domestic abuse commissioner

Role of the Domestic Abuse Commissioner

The Domestic Abuse Act 2021 establishes in law the Office of the Domestic Abuse Commissioner (DAC) for the purpose of providing public leadership on domestic abuse issues and to play a key role in overseeing and monitoring the provision of domestic abuse services in England and Wales. The role of the Commissioner is to encourage good practice in preventing domestic abuse; identifying adult and child victims and survivors, as well as perpetrators of domestic abuse; and improving the protection and provision of support to people affected by domestic abuse from agencies and government. As the Domestic Abuse Commissioner for England and Wales, I welcome the opportunity to feedback on the Government consultation on Domestic Homicide Reviews and would be pleased to discuss the contents of this response further, if requested to do so.

Scope of response

As the Domestic Abuse Commissioner for England and Wales, my response to this consultation is limited to matters related to amendments to Domestic Homicide Review (DHR) legislation (Domestic Violence, Crime and Victims Act 2004).

Consultation Response

1. *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*

The Domestic Abuse Commissioner is in favour of the proposal to update DHR legislation to consider all deaths that have, or appear to have, been the result of domestic abuse as defined in the Domestic Abuse Act 2021, on the basis that this aligns with the definition within the Domestic Abuse Act 2021, providing consistency across all Domestic Abuse related legislation and guidance.

In considering the inclusion of the Domestic Abuse Act 2021 definition, the Domestic Abuse Commissioner would urge the Home Office to consider both the opportunities

this presents to strengthen DHRs, and the gaps this will create in the existing scope when refreshing the statutory guidance, both of which are outlined below.

Voice of the Child

One of the significant differences in the Domestic Abuse Act 2021 definition was the inclusion of children as victims in their own right. Whilst the Domestic Abuse Commissioner agrees that the appropriate review procedures in which to address the death of a child would normally be within Child Safeguarding Practice Reviews (CSPR) and Child Practice Reviews (CPR) in Wales, the Commissioner would see the addition of the DA Act 2021 definition within DHR statutory guidance as an opportunity to ensure greater emphasis on children as victims and to strengthen the voice of the child within reports, both in terms of their experience of bereavement (either as a result of homicide or a death by suicide) and as a victim in their own right.

Recognising teenage relationships and understanding the differing needs from other age groups is important in ensuring that services meet victims needs and in preventing of future homicides. There should be greater emphasis on the need to draw on the expertise of the DHR panel in setting the terms of reference for any Local Child Safeguarding Practice Review (LSCPR), seeking their expertise and consulting on report findings and recommendations to ensure that learning is shared across both processes.

Recommendation 1: The Domestic Abuse Commissioner recommends that within the review of statutory guidance there should be a clear section on children as victims and that this is in two distinct parts, as follows:

1. **Safeguarding: There should be a clear statement made regarding the need to ensure appropriate safeguarding measures are considered when commissioning reviews and direction with regards to the interface between CSPRs/CPRs (Wales) and DHRs, including;**
    a. **Where one or both reviews should be undertaken and how in each instance one review should incorporate elements from the other. Giving due consideration to the need to join up the learning and recommendations between processes.**
    b. **Further clarity in the statutory guidance as to when a DHR would be appropriate where a child is over the age of 16 and the importance of ensuring that DA expertise is present in a Child Safeguarding Practice Review where this is the only commissioned review.**
    c. **Where both parties are under 16 there should be a requirement for a Local Child Safeguarding Practice Review (LSCPR) to be carried out in full consultation with the local area's DHR Panel. The DHR Panel should be asked to shape the terms of reference to ensure that the domestic abuse is fully explored and there should be domestic abuse expertise on the LSCPR Panel. The DHR Panel**

should also be consulted on the review report findings and recommendations and ensure learning is shared across both domestic abuse and child safeguarding partners and systems.

2. **Voice of the child: The Home Office should consult with specialist services supporting bereaved families to ensure that children's experiences as victims of abuse are integral to the review process. This should apply where they are survivors of abuse and dealing with the loss of a parent as a result of domestic abuse and, in some cases, witnesses to the homicide or victims of homicide at the hands of a parent or family member.**

Recognition of Honour Based Abuse and Forced Marriage

The Domestic Abuse Act 2021 definition of domestic abuse does not explicitly address so called honour-based abuse (HBA), forced marriage, female genital mutilation (FGM), or other harmful practices within the definition of behaviours. Although this is described in the Domestic Abuse Act 2021 statutory guidance as types of abuse perpetrated by family members it would be pertinent to, as a minimum, refer Community Safety Partnerships to this guidance when considering whether a death meets the definition of Domestic Abuse for the purposes of a Domestic Homicide Review, to ensure such cases are given the same consideration.

Recommendation 2: The Domestic Abuse Commissioner recommends that the statutory guidance for DHRs reflects all forms of abuse within the context of domestic abuse and gives clear direction to Community Safety Partnerships on HBA, FGM, Forced Marriage and harmful practices.

Exclusion of those living in the same household

The Domestic Abuse Commissioner recognises that this change will exclude some cases which would ordinarily have triggered a DHR, such as those living in the same household, but who would not fit the definition of intimate partner or familial relationships. The Domestic Abuse Commissioner would not support the exclusion of all cases which fall under this category. In some cases, such as the case of 'William',[1] it can be difficult to determine the nature of a relationship, nevertheless domestic abuse can be a significant feature in either the victim or perpetrators lives. This DHR describes an indication of an intimate relationship during the trial of the female perpetrator, whilst there are other indications that this was someone seeking to help another. The female perpetrator was known to have a history of victimisation and

[1] DHR 'William' Safer Kirkless 2016 Search DHRs: Search the Domestic Homicide Review Library – GOV.UK (homicide-review.homeoffice.gov.uk)

perpetration of domestic abuse and it would be wholly appropriate in these circumstances to conduct a review.

Determining the nature of a relationship where two people live in the same household can be difficult as often relationships are masked or hidden from family and friends for reasons such as cultural and religious belief, same sex relationships or live–in carer relationships. In some cases, family members of victims can be targeted and victimised, it may be that they are the victim of homicide such as in the case of Henry[2]. In this case, the victim was killed by the abusive partner of his daughter with whom he may have been living with at the time, within current guidance this met the criteria for a review. Due to the nature of the relationship between the victim of domestic abuse (Henry's daughter) and the perpetrator, being that of partners rather than spouse, and therefore the lack of personal connection in this instance and in light of the proposed changes, would it be that in similar circumstances vital learning could be lost?

Other examples may include live-in carers or where a vulnerable person is exploited and abused behind closed doors and behaviours within those relationships replicate the coercions and control seen in incidences of DA such as the killing of Jimmy Prout.[3]

In circumstances such as this the Domestic Abuse Commissioner, would be concerned that their exclusion would lead to gaps in learning and understanding of domestic abuse and its far-reaching implications and would not support the exclusion of those living in the same household.

The Domestic Abuse Commissioner accepts that there will be occasions in which a Domestic Homicide Review would not be appropriate such as where the relationship is solely that of lodger, tenant, multiple occupancy, or a temporary arrangement where there is no intimate, romantic, or familial relationship and no evidence of a relational connection to domestic abuse. In this instance it is important that CSPs adequately explore the information they have and ask key agencies what information they hold which would establish, or not, a relationship which meets the definition of domestic abuse.

Recommendation 3: The Domestic Abuse Commissioner recommends that within the statutory guidance Community Safety Partnerships (CSP) be required to make a case as to why a death should not be reviewed for instances where the relationship fits the category of living in the same household, detailing the steps they have taken to establish that the relationship does not meet the definition of domestic abuse.

Recommendation 4: The Domestic Abuse Commissioner recommends that within the statutory guidance any case made to Home Office not to conduct a review of those living in the same household should include a rationale for their

[2] DHR 'Henry' Tendering Community Safety Partnership 2016

[3] 'He's finally at peace': Torture murder victim Jimmy Prout's ashes are scattered at his favourite place - Chronicle Live

decision. This should include evidence that a relational connection to domestic abuse has been explored and not found, whether another process may be more appropriate and in the absence of one, how any learning from the death has been captured and disseminated.

Recommendation 5: The Domestic Abuse Commissioner recommends that the guidance compels Community Safety Partnerships and relevant agencies to refer to other relevant review processes where an appropriate one exists.

Corollary killings

There are circumstances in which someone who is the new partner of a victim of Domestic Abuse might meet the definition within the Domestic Abuse Act 2021 due to being 'personally connected' however this is likely to be rare and there may be missed opportunities to identify learning where their death is a direct consequence of Domestic Abuse but the 'relational connection' does not allow for a DHR to be established.

Smith, Fowler and Niolon describe corollary victims as a distinct group of individuals who come into contact with IPV, either through their relationship to one or both members of a couple experiencing IPV or through proximity to the violence and consider 'fatality reviews' an important resource for understanding these types of homicide.[4] The Domestic Abuse Commissioner believes it is important to ensure those deaths which have a relational connection to domestic abuse are not excluded from the review process.

Recommendation 6: The Domestic Abuse Commissioner recommends that the statutory guidance makes clear that a domestic abuse related death is not solely based on the relationship of the individuals but also on whether relevant behaviours and abuse within the definition of domestic abuse directly contributed to the death, and that a greater understanding of the circumstances which led to the homicide would contribute to preventing future deaths.

Relational Connection to Domestic Abuse

Whilst current statutory guidance does not explicitly exclude deaths with a relational connection to domestic abuse, such as unexplained deaths, from being subject to a review, the Domestic Abuse Commissioner believes more emphasis should be placed on the appropriateness of conducting a review in these circumstances and greater recognition of the relational connection to domestic abuse within the statutory guidance. This would be further strengthened by the inclusion of the term 'Domestic Abuse Related Deaths' in the title of reviews so that all those whose deaths are related

[4] Smith SG, Fowler KA, Niolon PH. Intimate partner homicide and corollary victims in 16 states: National Violent Death Reporting System, 2003-2009. Am J Public Health. 2014 Mar;104(3):461-6. doi: 10.2105/AJPH.2013.301582. Epub 2014 Jan 16. PMID: 24432943; PMCID: PMC3953789

to or somehow traceable to domestic abuse are in scope, considered and the appropriate mechanisms put in place to support review processes to take place in these circumstances, as with domestic abuse related suicides.

Recommendation 7: The Domestic Abuse Commissioner recommends the change in legislation allows for any future guidance to include an emphasis on connection, which considers when a death is related to or somehow traceable to domestic abuse as described by Websdale.

2 Are you in favour of renaming 'Domestic Homicide Reviews'?

The Domestic Abuse Commissioner supports the renaming of DHRs to better reflect the range of deaths which fall within the scope of a DHR but strongly opposes the use of the term 'fatality' as this does not reflect the seriousness of domestic abuse and the culpability of those who perpetrate abuse.

Recommendation 1: The Domestic Abuse Commissioner recommends the term Domestic Homicide Review be retained and broader title adopted to encompass domestic abuse related deaths by suicide and other domestic abuse related deaths as outlined below. The commissioner feels strongly that the term 'fatality' should not be adopted to describe any domestic abuse related death.

The term fatality is defined in the Merriam Webster dictionary as

- *The quality or state of causing death or destruction*
- *The quality or condition of being destined for disaster*
- *Something established by fate*

The Cambridge dictionary describes 'fatality' as

A death caused by an accident or by violence, or a person who has died in this way.

Language is important in influencing how domestic abuse is understood and tolerated within society, it can play a huge role in how we perceive the world and has the potential to unknowingly influence us.[5] The term fatality carries such strong inferences that the Domestic Abuse Commissioner feels it would distract from the intention and purpose of the definition of domestic abuse and the work which has been done by this Government to strengthen approaches to Domestic Abuse.

[5] Markman and Chestnut (2016), "Girls are as good as boys at math" Implies that boys are probably better: A study of expressions of gender equality" https://doi.org/10.1111/cogs.12637

The Domestic Abuse Commissioner is concerned by the use of the term ‘fatality’ for a number of reasons including that some would still frame this in the context of Homicide, thus failing to raise the status of those who die by suicide, as it is intended by this amendment. Fatality also lacks the seriousness of the term homicide.

The Domestic Abuse Commissioner feels the term fatality suggests the death is a consequence rather than a direct result of abusive behaviour which places less emphasis on the perpetrator and fails to convey the same level of seriousness as the term Homicide. Where this is not framed in the context of Homicide others may perceive this to relate more to accidental deaths where the term is more commonly used.

The Domestic Abuse Commissioner feels the term fatality is more often associated with a death caused by an accident, disaster or significant event/incident rather than in the context of intimate or family violence and abuse, therefore the Domestic Abuse Commissioner does not feel the term fatality goes far enough to reflect the cause or effect of a perpetrators actions and behaviour in the context of homicide and where a person dies by suicide or in any other context as a result of domestic abuse.

The term fatality, whilst commonly used in the US and other countries in relation to domestic abuse, is rarely used in Home Office guidance to describe a death as result of Domestic Homicide or where someone dies by suicide. It would be seem appropriate to align the language with terms such as domestic abuse related incidents, domestic abuse related crimes and domestic abuse related prosecutions, which is commonly recognised, used and understood.

Framing reviews in the context of fatalities places a Criminal Justice interpretation on the role of DHRs and their place in addressing DA. In the US, the CDC takes a comprehensive look at all violent deaths through the National Violence Death Reporting System (NVDRS), which includes all types of violent deaths including homicides and suicides, tracking deaths which are related to violence. The Center for Disease Control and Prevention (CDC) recognises violence as a major public health problem.[6] Framing DHRs in the context of their relational connection to violence and abuse would support a co-ordinated response to prevention of future deaths and a shared understanding that this issue cuts across all public services and interventions.

As such the Domestic Abuse Commissioner strongly opposes the term ‘fatality’ in the new title.

The Domestic Abuse Commissioner agrees however that a broader title is needed to ensure that reviews can be reflective of the circumstances surrounding a death(s), including as detailed above, those deaths related to or somehow traceable to domestic abuse, as well as domestic abuse-related suicides.

[6] CDC's National Violent Death Reporting System (NVDRS)

The term Domestic Abuse-Related Deaths would, in the Commissioners view, encapsulate the experiences of those who die by suicide or where a death is somehow connected or traceable to domestic abuse as outline by Websdale (2020).

Recommendation 2: The Domestic Abuse Commissioner would strongly suggest using the title 'Domestic Abuse-Related Death Reviews' as is referred to by Websdale[7] and by Rowlands and Danger[8] when talking about deaths by suicide and other Domestic Abuse Related Deaths.[9]

With regards to Domestic Homicides the Domestic Abuse Commissioner would be concerned that the acknowledgment of behaviours directly attributed to an act of violence against another which results in their death would not be adequately reflected in the Domestic Abuse Related Death title and feels strongly that 'Domestic Homicide Review' should be retained to be sure to be explicit in reflecting the manner in which someone dies, effectively establishing a branched approach.

Recommendation 3: The Domestic Abuse Commissioner recommends that the statutory guidance is very clear that where there is a Domestic Homicide this should be referred to as such in the commissioning of, participation in and narrative of the Domestic Homicide Review. The title Domestic Abuse Related Deaths should be retained for all other reports.

Adopting this approach would provide some discretion and flexibility for Community Safety Partnerships to specifically reflect the circumstances surrounding the death and give greater consideration to the wishes and feelings of families. It recognises that the context and characteristics of Intimate Partner Homicide and Adult Family Homicide can differ and should be acknowledged as well as considering the relational connection between domestic abuse and any incident which subsequently ends in the death of another where this can be connected to domestic abuse. This should include:

- Domestic Homicide Reviews (separated into Intimate Partner Homicide and Adult Family Homicides)
- Suicide- Domestic Abuse Related Deaths Reviews
- Domestic Abuse Related Death Reviews: All other deaths somehow connected or traceable to domestic abuse. This would include unexpected or unexplained deaths, corollary killings and in some circumstances and with discretion, could

[7] Websdale, N. (2020) 'Domestic Violence Fatality Review: The State of the Art', in R. Geffner et al. (eds) Handbook of Interpersonal Violence and Abuse Across the lifespan. Cham: Springer International Publishing. Available at: https://doi.org/10.1007/978-3-319-62122-7_133-1.

[8] The Challenges and Opportunities of Reviewing Domestic Abuse-Related Deaths by Suicide in England and Wales (springer.com)

[9] Rowlands, J. (2022) 'The Potential and Limitations of Domestic Homicide Review: A Response to Hope et al. (2021)', *Partner Abuse*. doi: 10.1891/PA-2021-0054

allow for the review of those instances which would otherwise be excluded, having previously been in scope, due to the change in definition.

The emphasis in any future guidance should be on decision making and commissioning decisions which supports a greater understanding of domestic abuse and the prevention of future harm/homicide.

Decision making of Community Safety Partnerships and other agencies with regards to when and how to refer an incident for consideration for a Domestic Homicide Review or Domestic Abuse Related Death Review will be important in ensuring that whatever the title of a review, the voice of the victims and their experiences of domestic abuse are central, and that families are engaged at the earliest opportunity to establish where domestic abuse played a significant role in the death. This should be supported by robust statutory guidance which addresses the consideration of those cases which do not clearly point towards a review process but nevertheless should be given due consideration.

The Domestic Abuse Commissioner recognises the concerns that where there is no conviction, charge or coroner's verdict which addresses culpability, the naming of a review may raise concerns for the gathering of evidence, repercussions for others and safe engagement in the review process. Additional guidance and discretion for Community Safety Partnerships in this context would be good practice to ensure reviews are established in a timely way. This should be a key consideration within the decision-making process with the views of partners involved in the review process sought and considered.

Recommendation 4: The Domestic Abuse Commissioner would recommend any future guidance includes;

- **Clear direction for police and other agencies regarding when a death may give rise to a review process and how to refer.**
- **Guidance on commissioning which includes a checklist/ clear criterion to be considered where a Community Safety Partnership is taking a view that a review should not take place with the requirement to clearly lay out the rationale for not proceeding with a review and how learning will otherwise be captured.**
- **Guidance on each sub-category of review and examples of where this may apply.**
- **Guidance for Community Safety Partnerships when considering the name of a review which addresses any safeguarding concerns for others such as children, extended family members, or those close to the victim.**

The Domestic Abuse Commissioner is pleased to see these changes to Domestic Homicide Reviews being considered in the wider Domestic Homicide Reforms and believes that overall, these would be positive amendments to improve the quality of

reviews, provide greater clarity about when a review is appropriate and improve decision making within Community Safety Partnerships.