January 2006 (IPCC, 2008). Initially this was to complain about being the victim of physical and sexual abuse by her husband, but later she tried to alert the police that her family were threatening to kill her as they felt she had dishonoured them by leaving her husband and finding a new boyfriend. She even provided the police with a list of names of her potential murderers. In general, she received a very poor response from the police (IPCC, 2008), which included: taking three months to write up her initial statement; accusing her of being “very dramatic” (IPCC, 2008, p. 8) and not taking the threats to her life seriously; wishing to arrest her for criminal damage when she broke a neighbour’s window whilst escaping an attempt on her life; and recording some of her complaints as “no crime” (IPCC, 2008, p. 4). This culmination of what Gill (2008a, p. 24) describes as “systemic failures” ultimately led to her death in January 2006 at the hands of her family (IPCC, 2008; Banaz: A Love Story, 2012; Gill, 2008a,b; Gupta, 2007, cited in Yurdakul and Korteweg, 2013, p. 211).
This is a harrowing example of how the police got it so wrong. They clearly did not understand the honour-related dynamics of this situation, which resulted in both dismissing her complaints and positioning her as a self-harming, hysterical vandal who made preposterous claims (IPCC, 2008; Banaz: A Love Story, 2012; Gill, 2008a,b; Gupta, 2007, cited in Yurdakul and Korteweg, 2013, p. 211). DASH was not implemented until 2009, but had an HBV-competent risk assessment tool been available to frontline officers at the time, it is possible this might have made a difference (The Police Foundation, 2014; Home Affairs Committee, 2008).

2.5 Improvements and the Conception of DASH

The blame for Banaz’s death fell partly on the failure of the MPS to roll out their HBV training programme to frontline officers, partly on the apparent lack of HBV focus by other UK forces, and partly due to the lack of an appropriate risk assessment tool (Dustin and Phillips, 2008; Home Affairs Committee, 2008). In response to this, various initiatives were implemented nationally to increase the police’s ability to effectively respond to HBV. These included training programmes for frontline officers with assistance from specialised NGOs; dedicated HBV helplines for victims; research into the motivation of perpetrators; the introduction of an HBV case flagging system; consultation with partner agencies; and engagement with the community (Pertile, 2008, 2010; Dean, 2008, Atherley, 2007; McVeigh, 2013; Gill, 2008b, 2010; The Job, 2006; ACPO, 2008). In 2007, ACPO organised a special roundtable with twenty representatives from NGOs to discuss the issues affecting victims of HBV (Gill, 2008b). The head of ACPO, referencing Banaz’s case, admitted that there were insufficient policies and resources in place. As a result, this forum generated several recommendations, which included “investment in safety planning…consistent arrest policies… [and] regular training…” (Gill, 2008b, p. 254). A year later, the
ACPO HBV Strategy was launched and forces were encouraged to implement their recommendations (ACPO, 2008; Pertile, 2010; IKWRO, 2014). Within this strategy, ACPO announced that it was working on a new risk assessment tool which would later become DASH (ACPO, 2008).

In summary, this chapter set the scene for the policing experience of HBV in the UK, from the early to late 2000s – pre-DASH – to emphasise the importance of an HBV-competent risk assessment tool. It was noted that well-intentioned strategic direction does not guarantee that every frontline officer will be sufficiently HBV-aware to make professional judgements about risk unaided (Gill et al, 2012). It is clear that the UK police’s journey to effectively policing HBV has been a rocky one and, judging by the justification for the current HBV inspection by HMIC, as well as other recent studies, there is still some way to go (HMIC, 2015; CRASAC, 2014; IKWRO, 2014).

Arguably, therefore, ensuring the availability of an effective HBV-competent risk assessment tool is the single most important step that can currently be taken on this journey whilst frontline officers are being brought up to speed and resources are limited (Bennett Cattaneo and Goodman, 2007; Connor-Smith et al, 2011; Kropp, 2004; Robinson, 2010; Messing and Thaller, 2013; Nicholls et al, 2013). In this vein, this paper seeks to assist with this element by drawing on academic evidence presented in the first two chapters to critically analyse DASH to ascertain whether it is fit to assess HBV risk. This will now be covered in the following chapter, along with an introduction to police use of risk assessment, and methods adopted, which will help lay the foundation for the analysis.
3. A CRITICAL ANALYSIS OF DASH

DASH was launched in 2009 (Richards, 2015; Robinson, 2010; The Police Foundation, 2014), yet a thorough search of the literature shows that there is extremely little written about it. The few items found are a mixture of inspection reports, and academic, magazine and blog articles, only three of which mention DASH in relation to HBV (The Police Foundation, 2014; HMIC, 2014; Roberts et al, 2014; Payton, 2013, 2014; Robinson, 2010; Walklate and Mythen, 2011; Wheller and Wire, 2014; Pease et al, 2014). These items are mixed in their opinion of DASH, but what is clear is that, to date, there is no evidence that DASH has been empirically validated (Wheller and Wire, 2014; Pease et al, 2014).

This is concerning as chapters one and two of this paper argue the importance of an HBV-competent risk assessment tool as the foundation for effectively identifying and responding to HBV cases. If DASH, the only such candidate used by UK police, is not fit-for-purpose in this regard, this could potentially put HBV victims in grave danger and undermine the public’s confidence in the police (Kropp, 2004, 2008; Nicholls et al, 2013; Robinson, 2010; Bennett Cattaneo and Goodman, 2007; Kercher et al, 2010; Walklate and Mythen, 2011; Roberts et al, 2014; Home Affairs Committee, 2008; Grant and Rowe, 2011). This supports the relevance of scrutinising DASH within this paper, and, in the absence of previous empirical testing which could have been used as a data source for analysis, this paper will use academic evidence presented in the previous two chapters to perform the analysis under two themes. DASH’s competence within these themes will then be discussed to ascertain whether this paper finds DASH fit to assess HBV risk. These themes
are: 1) The Accommodation of HBV-specific Risk Factors; and 2) The Appropriateness of Combining HBV and DV in One Risk Assessment Tool.

In order to lay the foundation for the analysis, the next sub-section describes how risk assessment became a priority within law enforcement and the evolution of the different methods/models that were built. From this context, one can then relate to the process in which DASH was created and the form it takes, as described in the brief sub-section following that. After which, the analysis begins.

### 3.1 The Rise of Risk Assessment

Risk assessment preludes risk management (Humphreys et al, 2005, Radford and Gill, 2006, and Hoyle, 2008, cited in Grant and Rowe, 2011, p. 51; Roberts et al, 2014; Kropp, 2004; Robinson, 2010) and the objective of successful risk management within a policing context is to decrease the likelihood of an individual coming to harm/further harm (Roberts et al, 2014; Robinson, 2010; Hoyle, 2008; Kropp, 2004). The implications for the police incorrectly assessing risk mean that the appropriate level and method of law enforcement intervention may not be allocated to a particular case (Bennett Cattaneo and Goodman, 2007; Robinson, 2010; Nicholls et al, 2013). As previously mentioned, this may be detrimental to the individual’s safety, and may also have a negative impact on the reputation of the police, resulting in loss of public confidence (Kropp, 2004, 2008; Nicholls et al, 2013; Robinson, 2010; Bennett Cattaneo and Goodman, 2007; Kercher et al, 2010; Walklate and Mythen, 2011; Roberts et al, 2014; Home Affairs Committee, 2008; Grant and Rowe, 2011).
During the 1980s, the UK government’s appetite for the welfare state approach diminished and was replaced with “a neo-liberal promotion of self-governance” (Haggerty, 2003, cited in Hoyle, 2008, p. 331; Walklate and Mythen, 2011; O’Malley, 1992). This was made manifest in public sector services by the introduction of a performance management and accountability culture (Davis, 2012; Fielding and Innes, 2007). For law enforcement, this resulted in an emphasis on prevention and management of crime rather than the solving of it, which caused the assessment of risk, and ambition to negate it, a priority (Zedner, 2007, cited in Hoyle, 2008, p. 329; Walklate and Mythen, 2011).

Between the 1980s and 1990s, risk was largely only assessed for general violence perpetration, rather than DV (Bennett Cattaneo and Goodman, 2007; Hilton et al, 2008; Kercher et al, 2010), and was undertaken by a clinical professional interviewing a perpetrator using unstructured professional judgement (Robinson, 2010; Bowen, 2011). Following criticism that this approach could result in practitioner bias and lack of accountability (Kropp, 2004, 2008; Bowen, 2011), actuarial models were developed. These models relied on strict adherence to answering formally structured checklists built on empirically validated, violence perpetration risk factors in order to achieve a risk prediction score (Bowen, 2011; Walklate and Mythen, 2011; Kropp, 2004;). The use of professional judgement or discretion was completely removed (Bennett Cattaneo and Goodman, 2007) and studies revealed that the predictive ability of actuarial models were more reliable at predicting future recidivism than unstructured professional judgement (Walklate and Mythen, 2011; Kropp, 2004, 2008; Hilton et al, 2008; Bowen, 2011).
Around the same time, awareness of DV as a crime was steadily increasing, both in the UK and other Western countries, which, as mentioned in chapter two, was widely regarded as a private family matter prior to the 1970s (Sims Blackwell and Vaughn, 2003; Grant and Rowe, 2011; Grauwiler, 2008; Robinson, 2010; Bowen, 2011; Felson and Pare, 2008; CDC, 2003, cited in Campbell, 2004, p. 1466; Dichter and Gelles, 2012 Sartin et al, 2006). With DV attributable to a third of female homicides in the UK (Stanko, 2008), and to counter the historically nonchalant police response, the government made it a priority to reduce risk of DV, which prompted the demand for the availability of DV-specific risk assessment tools for use by frontline practitioners, such as the police (Robinson, 2010; Bennett Cattaneo and Goodman, 2007; Bennett Cattaneo and Chapman, 2011; Kropp, 2004, 2008; Wheller and Wire, 2014; Messing and Thaller, 2013; Nicholls et al, 2013; Roehl et al, 2005; Hoyle, 2008).

Many actuarial models have been created for this purpose using empirically validated risk factors for DV (Roehl et al, 2005; Gelles, 1998, cited in Bennett Cattaneo and Goodman, 2007, p. 8-9; Williams and Grant, 2006; Hilton et al, 2004, cited in Connor-Smith et al, 2011, p. 2519; Hilton et al, 2008). Studies reveal these models have varying degrees of predictive ability, and are better than chance (Walklate and Mythen, 2011; Kropp, 2004, 2008; Hilton et al, 2008; Bowen, 2011; Roehl et al, 2005). However, there are certain concerns with this approach, not least because the exclusion of professional judgement interferes with an officer’s fundamental licence to apply discretion where it is merited (Walklate and Mythen, 2011; Grant and Rowe, 2011; Kropp, 2004, 2008; Robinson and Howarth, 2012; Bowen, 2011; Bennett Cattaneo and Goodman, 2007; Connor-Smith et al, 2011; Robinson, 2010; Bennett Cattaneo and Chapman, 2011).
This paved the way for the structured professional judgement approach which blended the structured framework of a checklist with the application of discretion (Kropp, 2004, 2008; Bowen, 2011). Several examples of this model, of which DASH is one, have been created (Campbell, 1986, 1995, cited in Bennett Cattaneo and Goodman, 2007, p. 8; Kropp et al, 1995, 1999, cited in Kropp, 2008, p. 210; Kropp et al, 2005, cited in Bowen, 2011, p. 219) including the PATRIARCH (Belfrage, 2005) which is the only other HBV-relevant risk assessment tool currently available, and is used by police forces in Sweden (Belfrage et al, 2012). As with the actuarial method, studies of this approach have revealed varying degrees of predictive ability (Hilton et al, 2008; Wheller and Wire, 2014; Roehl et al, 2005; Messing and Thaller, 2013; Kercher et al, 2010; Bowen, 2011; Nicholls et al, 2013).

It is not within the scope of this paper to discuss in any depth the merits and shortcomings of the three risk approaches or each individual risk assessment tool, as this paper concentrates on DASH only. Suffice it to say, the general conclusion of studies in this field reveal that, those tools empirically tested, across the three approaches, have a certain degree of ability to predict risk, provided they are applied accurately and in the context for which they were designed (Bowen, 2011; Nicholls et al, 2013; Grant and Rowe, 2011; Robinson and Howarth, 2012; Kropp, 2004, 2008; Kercher et al, 2010). However, risk assessment methods are in their infancy and there is vast scope for further empirical study (Messing and Thaller, 2013; Nicholls et al, 2013; Grant and Rowe, 2011; Connor-Smith et al, 2011; Robinson, 2010; Sartin et al, 2006; Kercher et al, 2010; Bowen, 2011).
3.2 The Creation of DASH

Following the initiatives implemented after Banaz Mahmod’s case, an ACPO Risk Management Expert Panel, consisting of representatives from the police, academics and the charity Coordinated Action Against Domestic Abuse (CAADA), came together in 2008 to create DASH (Robinson, 2010; Home Department, 2008). DASH was constructed using risk factors drawn from the existing DV risk assessment tools of the MPS and South Wales Police (Richards, 2003, and Robinson, 2004, cited in Robinson, 2010, p. 125) as well as academia, and police and victim consultation (Roberts et al, 2014; Robinson, 2010; Payton, 2014). After DASH was piloted, it was endorsed in March 2009 by the ACPO Council and made available to all forces in the UK with accompanying guidance and training (Robinson, 2010; The Police Foundation, 2014; HMIC, 2014).

DASH consists of a main checklist of twenty-seven questions relating to risk factors for DV (Richards, 2009; Robinson, 2010). When responding to a DV or HBV incident/complaint, all twenty-seven questions must be asked of the victim. If question twenty, “Is there any other person that has threatened you or that you are afraid of?” (Richards, 2009, p. 4), is answered positively, the practitioner is guided towards asking a further ten questions related to HBV. The answers to both sets of questions, along with the assessing officer’s professional judgement, are combined to achieve an overall risk score of ‘Standard’, ‘Medium’, or ‘High’ (Richards, 2009, p. 4). This score informs officers as to the appropriate risk management response.

3.3 Critical Analysis

As this paper is specifically interested in HBV, and as HBV is a sub-topic within DASH, it would not be relevant to analyse wider elements of DASH. Therefore, this
analysis will not cover DASH’s competence in risk assessing for DV, stalking and harassment. Training and instructions for use, overall content and layout, and the method in which the checklist is scored are also out of scope. Additionally, this paper does not address whether forces use DASH or not, or whether it is applied or quality assured correctly. Only the original DASH checklist (Richards, 2009) will be analysed. Other adapted or modified versions are out of scope.

Theme one will concentrate on the ten HBV-specific questions featured in DASH whilst theme two will focus on questions within the main DASH checklist as this also influences the HBV victim’s risk prediction.

3.3.1 Theme One: The Accommodation of HBV-specific Risk Factors

The ten HBV questions featured in DASH (see www.dashriskchecklist.co.uk; Richards, 2009, p. 6) are all, arguably, valid (Gill, 2004, 2005a, 2006, 2008a,b, 2009, 2010; Gill et al, 2012; Atherley, 2007; Roberts et al, 2014; Dean, 2008; FCO and Home Office, 2014b; Knudsen, 2003; The Job, 2006; Reddy, 2008; IKWRO, 2014; Dustin and Phillips, 2008; Belfrage et al, 2012; CIMEL and INTERIGHTS, 2001;
There are several questions which are clearly aligned to HBV presence, for example, chapters one and two of this paper illustrate how victims can be withdrawn from education and forced into marriage (Gill, 2005a, 2006; CRASAC, 2014; Awwad, 2004, and Goodwin, 1995, cited in Atherley, 2007, p. 27; Roberts et al, 2014), and HBV questions one, four and five within DASH address these aspects. However, some of the other questions are non-HBV-specific and need modifying or removing, for example “Isolation - is the victim very isolated?” (Richards, 2009, p. 6). This question needs to elaborate whether the victim feels isolated from people outside of the family in order to make it indicative of HBV. As chapter one described how victims are more likely to be closely supervised by family – a collective – this will not necessarily, depending on the victim’s subjective interpretation, invoke a feeling of isolation (IKWRO, 2014; The Job, 2006; Gill, 2005a, 2006, 2008b; Roberts et al, 2014; CRASAC, 2014; CIMEL and INTERIGHTS, 2001; ACPO, 2008; Atherley, 2007; Singh, 2015). Therefore, if the victim answers negatively to isolation, when, in fact, she is isolated from her friends, school or work, this false negative may contaminate DASH’s predictive validity. Question three regarding house arrest addresses intensive family supervision, and, therefore, the question around isolation could, arguably, be removed, particularly as it already appears in the main checklist, in order to avoid this potential misinterpretation.

Question seven, “A pre-marital relationship or extra marital affairs – is the victim believed to be in a relationship that is not approved of?” (Richards, 2009, p. 6) is, again, generic to HBV and DV, as described in chapters one and two (Hoyle, 2008;
Dichter and Gelles, 2012; Connor-Smith et al, 2011). It could, arguably, be moved to the main checklist where it currently does not feature. This would then leave room for a modified version of this question that is more HBV-specific. Female sexual impropriety is the most fundamental cause of honour-loss, which can largely be suspected through association, no matter how slight or platonic, with a male unapproved of by the family (Gill, 2003, 2005a, 2008b; Keyhani, 2013; Atherley, 2007; Onal, 2008; Reddy, 2008; Hussein, 2010, cited in Gill et al, 2012, p. 81; Siddiqui, 2005; Brandon and Hafez, 2008; Knudsen, 2003; USA: Department of State, 2006, cited in Nasrullah et al, 2009, p. 1; Meetoo and Mirza, 2007; Faqir, 2001, and Hoyek et al, 2005, cited in Dogan, 2013, p. 492; Shah Kakakhel, 2004; Roberts et al, 2014; Pertile, 2010; Belfrage et al, 2012). As chapter one describes how anything other than inter-tribal/clan/familial marriage is usually met with disapproval (Samad and Eade, 2002, cited in Atherley, 2007, p. 31; Gill et al, 2012; Knudsen, 2003; Roberts et al, 2014), a modified version of question seven such as, “Have you been accused of associating with anyone from an ‘inferior’ racial/ethnic/caste/class background?” (Singh, 2015) would, arguably, be a more suitable replacement.

Question two asks if there is evidence of victim self-harm. Self-harm, indeed, features as a risk factor for HBV within the literature (Atherley, 2007; Roberts et al, 2014). However, it is also, potentially, a symptom of DV victims, as, although the literature does not specifically label self-harm as a DV risk factor, there is evidence that DV victims can suffer diminishing mental health (Campbell, 2002, cited in Messing and Thaller, 2013, p. 1538), of which self-harm could be an expression (Mind, 2013). What makes self-harm unique from an HBV perspective is that victims can be encouraged or instructed to harm themselves by their perpetrators to achieve
redemption for costing the family their honour (Singh, 2015; Onal, 2008). Victims may feel pressured to comply for reasons such as fear, guilt, and dependence, as described in chapter one (ACPO, 2008; Salter, 2013; Dean, 2008; CRASAC, 2014; Siddiqui, 2005; FCO and Home Office, 2014b; Belur, 2008; Burman and Chantler, 2005; Roberts et al, 2014; Payton, 2014; Murray, 2008). This can include forced suicide, which is a convenient and popular honour killing disguise (BBC, 2003, cited in Atherley, 2007, p. 28; IKWRO, 2014; Siddiqui, 2005; ACPO, 2008). As diminished mental health is covered in the main checklist (Richards, 2009, p. 3), this question around self-harm can afford to be modified to make it more specific to self-harm committed under duress.

Question eight asks about separation from the victim’s intimate partner and question ten deals with threats to hurt or kill. Both of these questions, although valid, as chapter one highlights, already feature in the main checklist and are generic to both HBV and DV (Hoyle, 2008; Dichter and Gelles, 2012; Walklate and Mythen, 2011; Kropp, 2004; Robinson, 2010; Connor-Smith et al, 2011). Therefore, these questions could, arguably, be removed to avoid duplication and make room for other more HBV-specific questions related to characteristics and behaviours presented in chapter one, such as “Has your husband’s family complained about you to your own family?”; “Are you or does anyone suspect you to be homosexual and what is your family’s views of homosexuality within the family?”; “Has any perceived sexual indiscretion given rise to this incident or has sex been used for punishment?”; “Is any abuse directed at you because you are female or because you have only given birth to females?”; “Are you aware of any dowry or bride price concerns within your family that relate to you?”; and “Is your community aware of your problems with your family?” (Singh, 2015; Atherley, 2007; The Job, 2006; Payton, 2014; Gill, 2004;

This theme addressed how comprehensively DASH covers HBV-specific risk factors by comparing the ten HBV questions in DASH with the HBV characteristic and behavioural evidence provided in chapters one and two of this paper. This analysis reveals that not all of the questions relate to HBV-specific risk factors, characteristics or behaviours. Out of those that do, some relevance is diluted by over-generalised wording. This may cause the victim to misinterpret the questions, thus, provide distorted answers, which may adversely influence DASH’s predictive validity. Within this particular theme, the analysis, therefore, concludes that DASH’s alignment to HBV-specific risk factors is currently insufficient.
3.3.2 Theme Two: The Appropriateness of Combining HBV and DV in One Risk Assessment Tool

As previously discussed, DASH is a risk assessment tool for use in both HBV and DV cases. Having discussed the similarities and differences HBV has with DV in chapters one and two, and the impact this has on policing, this theme discusses the advantages and disadvantages of this format to address whether having the two elements combined in one risk assessment tool enhances or impedes its ability to identify and accurately assess HBV risk.

The advantages of the combined tool are three-fold. Firstly, HBV shares many of the same risk factors as DV, for example, victim fear; victim attempt(s) to separate from her intimate partner; sexual abuse; and reaching for outside help (Robinson, 2010; Hoyle, 2008; Dichter and Gelles, 2012; Walklate and Mythen, 2011; Kropp, 2004; Connor-Smith et al, 2011; Dugan et al, 2004, Bernard and Bernard, 1983, and Campbell, 1992, cited in Kercher et al, 2010, p. 7; Atherley, 2007; Roberts et al, 2014; Payton, 2014; Gill, 2004, 2005b; Pertile, 2010; The Job, 2006; Salter, 2013; Belfrage et al, 2012; CIMEL and INTERIGHTS, 2001; ACPO, 2008; IKWRO, 2014; Siddiqui, 2005). Having one risk assessment tool which covers both DV and HBV reduces duplication and simplifies the process (ACPO, 2008; Home Affairs Committee, 2008). This avoids the temptation, if there were two separate tools, for officers to carry only one because it is less time consuming/less to carry, as was the case in a recent study on Swedish police officers who favoured the use of a DV risk assessment tool (B-SAFER) over its HBV counterpart (PATRIARCH) (Belfrage et al, 2012) when responding to all familial disputes.
Secondly, because HBV is relatively unfamiliar to the majority of officers, as has been discussed in the first two chapters, it may not be obvious to officers when answering a domestic dispute that HBV is present. Payton (2014) found in her recent study on HBV risk factors that in cases where the perpetrators of HBV are the husband and his family/associates, the victim might not define this as honour-related as she only identifies honour judgement with her natal family, regardless of the fact that the characteristics of violence and intent behind it are honour motivated in the perpetrators’ minds. Thirdly, Payton (2014) found abuse cases where HBV was not present, but the parties concerned had typical characteristics of those belonging to HBV prevalent communities. In these cases, Payton found a DV policing response was more appropriate. Therefore, having a combined DV and HBV risk assessment tool helps officers respond to familial disputes more appropriately without being influenced by stereotypes, as was cautioned against in chapter one.

There is, arguably, a disadvantage with the combined tool. As HBV is a sub-section of DASH, consideration must be given to the questions included in the main checklist. As discussed, these are mandatory and, along with the ten HBV questions, influence DASH’s predictive validity regarding HBV risk. They should, therefore, be sufficiently relevant and understood by the HBV victim to avoid misinterpretation and to maintain her confidence in the police’s ability to help her.

Chapter one illustrates how the whole family, and possibly wider associates, usually collude in HBV perpetration, and that this is a major distinction between HBV and DV (Roberts et al, 2014; Dustin and Phillips, 2008; Salter, 2013; Gill, 2009; ACPO, 2008; Chesler, 2009, and Pimentel et al, 2005, cited in Cooney, 2014, p. 409). Payton (2013), therefore, argues for positioning the HBV trigger question, currently at
number twenty, nearer the beginning of the main checklist to establish, as soon as possible, whether collective perpetration is present. In this way, subsequent questions referring to single perpetration can be adjusted to collective perpetration by the assessor to keep them relevant to the HBV victim.

Chapter one also describes how HBV situations can consist of long periods of coercive control, but can very quickly escalate into extreme/fatal violence depending on the extent to which the family perceives an honour transgression has become public knowledge (Atherley, 2007; Ginat, 1979, and Kressel, 1981, cited in Baker et al, 1999, p. 171; Glazer and Abu Ras, 1994, and VanEck, 2003, cited in Payton, 2014, p. 2865-6; IKWRO, 2014). In this regard, it is possible that there is no physical harm until the victim is killed (Onal, 2008; McVeigh, 2007). The first question, “Has the current incident resulted in injury?” (Richards, 2009, p. 3) is, therefore, another example of why questions in the main checklist need to be carefully considered. By having this question at the start of the assessment, this may, early on, set a distorted perception that DASH equates absence of physical injury to low risk (Singh, 2015). An HBV victim who has not yet been physically assaulted may accept this perception, erroneously gauging her risk as lower than it is (Gill, 2004; Campbell, 2004; CRASAC, 2014), or she may be very aware of her accurate risk level, but become sceptical of DASH’s ability to reach the same conclusion (Hoyle, 2008; Brewer et al, 2007, cited in Dichter and Gelles, 2012, p. 45; Bennett Cattaneo and Goodman, 2007; Walklate and Mythen, 2011; Campbell, 2004; Connor-Smith et al, 2011; Kropp, 2004; Robinson, 2010; Bowen, 2011). This may lead to the victim’s loss of confidence in the police’s ability to help and she may disengage or become uncooperative (Singh, 2015; Payton, 2014; CRASAC, 2014; Belur, 2008). It might be prudent to amend this question to read, “Has the current incident resulted in
injury, or threat of injury or threat to life?” (Singh, 2015) and may be better positioned further down the form after “Are you very frightened?” and “What are you afraid of?” (Richards, 2009, p. 3). This will provide a more gradual lead-in to the question of injury whilst reducing the likelihood that it is misinterpreted as described above.

Some of the wording of questions within the main checklist could be amended inline with HBV terminology so that they are more relatable to HBV victims. For example, “Does (…) do or say things of a sexual nature that makes you feel bad…?” (Richards, 2009, p. 4) could be changed to “Does (…) do or say things of a sexual nature that makes you feel bad or ashamed…?” (Singh, 2015; Gill, 2004; Payton, 2014). HBV victims can relate to the word ‘shame’ as they understand this to be the consequence of losing honour, as mentioned in chapter one (Gill, 2003, 2008b; Brandon and Hafez, 2008).

There are other examples within the main checklist where questions are lacking in relevance to HBV, such as perpetrator jealousy of victim, perpetrator abuse of drugs and/or alcohol, and perpetrator abuse of pets (Roberts et al, 2014; Robinson, 2010; Singh, 2015; Klemperer, 2015). However, it is unnecessary to describe and critique each individual question here. The paragraphs above adequately support the suggestion that the main checklist within DASH must be sufficiently relevant and understood by the HBV victim to ensure DASH’s predictive validity is not adversely affected and her confidence in the police is maintained.

Drawing on academic evidence presented in chapters one and two, this theme discussed the advantages and disadvantages of combining an HBV and DV risk assessment tool to assess whether this format enhanced or impeded DASH’s ability
to identify and accurately assess HBV risk. This analysis reveals that combining the two elements promotes efficiency by reducing duplication and helps to detect HBV where it may not be obvious, whilst, conversely, preventing an inaccurate diagnosis of HBV based on stereotyping. However, some questions within the main checklist are not positioned or worded appropriately in order to make them sufficiently relevant or understood by HBV victims. Thus, the overall risk prediction may be incorrect if influenced by answers from misinterpreted questions in this checklist. This is, arguably, a significant concern, which is not mitigated by the advantages. This analysis, therefore, concludes that it can be appropriate to combine HBV and DV in the one tool, but the current arrangement in DASH impedes its ability to identify and accurately assess HBV risk.

In summary, this chapter performed a dual-themed, critical analysis of DASH drawing on academic evidence provided in chapters one and two of this paper. The results revealed that the HBV sub-section of DASH is not sufficiently aligned with HBV risk factors, and whilst there are significant advantages to combining HBV and DV risk assessment within one tool, as DASH does, some questions in the main checklist of DASH were identified as being irrelevant or ambiguous to HBV victims. Both issues identified in the two themes lead to the strong possibility that DASH’s predictive validity, with regard to HBV victims, will be compromised. Therefore, this analysis concludes that DASH is currently not fit to assess HBV risk.

The discussion and findings within this paper will now be summarised within the next section along with recommendations.
CONCLUDING REMARKS

The aim of this paper was two-fold. Firstly, it was to argue that an HBV-competent risk assessment tool is essential in the effective policing of HBV. Secondly, it was to critically analyse DASH, the only such candidate used by UK police, to ascertain whether it is fit-for-purpose within an HBV context.

The first aim was covered in chapters one and two. Chapter one discussed the definition and characteristics of HBV, and the honour mind-set behind it, to illustrate how much it contrasts with Western thinking (Gill, 2008a,b, 2010; Roberts et al, 2014; Salter, 2013; CRASAC, 2014). By highlighting the impact these factors have on the UK police’s ability to assess HBV risk throughout this chapter, this helped lay the foundation of understanding as to why UK law enforcement has struggled over the last ten to fifteen years to correctly assess the level of risk HBV poses to its victims (Atherley, 2007; IKWRO, 2014; Belur, 2008; The Job, 2006; Pertile, 2008; Brandon and Hafez, 2008), and why simply relying on DV policing techniques can be harmful (Belur, 2008; Roberts et al, 2014; Siddiqui, 2005; FCO and Home Office, 2014b; Meetoo and Mirza, 2007).

Chapter two set the scene for the policing experience of HBV in the UK, from the early to late 2000s, to illustrate the infancy of its approach and to emphasise the importance of an HBV-competent risk assessment tool. It discussed how the police became aware of HBV (BBC News Online, 2003, cited in Siddiqui, 2005, p. 269; Gill, 2008b; ACPO, 2008) and observed parallels between this journey and that of policing DV (Payton, 2014; Gill, 2004, 2008b; Messing and Thaller, 2013; Sartin et al, 2006; FCO and Home Office, 2014b; ACPO, 2008; Meyer, 2011; Podaná, 2010;
Baker et al, 1999; Smartt, 2006, cited in Keyhani, 2013, p. 263; Belfrage et al, 2012; Belur, 2008; Burman and Chantler, 2005), whilst simultaneously highlighting the importance of allowing for the differences between the two forms of familial abuse (Hoyle, 2008; Robinson, 2010; Payton, 2014; Roberts et al, 2014; IPCC, 2008). Positive developments in the policing of HBV, as well as set backs, were described, and the case of Banaz Mahmod was used to illustrate how the absence of an appropriate risk assessment resulted in tragic, but avoidable, consequences (The Police Foundation, 2014; Home Affairs Committee, 2008). This was followed by how the police applied learning from Banaz’s case to improve its response to HBV incidents, which resulted in the conception of DASH (Gill, 2008b, ACPO, 2008).

The first aim of this paper has, arguably, been achieved. Given all the evidence presented in the first two chapters, this paper concludes that the availability of an HBV-competent risk assessment tool is, indeed, essential to the effective policing of HBV. Whether or not DASH is, in fact, a competent candidate was investigated in chapter three.

The main purpose of chapter three was to critically analyse DASH to ascertain whether it is fit to assess HBV risk. This chapter justified the need for the analysis by explaining how coverage of DASH within the literature is very limited and does not include any empirical validation (Wheller and Wire, 2014; Pease et al, 2014), which is concerning after chapters one and two evidenced the importance of an HBV-competent risk assessment tool. After laying the foundation for the analysis by introducing police risk assessment use and methods, and describing the creation and format of DASH, the analysis, which was divided into two themes, commenced.
Theme one drew on academic evidence provided in chapters one and two to address how comprehensively DASH covers HBV-specific risk factors within the ten HBV questions. This part of the analysis found that all ten questions are arguably valid (Gill, 2004, 2005a, 2006, 2008a,b, 2009, 2010; Gill et al, 2012; Atherley, 2007; Roberts et al, 2014; Dean, 2008; FCO and Home Office, 2014b; Knudsen, 2003; The Job, 2006; Reddy, 2008; IKWRO, 2014; Dustin and Phillips, 2008; Belfrage et al, 2012; CIMEL and INTERIGHTS, 2001; Siddiqui, 2005; ACPO, 2008; CRASAC, 2014; Pertile, 2010; Keyhani, 2013; Salter, 2013; Amnesty International, undated, cited in Pertile, 2008, p. 34; Payton, 2014; Krantz and Garcia-Moreno, 2005; Yurdakul and Korteweg, 2013; Papp, 2014; Dogan, 2014; Wilson, 2007), but some are not specific to HBV and others are worded in a way that dilutes their relevance to the HBV victim. This creates a strong likelihood that the victim will misinterpret the questions, causing her to provide misleading answers, which may negatively affect DASH’s predictive validity for HBV victims. Therefore, the conclusion within this theme was that, currently, DASH is insufficiently aligned to HBV-specific risk factors.

Theme two also drew on academic evidence provided in chapters one and two to identify and evaluate the advantages and disadvantages of combining HBV and DV risk assessment. This was to ascertain whether this combination enhances or impedes DASH’s ability to identify and accurately assess HBV risk. Several advantages were identified, however, similar to the findings within theme one, theme two’s analysis exposed irrelevant and ambiguous questions within the main checklist. As this checklist is mandatory in all familial disputes (Richards, 2009), any misinterpreted questions may negatively influence DASH’s predictive validity for HBV victims in the same way as described above. Therefore, the conclusion within this theme was that it can be appropriate to combine HBV and DV in the one tool, but the
current arrangement in DASH impedes its ability to identify and accurately assess HBV risk.

The second aim of this paper has, arguably, been achieved. DASH is comprehensive in its content and the majority of questions are, arguably, valid. However, given the findings within these themes, this paper concludes that DASH is currently not fit to assess HBV risk.

This paper identifies that with careful consideration towards modification and re-positioning of certain questions in the main checklist and HBV sub-section, in line with HBV risk factors, DASH’s predictive validity, and ability to keep the HBV victim engaged, could potentially be improved in order to make it fit-for-purpose within an HBV context, without diluting its effectiveness in predicting DV risk. However, a condition of this recommendation is that any amended version is swiftly followed with comprehensive empirical testing (HMIC, 2014; Wheller and Wire, 2014; Pease et al, 2014). Additionally, this paper recommends that further empirical testing should be conducted to establish a definitive range of HBV risk factors which will help inform this process whilst adding to the very few items that already exist in the literature (Payton, 2014; Sartin et al, 2006; Gill, 2003, 2008b, 2010; Salter, 2013; Smith, 1989, cited in Belur, 2008, p. 429; Dogan, 2014).

As argued in this paper, provision of an HBV-competent risk assessment tool is a very important first step in getting the police response to HBV right. More widely, there is room, as highlighted in the literature, for other initiatives that would help raise awareness and contribute to an overall improved policing response to HBV. This paper recommends the following such initiatives: research to develop the most
appropriate response and investigative techniques for HBV (CPS, 2010, cited in Salter, 2013, p. 108; Gill, 2008b; Dogan, 2014); training for police officers and frontline police staff to understand these techniques, recognise HBV and learn how to deal sensitively with HBV victims (Gill, 2003, 2005b, 2008b; Gill et al, 2012; Keyhani, 2013; Tripathi and Yadav, 2004; Ammar et al, 2014; Home Affairs Committee, 2008; IKWRO, 2014); a consistent and comprehensive system of identifying, recording and flagging HBV cases within and between national forces (Gill, 2005b; Gill et al, 2012; IKWRO, 2014; ACPO, 2008); effective partnership working between the police and relevant NGOs/agencies to understand victim and community needs (Gill, 2005b; Gill et al, 2012; Ammar et al, 2014; IKWRO, 2014); assessment as to the extent national forces have implemented the recommendations of the ACPO HBV Strategy (IKWRO, 2014; Gill et al, 2012); assessment as to the accuracy and extent to which DASH is processed by responding officers (IKWRO, 2014, HMIC, 2014); and investigation into complaints/discoveries of inappropriate officer action within HBV-related incidents (Gill, 2008b, 2010; IKWRO, 2014).

It will be interesting to note the results of HMIC’s current HBV inspection (HMIC, 2015), when published, to establish whether DASH was scrutinised and whether their conclusion complements or contrasts with this paper. Whatever the outcome, it is clear that DASH, and, indeed, the wider topic of policing HBV, is under-debated within the literature so there is ample scope for further research (Wheller and Wire, 2014; Pease et al, 2014; Salter, 2013; Gill, 2008b, 2010; Smith, 1989, cited in Belur, 2008, p. 429; Dogan, 2014).
REFERENCES


*Domestic Abuse: Caught on Camera - Panorama* (2014) BBC One Television, 8 December.


Gill, A. (2008a) 'MPS "could have done more" to prevent the murder of Banaz Mahmod', *Safe: The Domestic Abuse Quarterly*, 26 (Summer), pp. 24-25


Macmillan, pp. 218-236


The Job (2006) 'Question of honour', The Job (September), pp. 16-19


