Domestic Homicide Review Legislation Consultation

Extract from Joint Response Submitted on 27th July 2023

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Definition of a Domestic Homicide Review

Current DHR legislation specifies that a DHR should be considered in instances where 'the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself'.

The DA Act 2021 introduced a statutory definition of domestic abuse that incorporates a range of abuses beyond 'violence, abuse and neglect' to include controlling or coercive behaviour, emotional and economic abuse. Explicitly including this definition in the DHR legislation would ensure that DHRs continue to contribute to our understanding of DA, and capture learnings to prevent fatal domestic abuse

4. Are you in favour of updating DHR legislation so that a DHR is considered for all deaths that have or appear to have been the result of domestic abuse, as domestic abuse is defined in the DA Act 2021 (see below)?

☒ Yes
☐ No
☐ Don't know
Please comment:

We are in favour of updating the Domestic Homicide Review legislation so that a review is considered for all deaths that have or appear to have been the result of domestic abuse, with domestic abuse as defined in the DA Act 2021.

With respect of this legislative change, in setting out this new revised definition, we recommend that the legislation should be amended to be clear that deaths should be considered for review where they are 'caused by, related to, or somehow traceable to' domestic abuse (Websdale, 2020, p. 1). This would set out an underlying principle that could inform decisions about the cases in scope. The use of the language 'caused by, related to, or somehow traceable to' domestic abuse clarifies that causality can be complex, and therefore better captures tragedies such as domestic abuse-related deaths by suicide (where direct attribution may not be possible, with domestic abuse being one of multiple contributory factors), and also

homicides (where direct attribution can be made with respect to the actions of the perpetrator).

In addition, such an amendment is necessary so that both deaths that clearly fall into the definition of domestic abuse as defined in the DA Act 2021 are reviewed (such as those involving former or current intimate partners or family members) *and* there is sufficient flexibility to review cases that may not directly do so.

In the following, we identify examples of cases where flexibility is required to ensure that all deaths caused by, related to, or somehow traceable to domestic abuse are reviewed. To illustrate the potential significance of reviewing such cases (including the learning generated), in boxes, we provide examples of DHRs that have been commissioned under the current statutory guidance. These DHR examples were drawn from Luna Reaver's own research repository of DHRs 2011 – 2021 consisting of the available records across all local authorities in England.

Such cases include:

1. *Domestic abuse-related deaths occurring outside of the context of normative family and intimate relationships*, measured in terms of temporality, status and/or perceived closeness:

    a. *'Dating' relationships*: Such deaths may not be considered as meeting the definition of an intimate personal relationship, perhaps because of their duration. For example, there is evidence that dating relationships are not always recognised, with this potentially being most significant for young people (Jaffe, Fairbairn and Sapardanis, 2018).

    > *Example*: In Milton Keynes, although 'Anthony' and 'Tony' were not in a relationship, a DHR was nonetheless conducted into the killing of Anthony. Anthony had initially met Tony via a dating website, with the DHR describing the relationship as casual. Notably, the report indicates that when deciding to commission the review there was 'some debate about whether this was… a domestic homicide' (Westmarland, n.d, p. 4). Although the evidence of domestic abuse was limited, the DHR identified learning around the disclosure of HIV status to sexual partners, as well as around mental health, links to illegal drugs (including 'date rape' type drugs and dating sites), and with respect to Lesbian, Gay, Bisexual and Trans+ (LGBT+) communities (including both awareness raising, community engagement).

    b. *Relationships where status may be unclear or not defined*: This may be particularly relevant to victims from minoritised communities, because the limits of administrative data collection can determine

how, for example, homicides are counted and understood (Cullen *et al.*, 2021). For example, in some cases, a relationship may not be disclosed to families, friends, or the wider community. In this context, the killings of LGBT+ people may not be captured because of how scope is defined and/or if relationships are obscured (if one or both parties was not 'out', the nature of a romantic/sexual relationship was unclear, or administrative data is unable to capture identity) (Rossiter, Reif and Fischer, 2020). Other circumstances could include where a relationship is not disclosed in the context of cultural background and/or religious belief.

> *Example*: A DHR in Brighton & Hove was conducted into the killing of 'Mr C' by 'Mr Y', despite the relationship being 'ambiguous', with Mr Y telling agencies that Mr C was his carer, and Mr Y describing the relationship as intimate (Croom, 2004, p. 14). The review identified learning around the understanding of domestic abuse, both among victim/survivors and employers, as well in terms of health and social care responses to patients and employees, commissioned services' responses, and communication between agencies and services.
>
> A similar example can be found in North Yorkshire, where a DHR was undertaken into the killing of Dianne by 'Margaret' (in this DHR, the victim's real name was used). The report noted Dianne and Margaret were 'almost certainly in a same sex relationship. This was not known to Dianne's family. Dianne did disclose their relationship to some agencies (notably during an emergency incident) but the exact nature of the relationship was not known to most professionals' (Cane, 2018, p. 45). The DHR identified learning for several agencies, as well as broader learning around identification, risk assessment and multiagency working. There was also learning why and how older LGBT+ people may (not, or only partly) disclose their relationship and how agencies might respond.

c. *Extended kinship and caring giving:* Deaths that occur in the context of kinship, including extended familial networks, or other types of caregivers (Bows, 2019; Bracewell *et al.*, 2022).

2. *Deaths of corollary victims*: corollary victims are those who are killed in the context of domestic abuse (Smith, Fowler and Niolon, 2014) but whose deaths, in an English and Welsh context, would not be reviewed because they are neither a former/current intimate partner or family member.

> *Example*: In Kent, a DHR was conducted into the killing of 'Ann' by her estranged son-in-law 'George'. George was married to Ann's daughter, 'Claire'. In this case, because Claire and George were married, Ann and George would have been classed as relatives under the Family Law Act 1996 and so 'personally connected' for the purposes of the DA Act 2021. However, had Claire and George not been married, this killing would not technically have fallen in the

scope of a DHR as Ann and George would not have been defined as being related in law. While the DHR identified learning for individual agencies, it emphasised learning with respect of interagency working, including information sharing and risk assessments, and stalking (Pryde, 2019).

Significantly, ensuring a consistent understanding that the deaths of corollary victims should be considered would allow for reviews into killings like that of Cassie Hayes by her girlfriend's – Laura Williams – former partner, Andrew Burke in January 2018 (BBC News, 2018). Prior to the killing Burke had been abusive towards both Hayes and Williams. The responsible Community Safety Partnership (CSP) did not conduct a review because it decided that the killing of Hayes "did not fit the criteria" (Maxwell, 2019). While technically the decision was consistent with the statutory guidance at the time, this reflected a preoccupation with 'relational distance' (Dobash and Dobash, 2012) and, consequently, excluded the killing of Hayes because the link was non-intimate and indirect. However, the killing of Hayes was domestic abuse-related in that the intimate relationship between Williams and Burke was directly related to Hayes' death. Furthermore, this was a missed opportunity to examine a tragic case of fatal violence in a same sex relationship where the killer was an ex-heterosexual partner (Herek, Cogan and Gillis, 2002; Rose, 2003).

3. However, we are not in favour of excluding consideration of killings and/or deaths associated with non-intimate/familial household members, i.e., a lodger or flatmate. This is because domestic spaces, and the relationships within them, can be linked to violence and abuse (Cook and Walklate, 2022). In particular, shared rented housing is becoming more common and involves increased risk of interpersonal violence and thus increased exposure among those facing socioeconomic precarity. So 'shared housing' contexts should be included both from an equalities perspective (else this policy risks failing an Equalities Impact Assessment) and to recognise changing models of housing (Wilkinson and Ortega-Alcázar, 2019). Deaths in this context should therefore be reviewed if they are caused by, related to, or somehow traceable to domestic abuse, particularly if no other statutory review would otherwise be conducted (e.g., an Offensive Weapons Homicide Review (OWHR); Safeguarding Adults Review (SAR) in England or Adult Practice Review in Wales; or Child Safeguarding Practice Reviews (CSPRs) in England or Child Practice Reviews (CPRs) in Wales).

   Such cases may include killings or deaths where:

1. A perpetrator who is a non-intimate/familial household member but who has, or appears to have, been motivated by gender-based violence, including sexual jealousy, and this has occurred in a domestic setting.

> *Example*: In Brent, a DHR was conducted into the killing of 'Elaine'. Elaine was killed by 'Elijah', who she had known for many years as a friend, and the significant witness to the homicide was Elaine's ex-partner, 'Michael'. Michael had been abusive to Elaine, and, at times, Elaine had stayed with Elijah. Some time before she was killed, Elaine and Elijah had a sexual encounter and, when this became known to Michael, it 'led to arguments and altercations between the three' (Cribb, n.d., p. 4). Elaine was killed by Elijah after the pair had gone to Michael's home. Notably, this DHR is clear that Elaine and Elijah were not in an intimate (or indeed, dating) relationship and were friends. However, despite ruling out domestic abuse, the report notes Elaine's possible fear of Elijah. Although there was learning for individual agencies, the most significant learning from this DHR related to the inability of agencies to recognise and respond holistically to Elaine's alcohol use, mental health issues, experiences of loss and abuse, and housing situation.

2. Other examples of relationships in a domestic setting, including those involving coercion and control.

> *Example*: In Kent, a DHR was conducted into the killing of 'Joyce Jackson', who was killed by injuries inflicted upon her by three brothers. The three brothers had lived at Joyce Jackson's home at various points (as did one of their girlfriends), after their mother had moved in. Notably, in this case, the Adult Safeguarding Board decided the circumstances of the case did not meet the criteria for a SAR but did meet the criteria for a DHR. The DHR identified learning around 'mate crime', as well as around the identification of and response to vulnerability, and other aspects of practice (including risk assessment) (Stevens, 2017).

The risk of excluding the deaths of non-intimate/familial household members – and so the loss of potential learning – by making this change far exceeds any potential savings. While the economic note supporting the consultation asserts there is likely to be a cost saving from a reduction in the number of DHRs, it also notes that no more than 3 DHRs conducted between October 2021 and 2022 would have been affected by this change. This reflects the evidence base that suggests DHRs into such killings are rare. Bates *et al*. (2021) reported that six of 151 DA-related deaths of adults identified by the police in the year to March 2021 involved a non-intimate/familial household relationship. Rowlands (2023) reports 2 of 60 DHRs involved such relationships. Given the social and economic costs of homicide (Wickramasekera *et al.*, 2015), efforts to reduce its likelihood are of significant value, and the likely savings incurred are considerably greater if learning could potentially prevent future deaths. This is not addressed in the cost framing.

We recommend that, when the Statutory Guidance is revised, this should be clearer about commissioning decisions in line with the amended legislation. The guidance should address both what deaths are in scope; the identification, referral, and decision-making process; the requirements with respect to consultation (notably, with specialist domestic abuse services, as well as families); and reporting (including transparency about the notifications received and decisions made). Such clarity around decision-making is important in ensuring the inclusion of domestic abuse-related deaths that occur outside of the context of normative family and intimate relationships or where the suspect is a non-intimate/familial household member (as discussed above), as well as domestic abuse-related deaths by suicide (where there is a lack of guidance for decision making, see Rowlands and Dangar, 2023). Furthermore, if a decision not to review is made, the Statutory Guidance should also include a positive requirement for the responsible CSP to consider referral to another appropriate statutory review.

Associated with this, the revised Statutory Guidance should also give appropriate direction with respect to the conduct of reviews into cases where operational considerations arise because of the specific circumstances being considered.

Finally, we do not address implications for children as victims and the voice of the children because of the inclusion of children as victims in their own right in the DA Act 2021. However, we support the submission by the Domestic Abuse Commissioner for England and Wales in this respect.

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Naming convention for Domestic Homicide Reviews

The name 'Domestic Homicide Review' can be misleading when the fatality in the review has not been ruled a homicide (e.g suicides and unexplained deaths).

5. Are you in favour of renaming 'Domestic Homicide Reviews'?

☒ Yes
☐ No
☐ Don't know
Please briefly explain reasoning for your response:

We welcome the proposal to rename Domestic Homicide Reviews for the reasons outlined in the consultation, in particular the potential for confusion and/or adverse impact on families in the event of a review into a domestic abuse-related death.

6. If 'Domestic Homicide Reviews' are renamed, should the Government:

☐ Introduce the term 'Domestic Abuse Fatality Review' for cases of domestic abuse related deaths that are not homicides, whilst retaining the terms 'Domestic Homicide Review' for domestic homicides.
☐ Re-name all 'Domestic Homicide Reviews' to 'Domestic Abuse Fatality Reviews'
☒ Use another term (or terms) to better reflect the range of deaths which fall within the scope of a DHR (please specify):

We are in favour of the proposal to rename Domestic Homicide Reviews. However, we do not believe that the term 'Domestic Abuse Fatality Review' is suitable for describing reviews, either with respect to homicide or other deaths, including domestic abuse-related deaths by suicide. Instead, we recommend referring to these reviews collectively as 'Domestic Homicide or Abuse-Related Death Reviews' to reflect the range of deaths in scope. This terminology is (a) broad enough to cover all types of killings or deaths that are caused by, related to, or somehow traceable to domestic abuse but (b) not so broad as to become meaningless or misleading and (c) is also respectful to the sensitive and traumatic nature of these killings and deaths.

First, *with respect to domestic homicides*. (e.g., killings by former or current partners, family members, or non-intimate/familial household members, i.e., a lodger or flatmate), we recommend that the term 'Domestic Homicide Review' is retained. This is because 'fatality' disguises the significance of these events. In contrast, homicide conveys the severity of these killings, including their impact and the actions of a perpetrator (i.e. including, usually, their criminal responsibility).

Second, *specifically considering domestic abuse-related deaths by suicide*, we recommend that the term 'Domestic Abuse-Related Death Review' is used. Our rationale is for this recommendation reflects the specific circumstances in England and Wales, the context of these deaths, and the terminology commonly used in policy and practice:

International comparisons and specific circumstances in England and Wales

Internationally, review systems that examine deaths in the context of domestic and/or family violence are often referred to as 'Fatality Reviews' (Websdale, 2020). On that basis, it is therefore understandable that the Home Office is considering adopting similar terminology. However, it is important to note that:

1. These international review systems do not always consider domestic abuse-related deaths. For example, one study reported that domestic abuse-related deaths by suicides – usually victim-focused – are reviewed in just over half of extant review systems (Bugeja *et al.*, 2017).
2. The review system in England and Wales is unique insofar as all in-scope deaths should be reviewed and findings are published as stand-alone reports (Cook *et al.*, 2023). This means there are particular challenges with respect to the naming of these reviews, because they are associated directly with published reports into individual deaths (Rowlands, 2023). These challenges are increased in the context of domestic abuse-related deaths by sucide (Rowlands and Dangar, 2023).

'Fatality' is problematic in the context of domestic abuse-related deaths

A fatality is defined in the Oxford English Dictionary as 'the quality of causing death or disaster; fatalness; a fatal influence' or 'a disaster resulting in death; a fatal accident or occurrence'. Fatality in this context is attributive. Based on this everyday definition, encompassing deaths by suicide in the context of domestic abuse under the term 'fatality' is problematic. Encompassing deaths by suicide in this way is problematic because it is difficult to attribute direct causality in these cases (Munro and Aitken, 2020) and yet, by using the term 'fatality', this could be understood to implication direct causation. This is potentially inaccurate and confusing.

'Fatality' is not commonly used to describe domestic abuse-related deaths

'Fatality' is not usually used in either practice or policy with respect to suicide, with 'death by suicide' or some similar description being common terminology (given its wrong to use 'committed' as suicide is no longer an offense). For example:

1. The 'National Confidential Enquiry into Suicide and Safety in Mental Health' primarily refers to 'deaths by suicide' or 'suicide deaths'. The only mention of fatal/ity is in relation to 'fatal overdose' (Appleby *et al.*, 2023).

2. The ‘National Suicide Prevention Strategy’ also primarily refers to ‘self-inflicted deaths’ or ‘suicide deaths’. Where fatal/ity is used, this tends to be in relation to trains/rail lines or deliberate or accidental drug overdoses (HM Government, 2012).
3. The latest report on the government’s strategy, ‘Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives’ also does not use the term fatal/ity and refers instead to ‘suicide deaths’ (HM Government, 2021).

Consequently, given ‘deaths by suicide’ or ‘suicide deaths’ are commonly used terminology in respect to suicide, it is our view that ‘fatality’ is inappropriate because it is inconsistent with existing policy and practice. This too is potentially confusing, while also suggesting a disconnect between government departments (here, the Home Office and the Department of Health and Social Care).

Third, *fatality would also be inappropriate for other circumstances*, such as in relation to a death by neglect, as well as being inconsistent with the terminology used by coroners who investigate deaths by suicide and a wide range of suspicious deaths.

Proposed model

A leading authority on reviews identifies how these systems, with some jurisdictional differences in scope, consider deaths that are ‘caused by, related to, or somehow traceable to’ domestic abuse (Websdale, 2020, p. 1). Following this, we recommend that:

1. There needs to be a clear understanding that the killings that are in-scope, specifically cases of murder or manslaughter (homicides), include both intimate partner or familial relationships (Sharp-Jeffs and Kelly, 2016).
2. That reviews into deaths by suicide need to be recognised as distinct and named appropriately (Rowlands and Dangar, 2023), given the challenges that arise if these cases as known as ‘Domestic Homicide Reviews’ (Dangar, Munro and Young Andrade, 2023).
3. Other potential deaths related to, or somehow traceable to, domestic abuse need to be captured as well, reflecting our response to consultation question 4.

We recommend referring to these reviews as ‘Domestic Homicide or Abuse-Related Death Reviews’ to reflect the range of deaths in scope, as illustrated in Figure 1 below.

Thereafter, and with appropriate direction in the revised Statutory Guidance, a decision can be made as to the relevant terminology to be used when reviewing a given case. To enable this, as for our response to consultation question 4, we recommend that Statutory Guidance should be revised, here to be clearer about the naming of these reviews and decision making in individual cases.

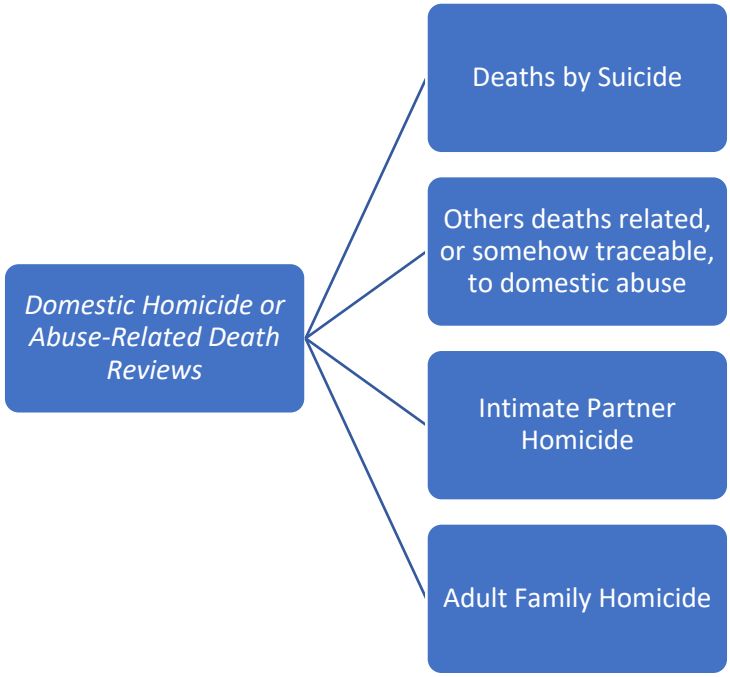

Figure 1 Range of deaths in scope of 'Domestic Homicide or Abuse-Related Death Reviews'

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