Role of Standing Together Against Domestic Abuse and the Domestic Homicide Review Team

Standing Together Against Domestic Abuse (STADA) is a national charity bringing communities together to end domestic abuse. Our aim is to support organisations to work in partnership to identify and respond effectively to domestic abuse. The Domestic Homicide Reviews (DHR) Team has been involved in the DHR process from its inception. To date, we have chaired more than 90 DHRs (including suicide and joint reviews), 95% of which have been approved by the Quality Assurance Panel on their initial submission. Additionally, the DHR Team sits on the Home Office Quality Assurance Panel and have conducted research collating findings from DHRs nationally.

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?*

STADA are in favour of extending the DHR legislation to align with the DA Act 2021. Extending the definition of domestic abuse will provide consistency and clarity on the definition of domestic abuse throughout legislation. The inclusion of 'coercive and controlling behaviour' within the DA definition is vital to reflect the meaning and context of domestic abuse – as motivated by a perpetrator's desire to exert power and control over the victim. Furthermore, of those who experienced domestic abuse in October 2021 to March 2022, 84.3% of victims described experiencing non-physical abuse.[1] Non-violent abuse, such as emotional and economic abuse, is widespread; the context of such abuse should be included within DHR learnings to ensure that they can be identified in order to recognise and safeguard victims further.

In considering the terminology of DHR legislation, STADA would additionally encourage the Home Office to ensure that thought is given to circumstances which may be excluded from proposed legislation. The DA Act 2021 states that for domestic abuse to occur, the victim and perpetrator are required to be "personally connected"[2] which occurs when two people have an intimate or familial relationship.[3] This distinction would exclude deaths involving flatmates, carers or corollary killings from DHRs.

[1] Office for National Statistics, 'Domestic abuse in England and Wales overview: November 2022' (2022).
[2] Domestic Abuse Act 2021, Section 1.
[3] Domestic Abuse Act 2021, Section 2.

Flatmates and Carers

Currently, a DHR is triggered where a homicide occurs between individuals living within the same household. We have coordinated numerous DHRs involving same-sex couples where perpetrators were described as 'flatmates', 'friends', or 'lodgers'. Relationships involving 'flatmates' or 'lodgers' may pertain to individuals in an intimate relationship who conceal their relationship for cultural and religious reasons. Due to 'masking', the full extent of such relationships is often only revealed following the commission of the DHR. Domestic abuse related deaths can also occur where 'friends' and 'flatmates' have no intimate relationship. For instance, consider the DHR into the death of Adult J (chaired by STADA). Adult J and the perpetrator (Adult K) were flatmates and had known each other for several years. They are described as being 'friends' and had 'no intimate relationship'. While Adult K had made advances towards Adult J, these were not reciprocated and, it was believed that Adult K was infatuated with Adult J. Indeed, Adult K had installed spyware in Adult J's laptop and had been secretly filming her in the shower. It is vital to continue commissioning DHRs in these contexts to explore and safeguard against abuse within shared housing.

Equally, domestic abuse can occur where the perpetrator is described as the victim's live-in 'carer'. DHR3[4] involved a victim who was an older man in a same-sex relationship with his carer (the perpetrator). Health professionals did not enquire about domestic abuse even though the victim disclosed that he had been assaulted. DHR3 demonstrates that when those in 'caring' relationships present as injured or depressed, their condition is frequently presumed to be the result of health or social care needs. Deaths involving 'carers' need to be commissioned as DHRs, otherwise there is a risk that the opportunity to develop learning on domestic abuse within this context will be seriously compromised.

STADA accepts that there are occasions in which a DHR is not appropriate. This would include scenarios where there was no personal relationship, and the victim and perpetrator were not residing within the same household. For instance, if the perpetrator were a stalker, infatuated with the victim but with no perceivable relationship, it would be disrespectful to the deceased victim to suggest that there was a relationship. However, STADA consider that DHRs should be commissioned in all situations where the victim perceived there to be a relationship. This would include friends and flatmates or instances where the perpetrator entered a faux relationship (or has an alternative primary, intimate relationship) and is exploiting the victim in some way (i.e. for financial gain or sexual exploitation).

Corollary killings

Corollary killings related to intimate partner conflict can include children, a new partner of the victim and allies of the victim (such as relatives, neighbours, friends, and

[4] Detailed in Standing Together Against Domestic Abuse, 'Domestic Homicide Review (DHR) Case Analysis' (2016).

lawyers). A 2012 UK study, investigating intimate partner homicides with male perpetrators, found that 63% of the murders were intimate partner homicides and the remaining 37% were intimate partner corollary killings.[5] Corollary killings are a hideous form of domestic abuse where perpetrators attempt to exert control over the victim through threats and acts of violence towards their loved ones. Such DHRs have valuable learning, however corollary killings would not fall under the remit of DHRs if utilising the prerequisite of a personal connection within the DA Act 2021.

To account for homicides in cases of flatmates, carers, and corollary instances, **STADA would recommend reframing the legislation to include homicides 'caused by, related to, or somehow traceable to' domestic abuse** to ensure that vital lessons are not lost.

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

STADA are in favour of retaining the term 'Domestic Homicide Reviews' for instances involving death by homicide. However, we recommend that **the terminology of 'Domestic Abuse Related Death' is adopted for domestic abuse related suicides or unexplained deaths.** Having two titles would honour victims of domestic homicide while also accounting for a wider range of deaths.

Argument against 'Domestic Abuse Fatality Reviews'

The term 'fatality' is defined in Oxford Languages as '*an occurrence of death by accident, in war, or from disease.*'[6] The terminology of fatality thereby inadvertently removes accountability from the perpetrator by deeming homicides as '*accidents'*. Equally, in the cases of death by suicide, 'Domestic Abuse Fatality Reviews' would be inappropriate as suicide related to domestic abuse is not an accident and takes place in response to a perpetrator's actions.

For families bereaved by a domestic homicide, it is frequently felt that justice has not been obtained through the criminal justice system. In some cases, the perpetrators are charged with manslaughter rather than murder. As such, renaming DHRs as 'Domestic Abuse Fatality Reviews' lessens the seriousness of DHRs and infers that the death had no direct correlation with the perpetrator. This is particularly relevant as many families have expressed experiencing victim blaming language throughout the aftermath of a domestic homicide.

[5] Dobash and Dobash, 'Who Died? The Murder of Collaterals Related to Intimate Partner Conflict' (2012) 18 Violence Against Women 662.
[6] The Oxford Languages Dictionary is utilised by Google and is therefore the first result on Google Search.

Finally, renaming DHRs would infer that previous DHRs are outdated and labelled incorrectly. This is both unfair on families who fought to bring DHRs and would undermine the valuable teachings available within those DHRs.

Argument to introduce 'Domestic Abuse Related Death Review' as a second category of DHRs

The context and circumstances of a death related to suicide differ from those of a domestic homicide. Moreover, domestic abuse related deaths by suicide are not insignificant with 16 out of 46 of Standing Together's current and recently finalised DHRs have involved suicide (35%).[7] Given the prevalence of suicide in domestic abuse related deaths, it is vital that communities and organisations begin developing their understanding of the dynamics of domestic abuse within these cases. An alternative title for such deaths would differentiate suicides from domestic homicides and serve as a reminder to Chairs that the research and points of learning within these reviews should be tailored to suicide.

STADA would additionally note that, when conducting DHRs where a victim has died by suicide, it is not always possible to obtain information pertaining to the alleged perpetrator due to agencies data protection obligations. Current statutory guidance does not clearly outline the expectation of agencies to share information on the alleged perpetrator, in cases where the victim dies by suicide. In such instances, the learning potential of the DHR is limited. As such, STADA recommend that the Home Office takes this opportunity to clarify the sharing of information by agencies in relation to the perpetrator of a suicide.

We have additionally chaired DHRs involving unexplained deaths where domestic abuse was relevant. For instance, DHR65[8] (chaired by STADA) involved a father and son and it was difficult to identify the primary perpetrator as assaults by both parties were extreme. The death occurred when the father had a medical emergency, and while the son called an ambulance, he refused to care for his father while they waited for an ambulance and his father died. Although this incident should not be classified as a domestic homicide, a review of the incidents leading up to this death would provide valuable insight into domestic abuse for the agencies involved. As such, STADA is in favour of a wider definition to ensure that no relevant domestic abuse related deaths are hidden and would advocate for a broad term to encompass DA learning in different contexts. STADA recommend the terminology of 'Domestic Abuse Related Death' is, therefore, adopted for DA related suicides and any unexplained deaths.

[7] This statistic involves all DHRs chaired by STADA from 2018 to present, including unpublished DHRs and DHRs which remain with the CSP.
[8] DHR65 is an unpublished DHR chaired by STADA.