Vulnerability Knowledge and Practice Programme (VKPP)

Domestic Homicides and Suspected Victim Suicides 2020-2024

Year 4 Report

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'You are the voice of the dead person, and you have a huge responsibility to ensure their story is recorded correctly. How can we learn from the past if it is not represented accurately?'

- Frank Mullane, CEO Advocacy After Fatal Domestic Abuse (AAFDA)

March 2025

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Foreword – Police Chiefs and the College of Policing

The police service remains committed to protecting victims of domestic abuse, bringing perpetrators to justice and preventing these horrific crimes. Alongside our partner agencies, we are determined to tackle the continued and enduring problem of domestic abuse and domestic homicide which remains seismic in nature and deep rooted within the fabric of our society.

The response to and prevention of Violence Against Women and Girls (VAWG) is a priority within policing, with domestic abuse being one of its most common forms. We want to build upon the best of what we already do, and sustainably implement the changes policing needs to tackle VAWG offending and improve public protection through effective joint working. We are about to launch a new National Centre for Violence Against Women and Girls and Public Protection (NCVPP). The centre will bring together the Vulnerability Knowledge and Practice Programme (VKPP), Operation Soteria and the VAWG taskforce from 1 April 2025. This is with a view to combining responses, knowledge and skills to build victim confidence, prevent harm and bring more offenders to justice. It will be hosted by the College of Policing, led by a senior chief officer, working in close partnership with the NPCC.

The findings in this report continue to demonstrate the devastating consequences of domestic abuse. Every single one of these deaths is a tragic and horrific loss, with the impact reaching across families, friends and communities for decades. Within this report we have highlighted the worrying prevalence of suicide following domestic abuse where victims see no way out and are driven to take their own lives. Alongside our partner agencies, policing needs to understand this and respond accordingly.

Throughout this project we have been greatly supported by numerous stakeholders, charities and academics who are experts in this field. We would also like to take the opportunity to remember the many victims and their families who have lost loved ones in tragic circumstances, many of which have helped us with this report and provided valuable feedback. Informed by the findings of this research, we continue to work on the police response to protect victims and to tackle such a heinous crime.

AC Louisa Rolfe OBE
Assistant Commissioner
Policing Reform Lead,
NPCC Crime Coordinating Committee Chair, NPCC Lead Domestic Abuse

CC Kate Meynell
Chief Constable
NPCC Lead Homicide

ACC Charlie Doyle
Assistant Chief Constable
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Chief Constable
Chief Executive Officer
College of Policing

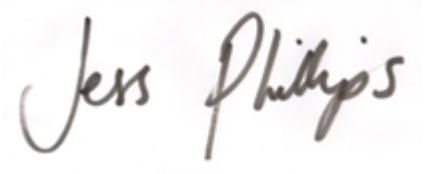
Foreword – Minister for Safeguarding and Violence Against Women and Girls

Domestic homicide is a horrific crime that disproportionately impacts women. We know that, in the year ending March 2024, over half of all adult female homicide victims were killed in a domestic homicide, and of those female victims, all but six were killed by a male suspect. We must go further to ensure that a light is shone on all domestic abuse related deaths and that bereaved families receive the support they need.

As Minister for Safeguarding and Violence Against Women and Girls (VAWG), I am absolutely committed to tackling these crimes and treating VAWG as the national emergency that it is. Better understanding of domestic homicide is a crucial part of this work. This Government will work together across public services, the private sector, and charities to go further than before to deliver a cross-Government transformative approach to halve VAWG in a decade, underpinned by a new VAWG strategy to be published later this year. We will use every tool available to target perpetrators and address the root causes of abuse, including introducing bold measures designed to strengthen the police response and support our education system to teach children about healthy relationships and consent.

The work of the Domestic Homicide Project provides important data for building our understanding of domestic abuse and domestic abuse related deaths. For instance, the most commonly recorded risk factors for suspects were mental ill health, coercive or controlling behaviour, alcohol use and drug misuse**.** This highlights the complexity of domestic abuse and the need for persistent and sustained efforts across Government to tackle such pervasive issues and ultimately, prevent future deaths. This report also provides valuable insights into suicides and unexplained deaths that follow domestic abuse which are not captured elsewhere.

I would like to thank the National Police Chiefs' Council, the Vulnerability Knowledge and Practice Programme and the College of Policing, and all those who have contributed to this project. We must continue to work together to shed light on the prevalence of domestic homicide and protect women and girls.



Jess Phillips MP

Minister for Safeguarding and Violence Against Women and Girls

Contents

Summary of Findings and Recommendations

The glossary of acronyms and terms used throughout this report, as well as Appendix B containing all datasets used for analysis, can be found on the VKPP website under the name 'Glossary of Terms and Appendix B – Data Tables'.

In 2020 the Domestic Homicide Project was established by police and government[5] in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides, unexpected deaths[6] and suspected suicides of individuals with a history of domestic abuse (DA) victimisation. In the wake of the Covid-19 pandemic, the Project aimed to establish the impact of the pandemic and associated restrictions on domestic homicides and learn lessons from every tragic death to seek to prevent future deaths. Based on its unique contribution, the Project has been embedded and expanded to fill a gap in information not available elsewhere or within the same timescales.[7]

In this year's report the Project team has included figures for six typologies (i.e., intimate partner homicide (IPH), adult family homicide (AFH), unexpected death, suspected victim suicide following domestic abuse (SVSDA), child death, and deaths classified as 'other'). In some cases, the report presents data within the combined category of domestic homicides, which includes both IPH and AFH.

It is important to note that domestic homicide figures do fluctuate from year to year, and therefore this report's comparison of four years' worth of data may reflect some general fluctuation. At least five years of data collection is needed to assess any patterns or trends in significance. Moreover, the increased identification and reporting of SVSDA and unexpected deaths are highlighted throughout.

Chapter 2: Domestic Homicides, Unexpected Deaths and Suspected Victim Suicides Following Domestic Abuse, April 2020 - March 2024

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Findings

Finding 1: Across the full four-year dataset (1st April 2020-31st March 2024) the Project recorded 1012 deaths in 979 incidents. These deaths were spread across the following

[5] The Project is funded by the Home Office, with strategic leadership from the NPCC and College of Policing.

[6] Unexpected deaths may be due to natural causes, accident, suicide or homicide where the circumstances and/or the cause of the death may be unclear or unknown.

[7] Please note that the Domestic Homicide Project is separate to the existing statutory process for Domestic Homicide Reviews, which is a 'review of the circumstances in which 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' (Home Office, 2016). As this process conducts an in-depth review to draw out learning from all agencies, not just policing, it may take years after the death for the Domestic Homicide Review (DHR) to be published. At the time of writing, reform of the DHR process by the Home Office, including the title, definition, criteria and guidance, is ongoing.

typologies: 501 domestic homicides (169 AFH and 332 IPH), 354 SVSDA, 71 unexpected deaths, 61 child deaths and 25 deaths classified as 'other'. In Year 4 (1st April 2023 - 31st March 2024), a total of 262 deaths were recorded. This included 98 SVSDA, 80 IPH, 39 AFH, 28 unexpected deaths, 11 child deaths and six deaths classified as 'other'.

The relatively small proportion of child deaths reported in Year 4 (4%, n=11/262) may be due to a limited number of force areas reporting all child deaths in line with the project definition. The reported data is likely to reflect child deaths with a perceived link to DA or associated with a familicide.

Alongside the overall scale of deaths recorded across four years (n=1012), the relative stability of IPH deaths across four years of data collection (n=87; n=84; n=81; n=80), highlights the enduring issue of DA-related deaths and need to continue work towards prevention.

Finding 2: SVSDA was the most recorded typology across the full four-year dataset (35%, n=354). The slight decrease in reported SVSDA cases in Year 4 (n=98) as compared to Year 3 (n=113) was also accompanied by an increase in the number of unexpected deaths between Year 3 (n=17) to Year 4 (n=28).

Additionally, late submissions as well as re-classifications of previously unexpected deaths contributed to increases in the Year 3 data after the publication of last year's report (from 93 to 113). Together, this suggests that the Year 4 figures may continue to change and that police forces may be utilising updated unexpected death guidance and submitting these cases whilst investigations into the death are ongoing until they are ruled a homicide, suicide or death by misadventure or natural causes.

Recommendation

Recommendation 1 [To the NPCC and Domestic Homicide Project]: The NPCC portfolio leads for domestic abuse, homicide and suicide prevention should work with the Domestic Homicide Project team to facilitate scoping, research and review of the policies and emerging practice associated with the police response to unexpected deaths. This work would help understand how updated guidance is being translated into practice.

Recommendation 2 [**To the College of Policing]:** The College of Policing should ensure the additional guidance developed by the Domestic Homicide Project team in collaboration with the National Homicide Working Group is captured, updated or enhanced where relevant within the College of Policing APP materials.

Chapter 3: Typologies and characteristics of victims and suspects

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Findings

Finding 3: Overall, the most common method of death was by sharp instrument accounting for 45% (n=225/501) of domestic homicides. Within SVSDA cases, hanging was the most common method of death (62%, n=219/354). Analysis showed that of all sharp instrument deaths across the dataset, 6% (n=16/251) took place in public spaces, with nine being IPH and seven being AFH. This holds important implications for the Government's Safer Streets initiative.

Finding 4: Across all four years (n=1056 suspects), 69% (n=730) of suspects were the current (49%, n=515) or ex- partner/spouse (20%, n=215) of the victim, primarily associated with IPH, SVSDA and unexpected deaths. SVSDA cases represented the typology with the highest proportion of suspects being the victim's ex-partner/spouse (41%, n=156/383). This similarly reflects the prevalence of separation or relationship ending within SVSDA cases (see Chapter 4). The suspect was the (adult) child of the victim in 12% (n=125) of cases across all four years.

Finding 5: The majority of victims were female (73%, n=735/1012), whilst 27% (n=277) were recorded as male across the full four-year dataset.

Analysis on victim-suspect pairings by sex and typology was conducted exclusively for domestic homicides (AFH & IPH) and SVSDA cases (n=845 cases). Across these typologies, most cases involved a female victim and male suspect (72%, n=608), whilst 14% (n=115) involved a male victim with a female suspect. 10% (n=84) of cases involved a male victim and male suspect, whilst 4% (n=31) involved a female victim and female suspect.

These pairings by sex present differently when comparing by typology, for example with IPH cases primarily involving a female victim and male suspect (82%, n=272/331), whilst this was the case for just under half of AFH cases (48%, n=77/160).

Finding 6: Across the four-year dataset, 60% (n=598/1012) of victims were aged 25 to 54 years old, with 15% (n=154) being 65 years or older. Suspects were slightly younger than victims, with 69% (n=732/1056) aged 25 to 54 years old, and 18% (n=188) being 55 years or older.

Finding 7: Other protected characteristics were also analysed, such as ethnicity, nationality and sexuality.

Beginning with police-recorded ethnicity and focusing on victims, a total of 79% (n=798/1012) were recorded as being of White ethnicities. Additionally, 8% (n=77) were recorded as being of Black ethnicities, 7% (n=69) of Asian ethnicities, 1% (n=15) of mixed ethnicities, and 3% (n=33) of 'other' ethnicities. Those of minority ethnic heritages (other

than White ethnicities) comprised 19% (n=194) of the combined four-year dataset, which is similar to figures collected by the 2021 Census. Potential disparities relating to specific ethnic groups discussed in Section 3.2.5. This chapter also details additional analyses of Black and minoritised victims of domestic homicide and SVSDA by sex and typology (see Section 3.3).

Regarding nationality, behind British (72% [n=728] of victims and suspects [n=756]) of suspects), Eastern European countries[8] were the second most commonly recorded (5% of victims (n=51) and suspects (n=56). The Femicide Census analysis of ten years' femicide data similarly highlights Eastern European, post-communist nations as being relatively highly represented in terms of victim nationality (Femicide Census, 2020).

Additionally, whilst the figures may be influenced by barriers to recording within the police context, 4% of victims (n=37/1012) and 3% of suspects (n=34/1056) were recorded as being LGBTQ+. The majority of LGBTQ+ victims (68%, n=25/37) were recorded within SVSDA cases, suggesting the importance of considering suicide prevention activities for victims of DA within this population.

Analysis such as this can help to identify communities who may be over-represented or under-served, facilitating partnership working, as well as targeted engagement programmes.

Recommendation

Recommendation 3 [To the Police, Public Health and Education]: The police should consider whether young people, including under 16s, may be experiencing domestic abuse and/or coercive control, in their early intimate relationships and how this might be identified within current structures. This necessitates collaboration with partner agencies, such as social care and education.

Recommendation 4 [To the Government and Domestic Homicide Project]: Supported by the research of the Domestic Homicide Project and other relevant stakeholders, the Government should enable further work to identify the prevalence of younger victims with a history of domestic abuse, particularly those relating to intimate relationships between adolescents.

Recommendation 5 [To the Domestic Homicide Project]: This Project team should continue to disaggregate collected data relating to protected characteristics such as ethnicity and sex to facilitate the identification of any potential disproportionality between groups that would otherwise not be visible across broader analysis of the dataset.

[8] According to the United Nations, 'Eastern European' primarily refers to individuals from: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Czech, Estonia, Georgia, Hungary, Latvia, Lithuanian, Polish, Republic of Moldova, Romania, Russian Federation, Serbia and Slovakia.

Chapter 4: Risk factors in Domestic Homicides and Suspected Victim Suicides

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Findings

Finding 8: Across the four-year dataset, the most commonly identified antecedent suspect risk factors were:

1) Mental ill health (43%, n=459);
2) CCB (39%, n=415);
3) Alcohol use (33%, n=352);
4) Drug misuse (30%, n=314);

Notably, for 18% (n=186/1056) of suspects, alcohol use and drug misuse were recorded as co-occurring risk factors. Moreover, considering the method of death alongside the risk factor of previous non-fatal strangulation (NFS), NFS was present in 21% (n=47/222) of cases of death by hanging, 14% (n=9/64) of deaths by strangulation, and 8% (n=2/25) of deaths by suffocation.

Additionally, these risk factors varied by typology, such as the predominance of mental ill health within cases of AFH (63%, n=111). The prevalence of CCB within SVSDA cases (56%, n=216) is explored further within Chapter 8. To intervene effectively, the police and other agencies must understand the 'problem profiles' of different DA-related deaths in their force.

Finding 9: Four risk factors were significantly associated with the suspect being identified by the police as a high-risk and/or serial perpetrator of DA, namely previous attempts or threats to kill ($p<.001$, n=963, Phi (effect size): 0.300), previous use of weapon ($p<.001$, n=963, Phi: 0.319), protective orders in place against the suspect ($p<.001$, n=961, Phi: 0.375) and previous breach of protective order ($p<.001$, n=961, Phi: 0.353).

Recommendation

Recommendation 6 [To the Police and Public Health]: The prevalence of mental ill health, coercive and controlling behaviour, alcohol use and substance misuse as risk factors in cases of domestic homicide and suspected victim suicides following domestic abuse indicates that police forces, mental health and substance misuse services should improve information sharing and map local provision for appropriate referrals to help improve safeguarding and prevent future deaths.

Recommendation 7 [To the Police]: The police should strengthen links between their internal suicide prevention and domestic abuse specialist teams to help safeguard victims at risk of suicide following domestic abuse.

Recommendation 8 [To the Police and Public Health]: The police should work with relevant partner agencies, such as health, to raise awareness about the risks posed by non-fatal strangulation, including in relation to domestic homicide and its prevalence within cases of suspected victim suicide following domestic abuse.

Chapter 5: Prior suspect and victim contact with the police and other agencies

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Findings

Finding 10: Across the four-year dataset (excluding cases of SVSDA), 54% (n=364/673) of suspects were known to the police for DA perpetration prior to the victim's death.

Within cases of SVSDA, 89% (n=341/383) involve a history of DA perpetration known to the police prior to the victim's death. Whilst this may be expected given the need for the police to know about the abuse in order to submit the case to this Project, this suggests that some cases are being identified posthumously through information from family, friends or other agencies. Furthermore, this means the victims are 'visible' to the police and other services, which creates opportunities for intervention.

Finding 11: 35% (n=247/705) of suspects known to the police for DA prior to the victim's death were high-risk and/or serial perpetrators. This was most common within IPH suspects (41%, n=75/185) and SVSDA prior DA perpetrators (38%, n=131/341), typologies that appear to demonstrate similar risk profiles overall.

Finding 12: Similar to previous reports, 10% (n=106/1056) of all suspects were recorded as having been previously managed by police or probation (e.g., under MAPPA, IOM, or DRIVE).

Finding 13: In 68% of incidents (n=662/979) across the four-year dataset the victim and/or suspect was known to a partner agency, with mental health services being the most recorded single agency (23%, n=230). Notably, 37% of all victims and/or suspects (n=362) were known to social services when combining cases known to adult, children or unspecified social services. Overall, victims and/or suspects being known to a partner agency was most common in cases of SVSDA (79%, n=281/356), which echoes findings about their visibility to the police.

For those cases in which the suspect was not previously known to police for any reason (n=101), 30% (n=30) involved a suspect and/or victim that were known to a partner agency, continuing to highlight the importance of multi-agency collaboration and information sharing.

Recommendation

Recommendation 9 [To the Government and NPCC]: The Government and NPCC should enable further research and evidence gathering on offender management to better understand the profile and behaviour of those that go on to commit homicide or are associated with suspected victim suicide following domestic abuse. With evidence that victims and suspects/perpetrators are often known to a range of partner agencies, including (mental) health services, this research should draw together multi-disciplinary learning across criminal justice, healthcare and social care sectors.

Chapter 6: Domestic Homicide Reviews

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Findings

Finding 14: Of those cases that were referred for a Domestic Homicide Review (DHR) or other type of review, 62% (n=490/789) were accepted, which rises to 85% (n=490/757) when considering only those cases that were referred and the referral outcome was known. Generally, the referral and acceptance rate for SVSDA cases appears to have increased over the four years of data collection, which indicates a need for additional analysis and investigation in the wake of changes to statutory guidance.

Recommendation

Recommendation 10 [To the Government]: The Government should monitor and evaluate changes influenced by the updated definition and forthcoming statutory guidance relating to DHRs (soon to be re-named Domestic Abuse Related Death Reviews), once the updated definition and guidance have been enacted.

Chapter 7: Deaths caused by a fall from height

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Findings

Finding 15: Five of the eight victims within the SVSDA typology had expressed suicidal thoughts or attempted suicide shortly before their death; with a timeframe ranging from three months to a few days before the death.

Finding 16: Similar to what is observed in the wider data, in the cases of fatal falls identified as AFHs (n=3), all the suspects were recorded by police as presenting mental ill health. At least two of the three had been previously detained under Mental Health Act.

Finding 17: In 15 (68%) cases the suspect was present at the time of the fall. In several cases the suspect was the person calling the emergency services, and all 15 of them claimed that the victim had fell or jumped.

Finding 18: In at least six cases there were records of recent DA incidents in the days preceding the death. Additionally, in some cases partner agencies had expressed concerns for the victim or other vulnerable people around them.

Finding 19: In eight cases, families and friends of the victim approached the police after the death making allegations of DA between the victim and suspect. Five of these cases were SVSDA and three were unexpected deaths.

Recommendation

Recommendation 11 [To the Domestic Homicide Project]: This Project team should continue to collect data on deaths involving a fall from height to facilitate further analysis and learning to inform future practice developments.

Chapter 8: Suspected suicide following domestic abuse

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Findings

Finding 20: There were 206 victims of SVSDA from an intimate partner also involving an identified history of CCB, associated with 210 DA perpetrators. This represents 58% of the 354 cases of SVSDA over the four-year dataset.

Finding 21: Illustrating the nature of risk in these cases, nearly half of these victims were known as high-risk (47%, n=97) and 55% (n=113) had been involved as victims in cases that were previously heard at MARAC.

When considering the risk factors that co-occurred with CCB in these cases, the most common were separation (48%, n=100), prior DA perpetrator's mental ill health (45%, n=95), alcohol use (42%, n=88), drug misuse (40%, n=85), prior DA perpetrator also known as a victim of DA (33%, n=69) and non-fatal strangulation (27%, n=56).

Finding 22: Across the four-year dataset, 12 cases of SVSDA achieved a posthumous prosecution. One of these achieved a charge for Unlawful Act Manslaughter, which is included as a case study that outlines the evidence gathering and investigation process as well as the outcome at trial. With additional evidence of cases of SVSDA involving further investigation and attempts to pursue posthumous charges, this will be an area of continued analysis.

Finding 23: During the third consultation with family members bereaved by fatal DA they shared their perspectives and experiences. Positive feedback included the importance of sharing data and practical experience across policing, changes to police tools and training (e.g., DARA, DA Matters, updated guidance), and that their voices were being heard in a way that affects changes. The family members also described areas of concern such as, the training and experience of young-in-service officers, access to property after a victim's

death, the impact and burdens on friends and family members after a death, with some expressing a lack of trust and confidence in the police.

The themes and concerns raised during this consultation provide important areas for future work by the government, police and their partners (see Section 8.3).

Recommendations

Recommendation 12 [To the CPS and Police Forces]: The CPS should review their strategy, policy and guidance relating to the posthumous prosecution of cases relating to suspected victims suicide following domestic abuse, taking into account learning from cases that result in a conviction, those which do not, and ongoing development of caselaw. Where police forces identify relevant cases, they should seek early advice from the Complex Case Unit to support the evidence gathering and investigation process.

Recommendation 13 [To the NPCC]: The NPCC's Homicide Working Group should enable and promote national forums for Senior Investigating Officers (SIOs) to monitor and share relevant practice for the investigation and posthumous prosecution of cases of suspected victim suicide or unexpected death following domestic abuse.

Recommendation 14 [To the Ministry of Justice]: Informed by the learning from this Project, the Ministry of Justice should work with the Office of the Chief Coroner to consider incorporating further training for Coroners surrounding domestic abuse, including its potential links to suicide.

MAIN REPORT

Chapter 1 – Introduction

1.1 Definitions and terminology

For the purposes of data collection, in order to capture as accurate as possible a picture of the scale of DA related deaths in quick-time, the Project adopted a wide definition of relevant deaths. In addition to domestic homicide by a (current or ex) partner or family member, the Project also counted child deaths in a domestic setting, as well as unexpected deaths and suspected suicides of individuals with a known history of DA victimisation[9].

The overall definition for the Project is, 'The death of a person, any age (including under 16), that has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. This includes where it appears that a person has died by suicide or there is an unexpected death as a result of or following DA.'

Throughout our analysis we divide cases into six typologies, primarily based on victim-perpetrator relationship:

Adult Family Homicide (AFH)
Homicide of an individual aged 18 or over by an adult family member.
Intimate Partner Homicide (IPH)
Homicide of an adult aged 18 or over by a current or former intimate partner.
Suspected Victim Suicide Following Domestic Abuse (SVSDA)
Suspected suicide of a person aged 16 or over following known DA against them. Where we present analysis of the whole dataset in this report and use the umbrella term 'suspect', in cases of SVSDA this refers to the perpetrator of the prior DA. Where we only discuss SVSDA, we use the term 'prior DA perpetrators'.
Unexpected Death
Unexpected deaths include those under investigation but not (yet) deemed a homicide, suspected suicide or non-suspicious death.[10]

[9] This broad definition of SVSDA does not require a causal link between the death and prior DA, nor does it specify a time frame for the abuse. This allows police some flexibility in interpreting which cases to submit, with emphasis on including cases when in doubt.

[10] Please note that it is the purview of the Coroner to investigate deaths which are deemed to be unnatural, violent, where the cause is unknown or the deceased died while in custody or in a state of detention (*Coroners and Justice Act*

Child Death
Homicide of a child aged under 18 by a family member or family member's partner.
Other
Where the relationship is not intimate partner or familial but the victim and suspect live together, e.g., lodger or flatmate

In addition to this Project's inclusion of SVSDA, counting of deaths in this report will differ from Home Office Homicide Index (HOHI) figures on domestic homicides, based on differences in definition, inclusion criteria and data collection:

1. The DH Project definition includes children aged 0-15 (suspected to have been) killed by a family member within child deaths, but this would not be included within the HOHI definition of domestic homicide (16 years or older).

2. Furthermore, in contrast to the HOHI definition of domestic homicide, our Project includes the category of 'other' deaths - individuals that are living together but are not related or in an intimate relationship.

3. Because we gather information on deaths in quick-time, suspects are counted pre-charge. This differs from the HOHI, which captures homicide suspects at a later point, once charged.

4. Similarly, by capturing deaths pre-charge and pre-inquest, we include deaths that are, at the time of initial report to us, unexpected. Unexpected deaths may not yet have been formally deemed a homicide or suicide. If, following further investigation, the police deem these cases to be non-suspicious deaths by natural causes they are excluded from our dataset before analysis.

5. This Project conducts data reconciliation with other public data sources that are checked against police records, including Counting Dead Women and the ManKind Initiative.

In some cases, we present data with combined figures for IPH and AFH. These figures are most similar to the HOHI definition of domestic homicide, with remaining differences based on data collection noted above.

1.2 About the data

This report provides analysis of four years of data from 1st April 2020 to 31st March 2024, primarily focusing on the entire four-year dataset, but also looking at previously unreported data from 1st April 2023 to 31st March 2024 (Year 4) in isolation.

2009, c.25). Verdicts possible during an inquest include natural causes; accident; suicide; unlawful or unlawful killing; industrial disease; and open verdicts, where there is insufficient evidence for any other verdict (Aftermath Support, 2024).

As in previous reports, the Project team coded the data quality and completeness of each submission (n=979), both using a three-point grading system. Overall, 74% of submissions were initially assessed as being complete (n=722) and 83% of good or excellent quality (n=816). The Project team also conducts follow ups in attempt to capture any missing/incomplete data.

Forty out of 43 (93%) police forces in England and Wales submitted data for Year 4. Three forces did not submit relevant deaths in their areas, confirming that they had nothing to report. Sixty initial submissions across the four-year dataset were excluded from the analysis due to new information indicating the incidents were not crimes or not domestic-related. This also includes sudden/unexplained/unexpected deaths that, upon further investigation, no longer met the Project's definition.

As above, the Project team also completed data reconciliation exercises with the cases collected by Counting Dead Women and the ManKind Initiative. Data reconciliation with the Counting Dead Women Twitter account identified a further 12 submissions that were checked against relevant police force records. Reconciliation reviewing ManKind's website did not identify any new cases. We are grateful to these organisations for their work to identify and collate this information, as well as their generosity and co-operation in helping triangulate the cases.

Similar to previous years, this report includes responses to the recommendations made in the Year 3 report. Appendix A details these recommendations directed towards policing, government, the College of Policing, and this Project, along with updates on progress for each one.

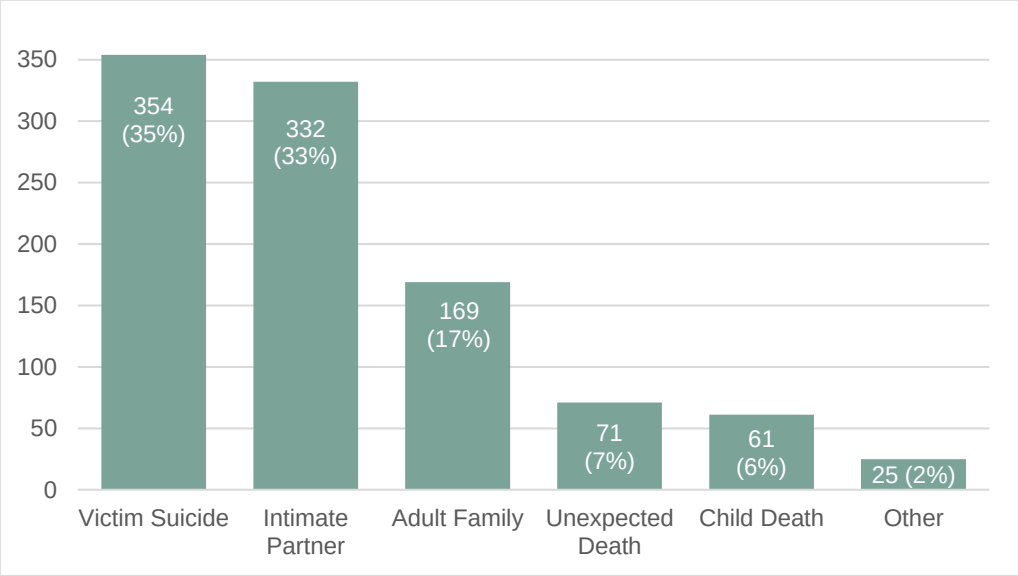
All content presented in the report is the exclusive work product of the Domestic Homicide Project. It has been constructed through rigorous research and data collection processes specific to the scope of the project. Should any individual or organisation wish to use the Domestic Homicide Project's data in their own outputs, please contact the authors via **dhproject.vkpp@college.police.uk** to ensure clarity regarding the meaning and interpretation of the presented findings. Any use of this information must include proper citation of the Domestic Homicide Project, and presenting the data as one's own without prior consent is strictly prohibited.

Chapter 2 - Domestic Homicides, Unexpected Deaths and Suspected Victim Suicides Following Domestic Abuse: April 2020 - March 2024

2.1 Overall deaths April 2020 - March 2024

Across the four-year dataset, this Project has counted 1012 deaths in 979 incidents. These deaths were spread across the following typologies: 501 domestic homicides (169 AFH and 332 IPH), 354 SVSDA, 71 unexpected deaths, 61 child deaths and 25 deaths classified as 'other' (see **Figure 1** below).

Figure 1 *Number and proportion of deaths by typology (April 2020 – March 2024)*



2.2 Overall deaths: April 2024

In Year 4, the Project counted a total of 262 deaths out of 253 incidents across all case types. This included 98 SVSDA, 80 IPH, 39 AFH, 28 unexpected deaths, 11 child deaths and six deaths classified as 'other'.

When comparing Year 4 to Year 3, whilst there was a slight decrease in the number of reported SVSDA deaths (from 113 to 98), there was also a statistically significant increase in the number of unexpected deaths from 17 in Year 3 (M=14.33, SD=2.05) to 28 in Year 4 ($t(2)=8.84$, $p<.05$). During the Year 3 reporting period, 93 SVSDA deaths were recorded (April 2022 – March 2023). Due to late submissions (n=10) as well as reclassifications of unexpected deaths (n=10), the total number for SVSDA deaths within the Year 3 timeline has increased by 20 (n=113).

These changes might be due to forces following guidance and recording and submitting cases as unexpected deaths where ongoing (coronial and/or police) investigations have not officially ruled deaths as suicides (see **Table 1**). To better understand the translation of relevant guidance and policies into practice, as part of the external engagement by HMICFRS for the development of their PEEL Assessment Framework for 2025/27, the Project team raised the topic of police identification of and responses to unexpected deaths and SVSDA for consideration of inclusion within their future inspection activity.

Despite the differences in reporting of unexpected deaths, SVSDA remains the most recorded typology across the full four-year dataset (35%, n=354). As highlighted in the previous report, the overall increase in reported SVSDA likely reflects improved case identification and submission to this Project, rather than an empirical rise in cases. This improved case identification may be due to greater awareness of the link between suicide and DA, through the recommendations and dissemination of this Project as well as wider research efforts (e.g., Rowlands and Dangar, 2024; Munro, Bettinson and Burton, 2024).

Notably, the number of IPH deaths has remained relatively stable over the course of four years of data collection, with almost no change from Year 3 to Year 4 (31%, n=81/265, to 31%, n=80/262; see **Table 1**). Alongside the overall scale of deaths recorded over the past four years (n=1012), this continues to highlight the enduring nature of this issue and need to work towards prevention.

Additionally, the relatively small number of reported child deaths in Year 4 (n=11) likely reflects underreporting, whereby not all police forces are continuing to report all child deaths according to the project definition. Instead, the data primarily appears to represent child deaths linked to child abuse or familicide. Consequently, the following chapters primarily focus on analysing AFH, IPH, unexpected deaths, and SVSDA.

However, domestic homicides and suicides of younger victims (aged 16-24) are discussed in depth within our recent Spotlight Briefing (Bates et al., 2024). Furthermore, data from the Crime Survey of England and Wales (CSEW) for the years ending March 2023 showed the relatively high prevalence of DA victimisation in those aged 16 to 19. The CSEW data showed that a significantly higher proportion of individuals aged 16 to 19 were victims of DA as compared with those aged 45 to 54 and 60 years and older (ONS 2023b).

Whilst this project's overall definition includes 'any age', we have not received submissions from police forces involving the death of an individual under 18 years old who was suspected to have been killed by an intimate partner or a SVSDA of an individual under 16 years old. This research suggests that DA-related deaths of those under 16, including with a potential history of intimate partner abuse, may not always be classified in a way that allows them to be identified by the police or other agencies.

Importantly, due to yearly fluctuations in domestic homicide figures, this report's comparison of four years' worth of data may reflect this general fluctuation. At least five years of data collection is needed to assess patterns or trends in significance.

Click here to return to the summary findings and recommendations for Chapter 2

Table 1 *Number and proportion of deaths by typology – changes between Years 1, 2, 3 and 4.*

	2020/2021		2021/2022		2022/2023		2023/2024		Overall	
	N	**%**	**N**	**% point difference compared to previous year**	**N**	**% point difference compared to previous year**	**N**	**% point difference compared to previous year**	**N**	**%**
Domestic Homicides (AFH & IPH)	125	56%	141	54% (-2%)	116	44% (-10%)	119	45% (+1%)	**501**	**50%**
Suspected Victim Suicide	61	27%	82	32% (+5%)	113	43% (+9%)	98	37% (-5%)	**354**	**35%**
Intimate Partner Homicide	87	39%	84	32% (-7%)	81	31% (-1%)	80	31% (N/A)	**332**	**33%**
Adult Family Homicide	38	17%	57	22% (+5%)	35	13% (-9%)	39	15% (+2%)	**169**	**17%**
Unexpected Death	12	5%	14	5% (N/A)	17	6% (+1%)	28	11% (+4%)	**71**	**7%**
Child Death	20	9%	16	6% (-3%)	14	5% (-1%)	11	4% (-1%)	**61**	**6%**
Other	7	3%	7	3% (N/A)	5	2% (-1%)	6	2% (N/A)	**25**	**2%**
Total per year	**225**	100%	**260**	100%	**265**	100%	**262**	100%	**1012**	**100%**

Chapter 3 – Typologies and characteristics of victims and suspects

3.1 Case characteristics

The numbers and percentages referred to throughout this section can be found in the data tables in Appendix B (separate document).

3.1.1 Method of death

The most common method of death was sharp instrument, accounting for 45% (n=225/501) of domestic homicides (52%, n=88/169 of AFH and 41%, n=137/332 of IPH; see **Figure 2**). This reinforces findings from (domestic) homicide and femicide data, which indicate that sharp instruments have remained the most common method of killing over time (Femicide Census, 2020; Home Office, 2023; Hoeger et al. 2024).

In part, this reflects the fact that knives are readily available, especially in domestic settings. Additional analysis showed that of all sharp instrument-related deaths across the four-year dataset, only 6% (n=16/251) occurred in public spaces, nine of which were IPH deaths and the remaining seven being AFH deaths. This highlights how domestic homicides involving sharp instruments differ from street-related knife crime, as they predominantly occur within private premises. The Criminal Justice Bill on knife crime (Home Office and Ministry of Justice, 2024) has introduced police powers to confiscate knives from properties if they believe they will be used in serious crime, which applies to illegal or visibly harmful knives—such as zombie knives—as well as everyday household items like kitchen knives that are commonly used in the context of DA and domestic homicide.

Whilst the bill adds strategies to combat knife availability, tackling DA-related knife violence remains challenging due to the ease of (re)acquiring household kitchen knives. Effectively reducing knife-related incidents in DA environments may therefore require broader approaches grounded in robust risk assessment and cohesive multi-agency working between police and associated partner agencies. This is an objective to be addressed within the Government's Safer Streets fund (Home Office, 2024).

Additionally, following a 14-week consultation on murder sentencing that concluded in March 2024, a recent press release from the government has announced a review of homicide law and murder sentencing framework. This is particularly relevant in cases of sharp-instrument related deaths, where the sentencing guidelines starting point for murders where a knife has been taken to the scene with intent to harm is a 25-year sentence. Conversely, in cases where the knife is already available at the scene—which appears to be the case in most domestic homicides recorded in this report—the minimum term for sentencing decreases to 15 years.

The second most common method of death was hanging, accounting for 62% of SVSDA (n=219/354; see **Figure 2**). This has consistently been the most reported method of death

for SVSDA over time (52%, n=32/61 for Year 1; 63%, n=52/82 for Year 2; 66%, n=75/113 for Year 3; and 61%, n=60/98 for Year 4).

Figure 2 *Proportion of Domestic Homicides and SVSDA victims by method of death (April 2023 – March 2024)*

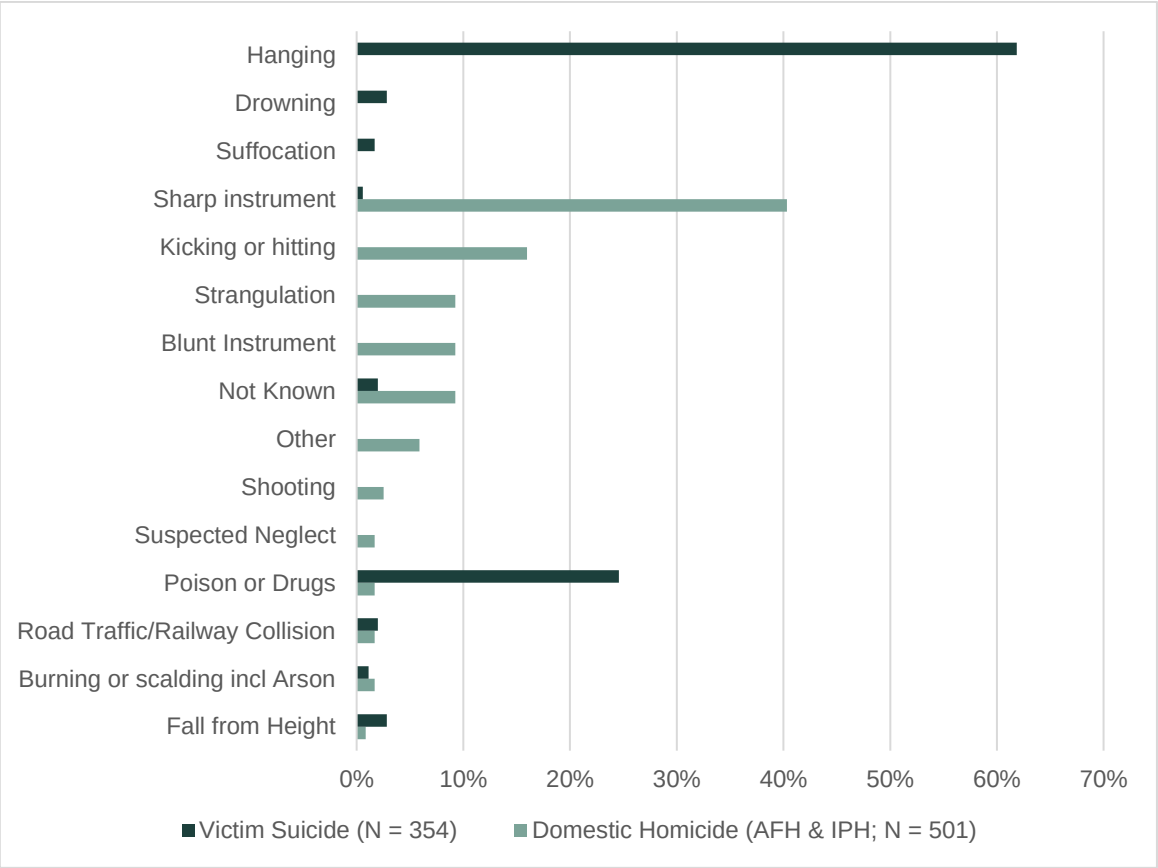


Table 2 *Number and proportion of victims by method of death – April 2020 to March 2024*

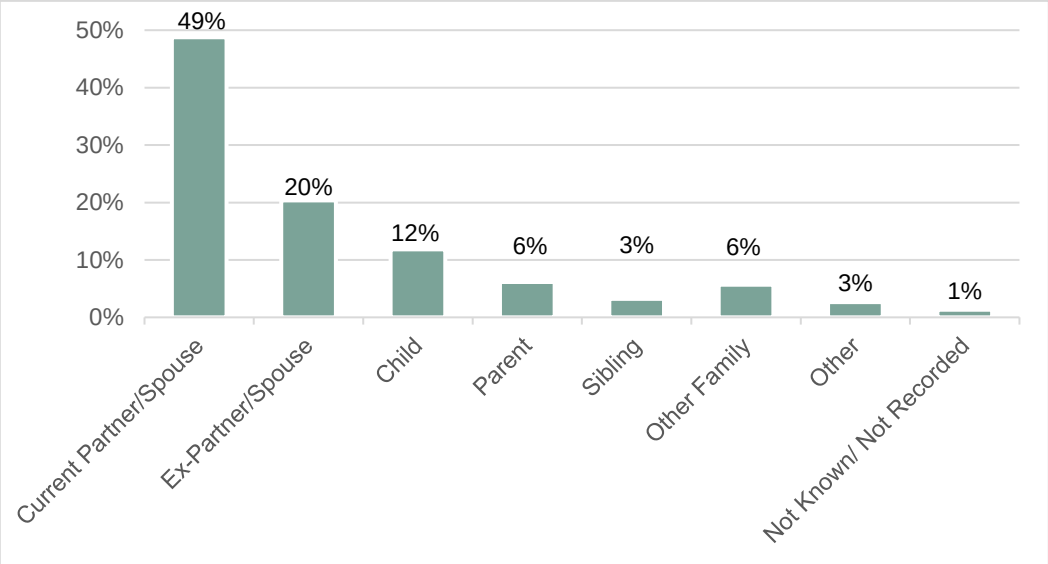
	Adult Family		Intimate Partner		Victim Suicide		Unexpected Death		Child Death		Other		Overall	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
	169	**17%**	**332**	**33%**	**354**	**35%**	**71**	**7%**	**61**	**6%**	**25**	**2%**	**1012**	**100%**
Sharp instrument	88	52%	137	41%	2	1%	2	3%	15	25%	9	36%	**253**	**25%**
Hanging	0	0%	0	0%	219	62%	3	4%	0	0%	0	0%	**222**	**22%**
Poison or Drugs	2	1%	5	2%	87	25%	12	17%	2	3%	0	0%	**108**	**11%**
Not Known	9	5%	28	8%	7	2%	29	41%	6	10%	2	8%	**81**	**8%**
Strangulation	4	2%	47	14%	1	0%	1	1%	8	13%	3	12%	**64**	**6%**
Kicking or hitting	19	11%	26	8%	0	0%	4	6%	8	13%	1	4%	**58**	**6%**
Blunt Instrument	22	13%	26	8%	0	0%	2	3%	2	3%	3	12%	**55**	**5%**
Other	4	2%	13	4%	1	0%	6	8%	4	7%	3	12%	**31**	**3%**
Suffocation	3	2%	11	3%	6	2%	0	0%	3	5%	2	8%	**25**	**2%**
Burning or scalding (including Arson)	3	2%	9	3%	4	1%	0	0%	5	8%	0	0%	**21**	**2%**
Fall from Height	3	2%	5	2%	10	3%	2	3%	1	2%	0	0%	**21**	**2%**
Suspected Neglect	8	5%	5	2%	0	0%	7	10%	1	2%	0	0%	**21**	**2%**
Road Traffic/Railway Collision	2	1%	7	2%	7	2%	2	3%	1	2%	0	0%	**19**	**2%**
Shooting	1	1%	12	4%	0	0%	0	0%	2	3%	2	8%	**17**	**2%**
Drowning	1	1%	1	0%	10	3%	1	1%	3	5%	0	0%	**16**	**2%**

3.1.2 Suspect's relationship to the victim

Across all four years (n=1056 suspects), 69% (n=730) of suspects were the current (49%, n=515) or ex-partner/spouse (20%, n=215) of the victim (see **Figure 3**). Consistent with the previous years, these incidents related to IPH, SVSDA and unexpected deaths. It was most common for suspects of IPHs to be recorded as the victim's current partner/spouse (82%, n=278/338). SVSDA cases represented the typology with the highest proportion of suspects recorded as the victim's ex-partner/spouse (41%, n=156/383, compared to 16%, n=54/338 for IPH, and 7%, n=5/72 for unexpected deaths).

The suspect was the child of the victim in 12% (n=125) of cases across all four years, primarily represented within AFH cases (60%, n=105/176). Within this typology, suspects also included the victims' parent (3%, n=5), sibling (14%, n=24), as well as suspects classified as 'other family' members (24%, n=42)[11].

Figure 3 *Proportion of suspects by relationship to victim – April 2020 to March 2024*



3.2 Demographics

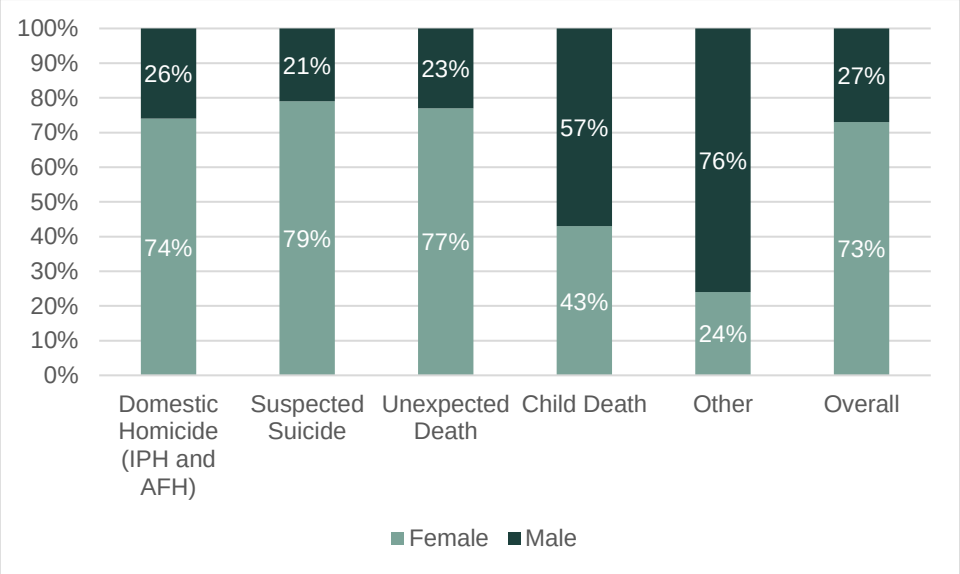
3.2.1 Victim sex

Across all four years (n=1012), most victims (73%, n=735) were recorded as female, whilst 27% (n=277) were recorded as male (see **Figure 4**). This difference by sex was particularly noteworthy for victims of IPH (83%, n=275 females compared to 17%, n=57 males), SVSDA (79%, n=279 females, compared to 21%, n=75 males) and unexpected deaths (77%, n=55 females, compared to 23%, n=16 males). This difference was less prominent within AFH deaths (56%, n=94 female, compared to 44%, n=75 male). Furthermore, the majority of victims were recorded as male within child death (57%,

[11] 'Other family' referred to suspects who were identified as a victim's stepparent/child/sibling, grandparent/child, or in-law, and on some occasions a partner/ex-partner to a relative of the victim.

n=35/61) and 'other' death (76%, n=19/25) cases, although these sample sizes are smaller relative to the other typologies.

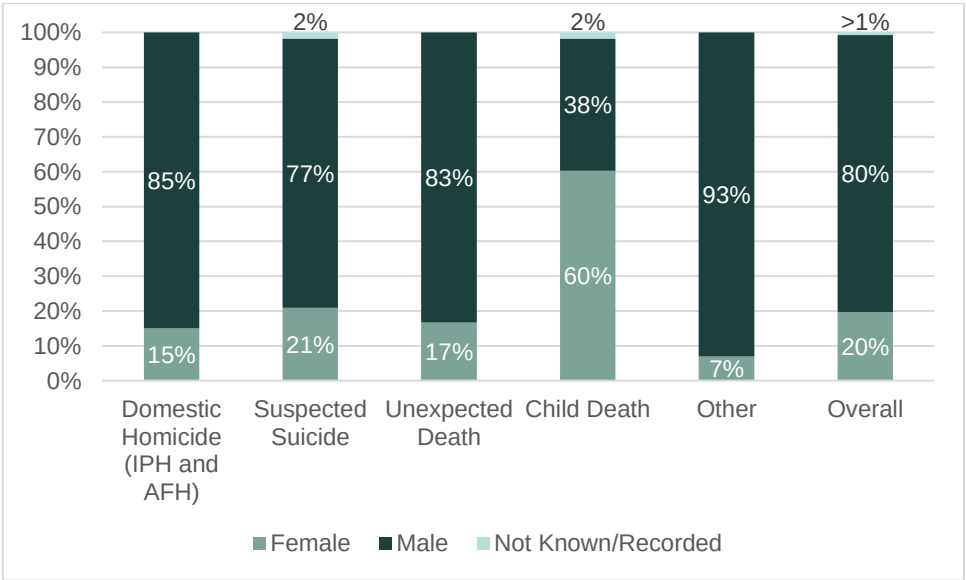
Figure 4 *Proportion of victims by typology and sex – April 2020 to March 2024*



3.2.1 Suspect sex

In contrast to victims, across all four years (n=1056), the vast majority of suspects were recorded as male (80%, n=840 vs 20%, n=208 female). This difference by sex of the suspect was observed across all typologies other than child deaths (see **Figure 5**).[12]

Figure 5 *Proportion of suspects by typology and sex – April 2020 to March 2024*



[12] Male suspects accounted for 86% (n=153/176) of AFH cases, 83% (n=282/338) IPH cases, 83% (n=60) unexpected death cases, 77% (n=296) SVSDA cases and 93% of deaths classified as 'Other'. By contrast, female suspects (60%, n=35) were more common than male suspects (38%, n=22) in child death cases. In just under 1% of cases overall (n=8), the suspect's gender had not been confirmed or recorded; this applied to seven SVSDA suspects and one child death suspect.

3.2.2 Victim-Suspect pairings by sex

Analysis on victim-suspect pairings by sex and typology was conducted exclusively for domestic homicides (AFH & IPH) and SVSDA cases (totalling 845 cases). Across these typologies, most cases involved a female victim and male suspect (72%, n=608), whilst 14% (n=115) involved a male victim with a female suspect. When looking at same sex cases, 10% (n=84) involved a male victim and male suspect, whilst 4% (n=31) involved a female victim and female suspect.[13]

Similar to the overall figures presented above, victim-suspect pairings by sex present differently when comparing by typology. For example, whilst 48% (n=77/160) of AFH cases involved a female victim and male suspect, the vast majority of IPH cases involved a female victim and male suspect (82%, n=272/331). Additionally, within SVSDA, 73% (n=259/354) of cases involved a female victim and male prior DA perpetrator.

Based on the nature of the submissions to this project, there were domestic homicide cases which involved multiple victims (2% n=10/491). This was particularly prevalent in cases of AFH (n=9) compared to IPH (n=1). There are also domestic homicide and SVSDA cases which involved multiple suspects (6%, n=52/845). For domestic homicides, this appeared to be more common in cases involving a male victim with more than one male suspect (39%, n=9/23), though was particularly common in SVSDA cases involving one female victim and more than one male prior DA perpetrator (72%, n=21/29).[14]

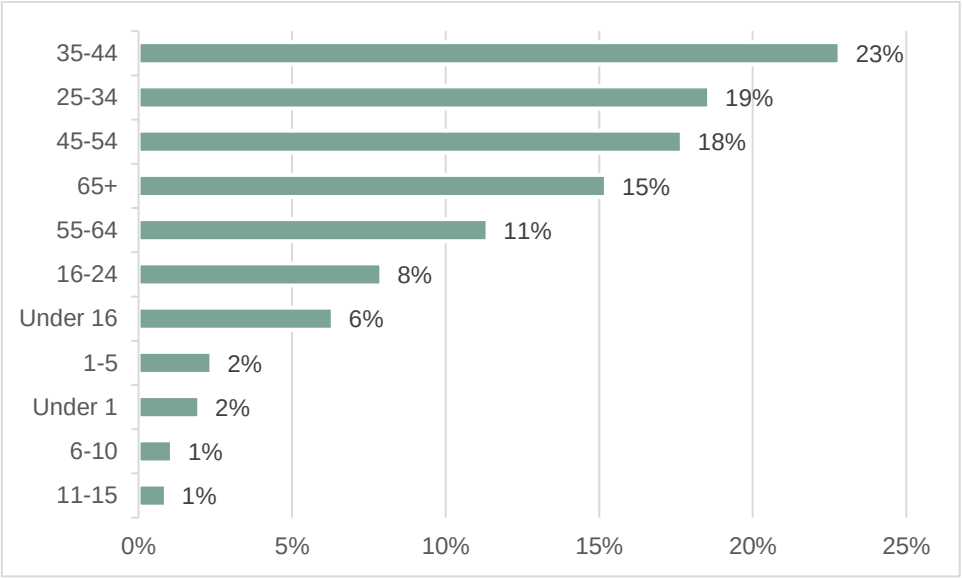
3.2.3 Victim age

Across the four-year dataset, 60% (n=598/1012) of victims were aged 25 to 54 years old, with 15% (n=154) being 65 years or older, as per **Figure 6** below:

[13] There were seven SVSDA cases in which the sex of the prior DA perpetrator(s) was not recorded. See full analysis in Appendix B Data Table 4.

[14] The calculations shown in Appendix B – Data Table 11 include cases in which the suspects/prior DA perpetrators belonged within two or more separate typologies (e.g., an intimate partner and a family member). The figures presented here include only the overall number of victims to avoid any double counting.

Figure 6 *Proportion of victims by age group (April 2020 – March 2024)*

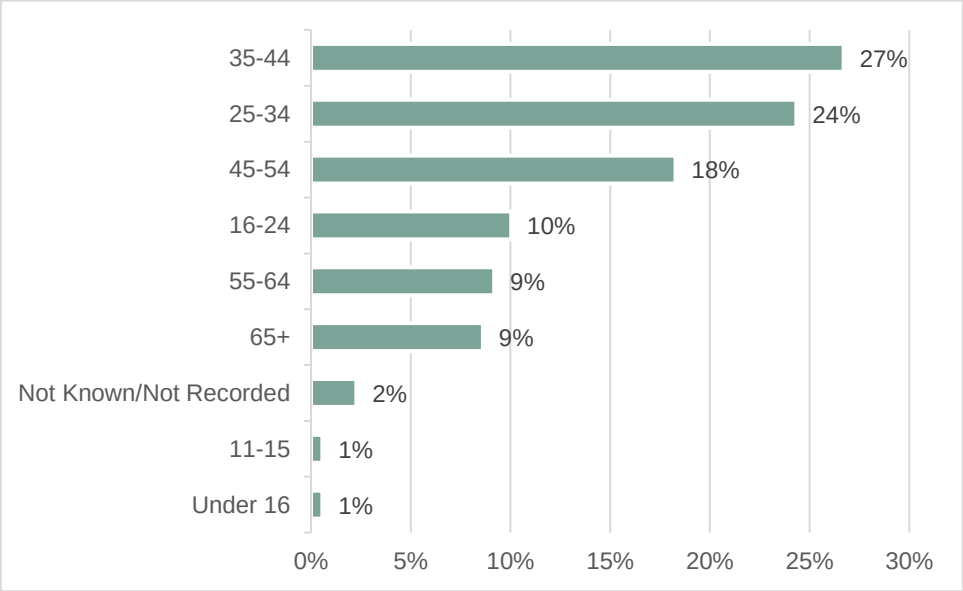


When comparing by typology across the four-year dataset, the vast majority of AFH victims were aged 45 years and older (85%, n=143/169), with most of these being 65 years and older (39%, n=65/169). Almost half of IPH victims (48%, n=159/332) were between 25 to 44 years old. Similarly, SVSDA victims were most commonly aged between 25 to 44 years old (58%, n=205/354). In unexpected death cases, the most common singular age group for victims was 35 to 44 (28%, n=20/71).

3.2.3 Suspect age

Across the four-year dataset, 69% (n=732/1056) of suspects were aged 25 to 54 years old, with 18% (n=188) being 55 years or older, as per **Figure 7** below:

Figure 7 *Proportion of suspects by age group (April 2020 – March 2024)*



When comparing typologies across the four-year dataset, the vast majority of AFH suspects were between 16 to 44 years old (69%, n=122/176). In IPH cases, the most

common age groups were comparatively older, with most IPH suspects between 25-54 years old (59%, n=230/338). This appeared similar to prior DA perpetrators in cases of SVSDA, where the majority were between 25 to 54 years old (75%, n=288/383). In unexpected death cases, the most common singular age group for suspects was 35 to 44 (24%, n=17/72).

3.2.4 Victims ethnicity and nationality

Submitters were asked to record, where known, the ethnicity of the victim and suspect/perpetrator, using the same ethnicity categories used by the Census. Across the four-year dataset, a total of 79% (n=798/1012) of victims were recorded by officers as being of White ethnicities. Additionally, 8% (n=77) were recorded as being of Black ethnicities, 7% (n=69) of Asian ethnicities, 1% (n=15) of mixed ethnicities, and 3% (n=33) of 'other' ethnicities. In 2% (n=20) of cases, the victim's ethnicity was not known or not recorded. Taken together, those of minority ethnic heritages (other than White ethnicities) therefore comprised 19% (n=194) of the combined four-year dataset (see **Figure**).

Regarding nationality, most victims were recorded as being British (72%, n=728), which was consistent across all typologies. The top three most common nationalities after British were Eastern European[15] (5%, n=51), Indian (1%, n=12) and Welsh (>1%, n=6). In 15% (n=156) of cases, the victim's nationality was not known or had not been recorded.

3.2.4 Suspects ethnicity and nationality

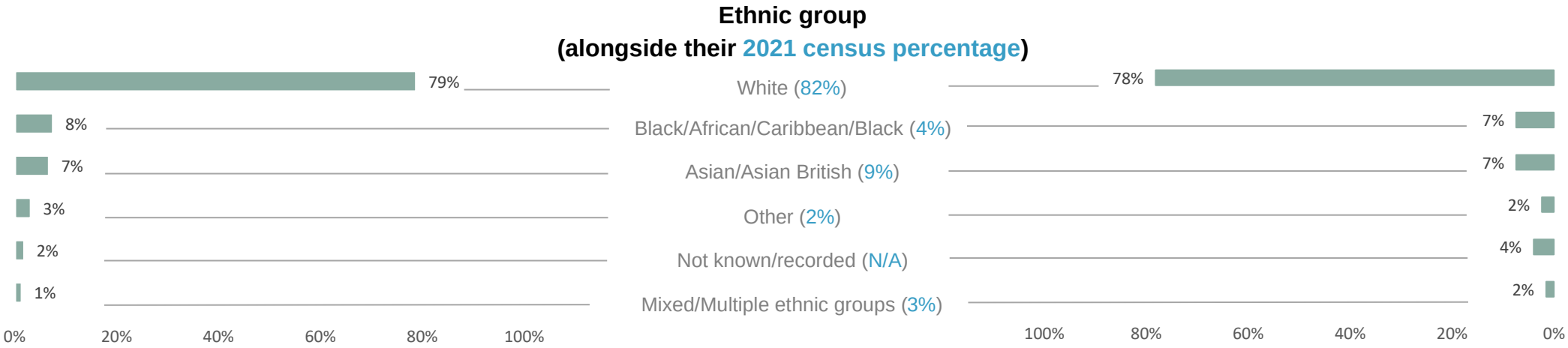
Across the four-year dataset, a total of 78% (n=825/1056) of suspects were recorded by officers as being of White ethnicities. Additionally, 7% (n=78) were recorded as being of Black ethnicities, 7% (n=70) of Asian ethnicities, 2% (n=16) of mixed ethnicities, and 2% (n=25) of 'other' ethnicities. In 4% (n=42) of cases, the suspect's ethnicity was not known or not recorded. Taken together, those of minority ethnic heritages (other than White ethnicities) therefore comprised 18% (n=189) of the combined four-year dataset (see **Figure 9**).

Regarding nationality, most suspects were recorded as being British (72%, n=756), which was consistent across all typologies. The top three most common nationalities after British were Eastern European (5%, n=56), Indian (1%, n=10) and Welsh (>1%, n=7). In 15% (n=161) of cases, the suspect's nationality was not known or had not been recorded.

[15] According to the United Nations, 'Eastern European' primarily refers to individuals from: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Czech, Estonia, Georgia, Hungary, Latvia, Lithuanian, Polish, Republic of Moldova, Romania, Russian Federation, Serbia and Slovakia.

3.2.5 Victims and Suspects ethnicity compared to the 2021 census

Figure 8 *Proportion of victims by ethnicity* — **(April 2020 – March 2024)** — ***Figure 9*** *Proportion of suspects by ethnicity*



The Project dataset includes a lower proportion of victims of White ethnicities (79% compared to 82%) and a similar proportion of victims of minority ethnic heritages (19% compared to 18%), compared to the general population as measured by the 2021 Census. Within this 19% of minority ethnic victims, there are slightly higher proportions of victims of Black ethnicities (8% compared to 4%), and ethnicities classified as 'Other' (3% compared to 2%), though slightly lower proportions of victims with Asian ethnicities (7% compared to 9%) and Mixed or Multiple ethnicities (1% compared to 3%).

Taken together, those of minority ethnic heritages (other than White ethnicities) comprise **18%** of the general population as measured by the 2021 Census. This compares to 19% minority ethnic victims and 18% minority ethnic suspects in the four-year dataset.

The Project dataset includes a lower proportion of suspects of White ethnicities (78% compared to 82%) and an equal proportion of suspects of minority ethnic heritages to the general population, as measured by the 2021 Census (18%). However, the Project dataset includes a higher proportion of suspects of Black ethnicities than recorded in the general population (7% compared to 4%), though a slightly lower proportion of suspects with Asian ethnicities (7% compared to 9%) and Mixed or Multiple ethnicities (2% compared to 3%).

3.3 Analysis of black and minoritised victims of Domestic Homicides and SVSDA

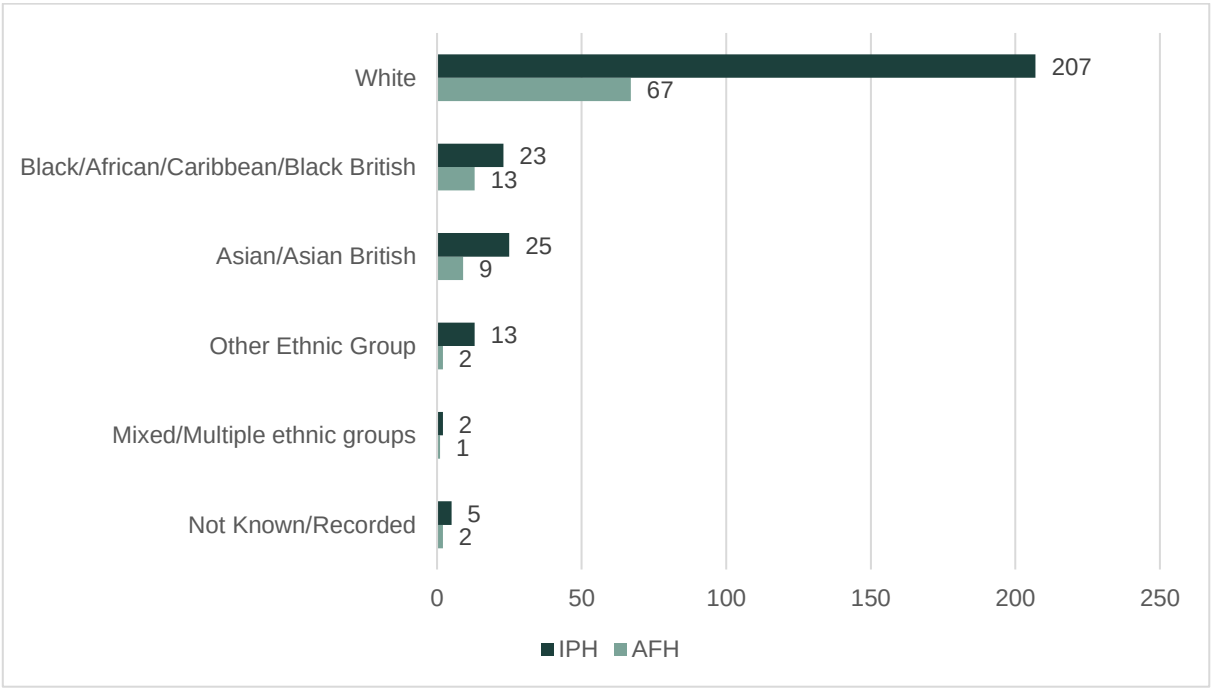
The analysis below builds upon the above findings regarding the disproportionate number of victims from Black ethnicities in comparison to their representation within the population according to the 2021 Census. It is also informed by a report by Imkaan and the Centre for Women's Justice (Ofer, 2023), which utilised analysis from 44 case studies of domestic homicides and SVSDA involving Black and minoritised female victims to develop 14 recommendations for the NPCC, College of Policing, Home Office and the Department of Health and Social Care.

One of these recommendations related to the importance of disaggregating relevant data to ensure any potential disproportionality can be identified. The Project team conducted additional analysis on domestic homicides and SVSDA focusing on Black and minoritised female and male victims to illustrate any differences by sex of the victim and ethnicity.

3.3.1 Black and minoritised female victims of Domestic Homicide

Of the 501 domestic homicide victims (169 AFH and 332 IPH) recorded between Year 1 and Year 4, 369 (74%) were female. Of these female victims, 24% (n=88) were from Black and minoritised backgrounds, representing 18% of all 501 domestic homicide victims. Of these 88 victims, 41% (n=36) were recorded as Black/African/Caribbean/Black British, 39% (n=34) as Asian/Asian British, and 3% (n=3) as Mixed/Multiple ethnic groups. A total of 15 (17%) minoritised victims were recorded as being of 'Other' ethnicities (see **Figure 8**). For 2% of female victims (n=7/369), ethnicity was not known or recorded.

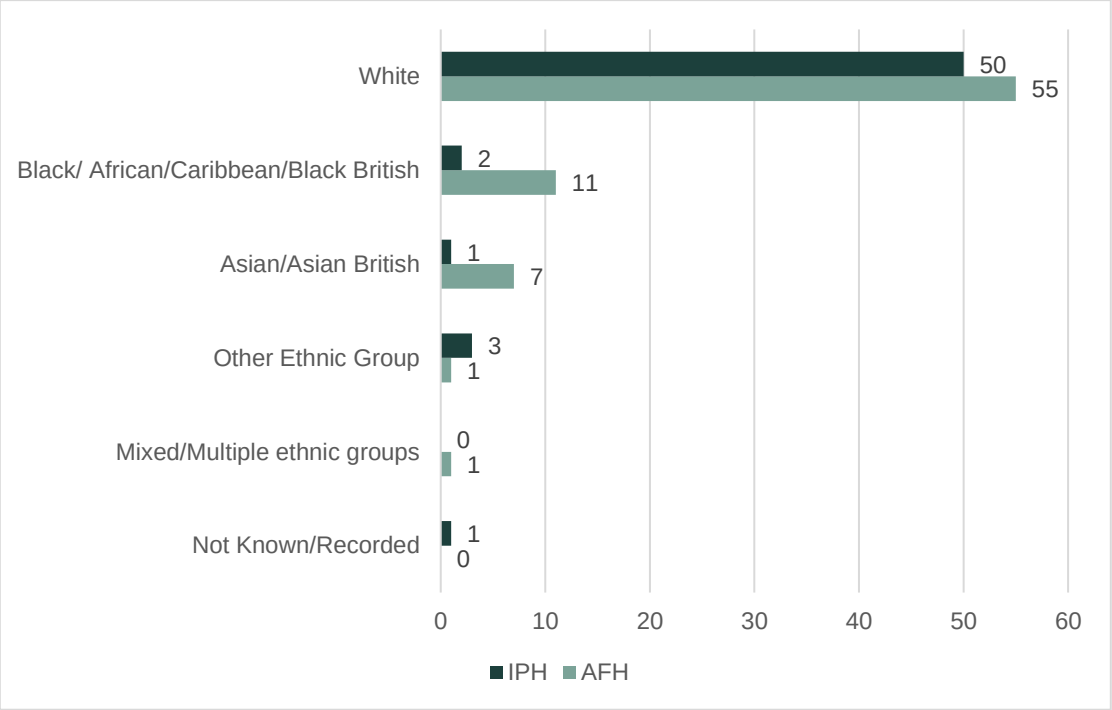
Figure 8 *Number of Domestic Homicide cases with female victims, by ethnic group (April 2020 – March 2024, n=369)*



3.3.1 Black and minoritised male victims of Domestic Homicide

Between Year 1 and Year 4, 5% (n=26/501) of domestic homicide victims were males from Black and minoritised backgrounds. Of these 26 victims, half (n=13) were recorded as Black/African/Caribbean/Black British, 31% (n=8) as Asian/Asian British, and 3% (n=4) classified as of 'Other' ethnicities. Only one male victim was of mixed/multiple ethnicity (see **Figure 11**), and only one did not have a known or recorded ethnicity.

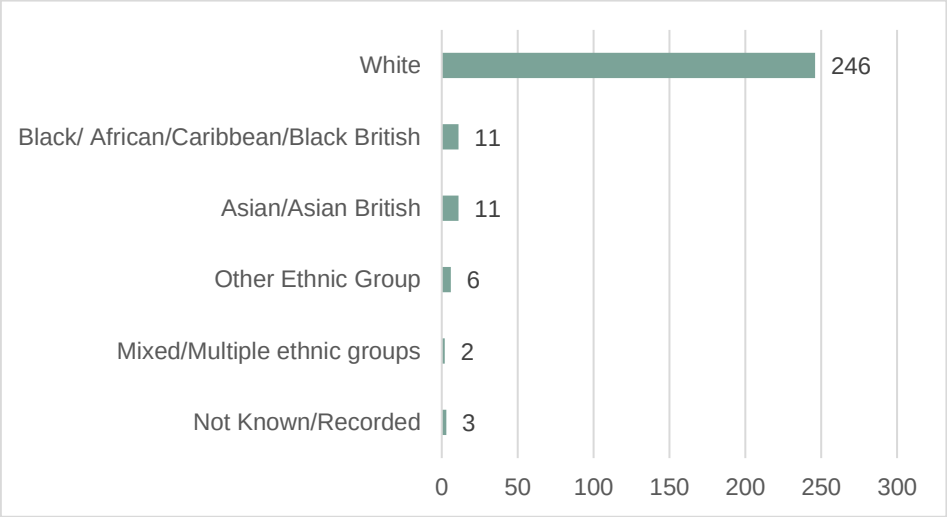
Figure 11 *Number of Domestic Homicide cases with male victims (April 2020 – March 2024, n=132)*



3.3.2 Black and minoritised female victims of Suspected Suicide

Of the 354 victims of SVSDA recorded between Year 1 to Year 4, 8% (n=30) were female victims from Black and minoritised backgrounds. Of these 30 victims, 37% (n=11) were recorded as Black/African/Caribbean/Black British, 37% (n=11) as Asian/Asian British, 20% (n=6) as of 'other' ethnicity and just under 1% (n=2) as Mixed/Multiple Ethnic Groups (see **Figure 12**). For 1% of female victims (3/279), ethnicity was not known or recorded.

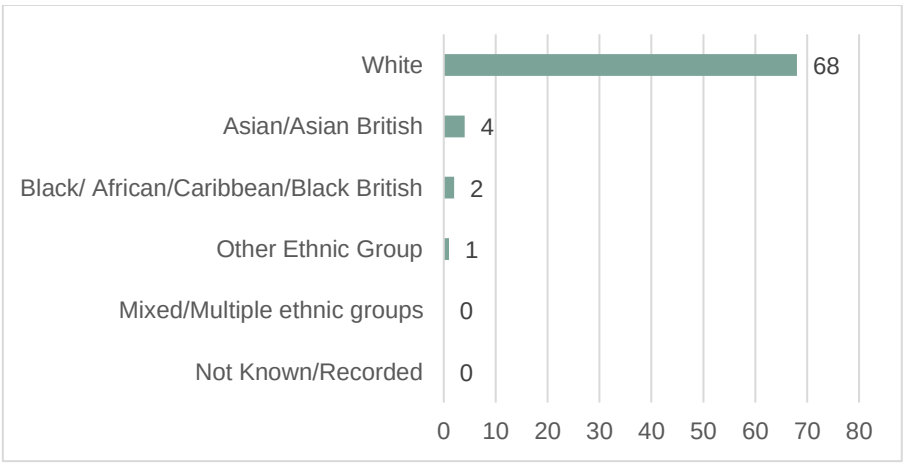
Figure 12 *Number of SVSDA cases with female victims by ethnic group (April 2020 – March 2024, n=279)*



3.3.2 Black and minoritised male victims of Suspected Suicide

Between Year 1 and Year 4, 2% (n=7/354) of victims of SVSDA were males from Black and minoritised backgrounds. Of these seven victims, 57% (n=4) were recorded as Asian/Asian British and 29% (n=2) as Black/African/Caribbean/Black British. The remaining one victim was recorded as being of 'other' ethnicity (see **Figure 9**).

Figure 9 *Number of cases of SVSDA with male victims by ethnic group (April 2020 – March 2024, n=75)*



3.4 Other protected characteristics and additional factors

3.4.1 Victims' sexual orientation, religion, care needs and pregnancy status

Across the four-year dataset, 37 of the 1012 victims (4%) were recorded as being LGBTQ+. For 26% (n=266) of victims this characteristic was listed as 'not known' or not recorded. Three of the victims within the four-year dataset were recorded as having

undergone gender reassignment, compared to zero recorded in last year's report, although this characteristic was 'not known' or not recorded for 14% (n=143) of victims.

The above figures may be influenced by potential challenges for policing regarding the identification of LGBTQ+ relationships as well as the identification of DA within those relationships. Research by Butterby and Donovan (2024) suggests that the police may see DA within LGBTQ+ relationships as 'mutual' because the partners are seen as equals in terms of power dynamics and physical strength. They also report that the police may be more responsive to physical violence than other forms of DA, missing unique dynamics within LGBTQ+ relationships or dismissing their seriousness (ibid).

Notably, 68% (n=25/37) of LGBTQ+ victims across the four-year dataset were recorded within SVSDA cases. This proportion marks a seven percentage-point increase from last year's report and suggests the importance of considering opportunities to support suicide prevention activities. Research indicates that LGBTQ+ victims of DA are less likely to seek support from mainstream agencies, including the police and statutory agencies, particularly due to feelings of distrust (Donovan & Barnes, 2020; Donovan & Hester, 2011; Donovan & Hester 2014).

Around 4% (n=45) of the 1012 victims were recorded as having a known religion, with 2% (n=19) recorded as having no religious beliefs and the remaining 94% (n=948) being 'not known' or not recorded. Although religious characteristics remain scarcely recorded by forces, the four-year dataset marks a marginal increase in recorded religion for victims, which may be partly due to improvements in obtaining richer data from submitters during six-month follow up requests. Of the 45 victims where religion was known, 51% (n=23) were identified as Christian.

Furthermore, 22% (n=227/1012) of victims were recorded as having care needs related to their mental health, whilst 11% (n=114) were identified as having care needs in relation to their physical health. There were also 32 (3%) victims with a learning or developmental need, and 19 (2%) victims recorded as having dementia. In 33% (n=336) of cases it was not known or recorded whether the victim had any care needs. **Table 3** in the following section highlights the number and proportion of victims with care needs in comparison to suspects with care needs.

Finally, 1% (n=15) of victims were recorded as being pregnant or having given birth within the previous six months.

3.4.1 Suspects' sexual orientation, religion, care needs and pregnancy status

In the four-year dataset, 34 of the 1056 suspects (3%) were recorded as being LGBTQ+. For 31% (n=325) of suspects, this characteristic was listed as 'not known' or not recorded. One suspect within the four-year dataset was recorded as having undergone gender reassignment, compared to zero recorded in last year's report, although this characteristic was 'not known' or not recorded for 18% (n=192) of suspects. As seen for victims, the majority of LGBTQ+ suspects were recorded in cases of SVSDA (65%, n=22/34).

Around 3% (n=36) of the 1056 suspects were recorded as having a known religion, with 2% (n=23) recorded as having no religious beliefs and the remaining 94% (n=997) being not known or not recorded. Of the 36 suspects where religion was known, 39% (n=14) were identified as Christian.

Furthermore, 43% (n=459/1056) of suspects were recorded as having care needs related to their mental health, whilst 5% (n=56) were identified as having care needs in relation to their physical health. There were also 35 suspects with a learning or developmental need (3%), and 7 suspects recorded as having dementia (1%). In 36% (n=380) of cases it was not known or recorded whether the suspect had any care needs (see **Table 3**).

Similar to victims, 1% (n=15) of suspects were recorded as being pregnant or having given birth within the previous six months. Whilst this is a relatively small number within the overall dataset, the Project's Spotlight Briefing on Younger Victims (Bates et al. 2024,) and analysis of cases involving a fall from height (see Chapter 7) highlight the importance of capturing this information.

3.4.2 Comparisons between victims' and suspects' care needs

When comparing suspects to victims, there were some variations by typology regarding the prevalence rate of particular care needs. For victims, physical health needs were most common in AFHs (15%, n=25/169), IPH (12%, n=40/332) and unexpected deaths (21%, n=15/71), whilst mental health needs were most common in cases of SVSDA (47%, n=165/354) and deaths classified as 'other' (20%, n=5/25). For suspects, mental health emerged as the predominant care need across all typologies by a substantial margin, though was highest in suspects of AFH (63%, N=111/176). It is important to note that any references to mental ill health are based on their recording by the police, and whilst some of these cases will be based on formal clinical diagnosis or evidence of treatment, others may be based on self, partner, family/friend, or police-reported mental illness or self-harm. For additional information about suspect mental ill health risk factors see Section 4.2.

Table 3 *Number and proportion of victims and suspects with care needs (April 2020 – March 2024)*

	Physical health care needs		Mental health care needs		Learning or developmental needs		Dementia	
	N	%	N	%	N	%	N	%
Victims (n=1012)	114	11%	227	22%	32	3%	19	2%
Suspects (n=1056)	56	5%	459	43%	35	3%	7	1%

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Chapter 4 – Risk factors in Domestic Homicides and Suspected Victim Suicides

4.1 Overall risk factors

Police forces were asked to identify 25 potential risk factors relating to the relationship and the suspect, where known. Though it is not possible to claim that their presence categorically leads to domestic homicide or SVSDA, they are commonly found in such cases. These factors were identified through a review of academic research on domestic homicide, which is included in the Year 1 report (Bates et al., 2021)[16]. Importantly, although the Project team follows up with forces for clarification, the figures are likely underestimates, because it is captured early within the investigation and the police alone may not hold all this information unless directly reported to them.

As shown in **Figure 10**, across the four-year dataset, the most commonly recorded risk factors in relation to the suspect (n=1056) were identified as:

1) Any mental ill health[17] (43%, n=459)
2) A history of CCB (39%, n=415)
3) Alcohol use (33%, n=352)
4) Drug misuse (30%, n=314)

Importantly, some of these risk factors may co-occur. For example, 18% (n=186) of suspects had *both* alcohol use and drug misuse as co-occurring risk factors.

Additionally, another commonly recorded risk factor was the suspect being known to the police as a victim of domestic abuse (23%, n=240). Notably, as highlighted within Barlow et al.'s (2023) research there are recurring challenges in identifying the primary perpetrator in domestic abuse cases where all parties involved have a history of offending against each other. Interviews with police officers alluded to limitations in traditional risk assessment tools (such as the DASH) to capture broader patterns of abuse when such complex dynamics are present. This is a limitation that the move to the DARA tool for first responders within policing aims to address, improving the identification of course of conduct offences such as controlling or coercive behaviour. Additionally. Barlow et al. (2023) described how perpetrators of CCB may try to manipulate the police by portraying themselves as victims of domestic abuse and employ false/counter reporting of abuse.

[16] Based on information obtained in the 'previous police contact' sections of the submission form, the Project team revised the form on 08/04/2024 with two additional suspect risk factors: 'Harassment / malicious communication (digital or in-person)' and 'Image-based sexual abuse of victim'. This has not been collected retrospectively; therefore, the current figures in this report do not reflect their overall prevalence across the four-year suspect dataset.

[17] Please note that this risk factor includes those suspects with police-recorded mental health care needs, including depression / anxiety, psychotic disorder, previously suicidal, and 'other' mental health care needs. Each suspect may also have more than one mental health care need.

In last year's report, we shared findings from a qualitative review of SVSDA cases submitted in Year 3 that aimed to identify the primary perpetrator of domestic abuse (Hoeger, 2024 et al.; Section 7.1.2). In Year 3, 28% (n = 28/102) of domestic abuse perpetrators associated with SVSDA were also previously known to the police as a victim of domestic abuse. The dynamics of the abuse appeared to differ by sex. Specifically, male perpetrators of domestic abuse who were previously known to the police as victims of domestic abuse were most often identified as the primary perpetrator of the abuse (n = 10/13). In contrast, female perpetrators of domestic abuse who were previously known to the police as victims of domestic abuse were most often identified as the primary victim (n= 7/15). Based on the limitations of analysing police-reported data and challenges raised in the literature, additional research is needed to draw further conclusions.

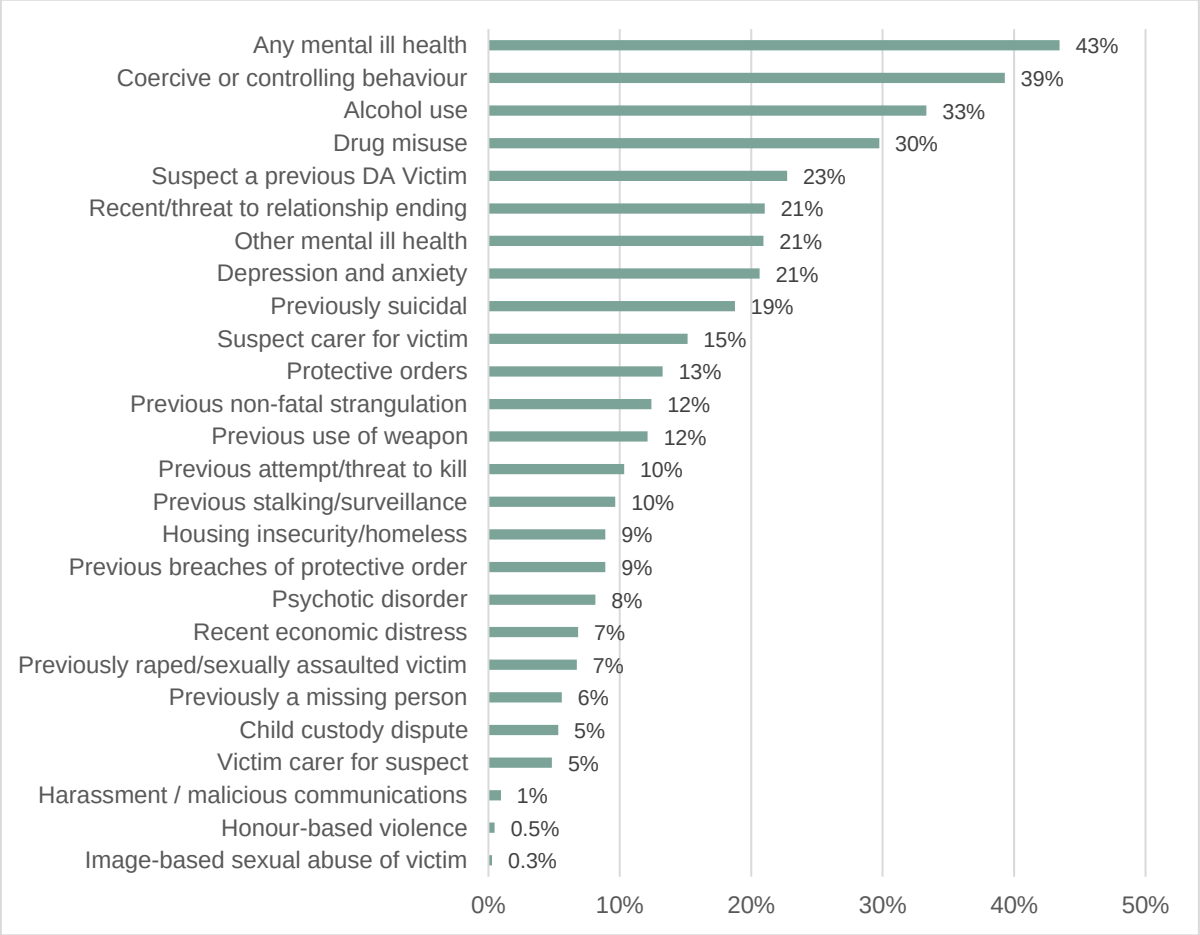
Another commonly recorded risk factor was a threat of ending the relationship or a recent separation (21%, n=222). The actual, attempted, or perceived attempt of separation by the victim is a risk factor featuring prominently in the wider literature (e.g. Campbell et al., 2007). As part of its efforts to halve violence against women and girls, the government has recognised the relevance of this risk factor for IPH and has recently announced the addition of murders related to the end of a relationship as a new statutory aggravating factor for sentencing.

Notably, when looking at method of death alongside the risk factor of previous non-fatal strangulation (NFS), 23% (n=25/108) of victims that died by poisoning or drugs had also been victims of NFS. Additionally, NFS was also present in 21% (n=47/222) of cases of death by hanging, 14% (n=9/64) of deaths by strangulation, and 8% (n=2/25) of deaths by suffocation.

Four risk factors were significantly associated with the suspect being identified by the police as a high-risk and/or serial perpetrator of DA, namely previous attempts or threats to kill ($p<.001$, n=963, Phi (effect size): 0.300), previous use of weapon ($p<.001$, n=963, Phi: 0.319), protective orders in place against the suspect ($p<.001$, n=961, Phi: 0.375) and previous breach of protective order ($p<.001$, n=961, Phi: 0.353).

Notably, the presence of CCB was significantly associated with the suspect being previously known to police for DA ($p<.001$, n=953, Phi: 0.302). There might be several explanations for this association. For example, it could be a sign that police forces are improving on their ability to identify and record CCB; or it could be related to the fact that CCB is the only risk factor that is also a crime specific to context of DA.

Figure 10 *Proportion of suspects with recorded risk factors (April 2020 – March 2024)*



4.2 Risk factors by case type

When considering Year 4 cases (1st April 2023 to 31st March 2024), the top risk factors were relatively consistent though differed slightly by typology (see **Table 4**). For instance, CCB was not as prevalent in cases of AFH as compared to other typologies. Notably, the co-occurrence between alcohol use and drug misuse appeared proportionally consistent across suspects of AFH (22%, n=9/41), IPH (22%, n=18/81) and unexpected deaths (22%, n=6/27), as well as prior DA perpetrators in cases of SVSDA (22%, n=24/107).

We also examined the prevalence of specific mental ill health risk factors[18] (i.e., those underpinning the 'Any mental ill health' risk factor) by typology across the four-year dataset (see **Table 5**). Mental ill health classified as 'other'[19] was the most commonly recorded for suspects across all typologies (21%, n=221/1056), closely followed by depression and anxiety (21%, n=218).

[18] It is important to note that any references to mental ill health are based on their recording by the police, and whilst some of these cases will be based on formal clinical diagnosis or evidence of treatment, others may be based on self, partner, family/friend, or police-reported mental illness or self-harm.

[19] 'Other mental ill health' refers to any mental ill health risk factors identified without any official clinical diagnoses. This may include self-reported concerns from the suspect regarding their mental health, reported concerns from the suspect's family/friends/partners, and/or a history of self-harm.

Table 4 Most common suspect risk factors by typology (April 2020 – March 2024)

Adult Family	Intimate Partner	Suspected Suicide	Unexpected Death	Child Death	Other**
Any mental ill health (63%, n=111)	Any mental ill health (41%, n=140)	Controlling or coercive behaviour (56%, n=216)	Alcohol use (43%, n=31)	Carer for the victim (81%, n=47)	Alcohol use (31%, n=9)
Alcohol use (34%, n=59)	Controlling or coercive behaviour (40%, n=134)	Any mental ill health (40%, n=152)	Controlling or coercive behaviour (40%, n=29)	Any mental ill health (41%, n=24)	Drug misuse (31%, n=9)
Drug misuse (34%, n=59)	Alcohol use (31%, n=106)	Alcohol use (38%, n=144)	Any mental ill health (35%, n=25)	Suspect previously a DA victim (26%, n=15)	Any mental ill health (24%, n=7)
Carer for the victim (20%, n=35)	Drug misuse (24%, n=81)	Recent or threat to relationship ending (35%, n=135)	Drug misuse (33%, n=24)	Drug misuse (21%, n=12)	Housing/homeless* (17%, n=5)
Previous use of a weapon* (16%, n=29)	Recent or threat to relationship ending (24%, n=80)	Suspect previously a DA victim (32%, n=121)	Carer for the victim (32%, n=23)	Recent child custody dispute* (14%, n=8)	Suspect previously a DA victim (14%, n=4)
					Carer for the victim (14%, n=4)
					Previously raped or sexually assaulted the victim* (14%, n=4)

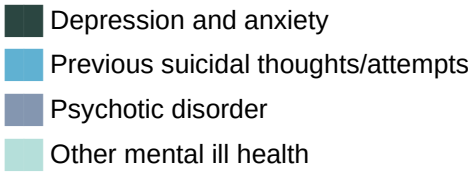
Alcohol use
Drug misuse
Suspect previously a DA victim
Carer for the victim
Recent or threat to relationship ending
Any mental ill health
Controlling or coercive behaviour

*Non-coloured risk factors represent those that were found to proportionately be one of the most common in just one typology.

**The 'Other' typology lists seven risk factors due to three of the most common risk factors applying to an equal number of suspects.

Table 5 *Most common risk factors related to 'any mental ill health' by typology (April 2020 – March 2024)*

Adult Family	Intimate Partner	Suspected Suicide	Unexpected Death	Child Death	Other
Other mental ill health (38%, n=66)	Depression and anxiety (22%, n=74)	Depression and anxiety (21%, n=81)	Depression and anxiety (24%, n=17)	Other mental ill health (17%, n=10)	Depression and anxiety (10%, n=3)
Psychotic disorder (22%, n=38)	Other mental ill health (22%, n=73)	Previous suicidal thoughts/attempts (21%, n=80)	Other mental ill health (11%, n=8)	Previous suicidal thoughts/attempts (16%, n=9)	Other mental ill health (10%, n=3)
Depression and anxiety (20%, n=35)	Previous suicidal thoughts/attempts (22%, n=73)	Other mental ill health (16%, n=61)	Previous suicidal thoughts/attempts (8%, n=6)	Depression and anxiety (14%, n=8)	Previous suicidal thoughts/attempts (7%, n=2)
Previous suicidal thoughts/attempts (16%, n=28)	Psychotic disorder (5%, n=18)	Psychotic disorder (4%, n=17)	Psychotic disorder (8%, n=6)	Psychotic disorder (9%, n=5)	Psychotic disorder (7%, n=2)



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Chapter 5 – Prior suspect and victim contact with the police and other agencies

This section describes the analysis of how victims and suspects were known (if at all) to the police and other services.

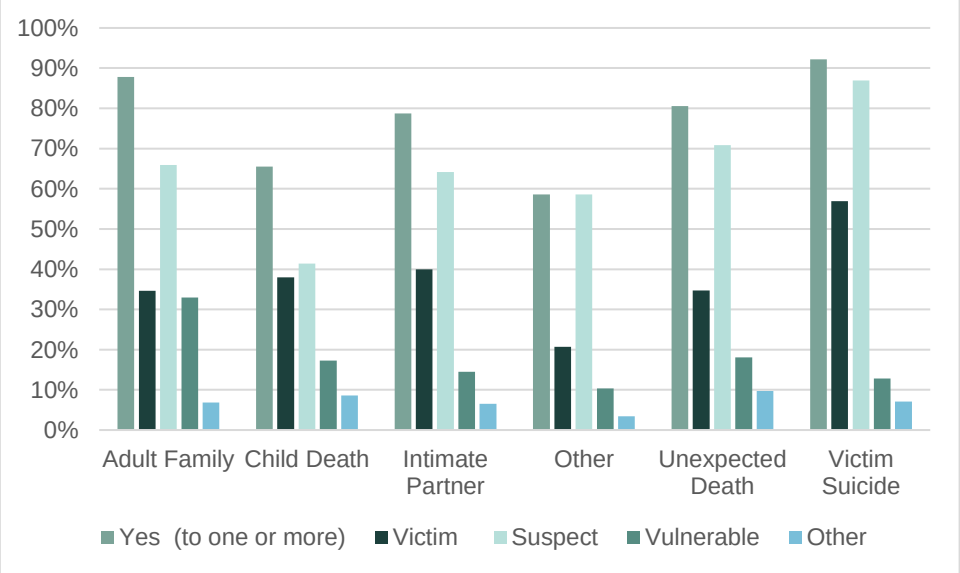
5.1 Suspect previously known to the police

Across the four-year dataset and including all typologies, 83% (n=875/1056) of suspects were previously known to the police for any reason (i.e., as a victim, suspect, vulnerable person, witness etc.). However, this varied by typology, as illustrated by **Figure 11**.

Those most known to the police were the prior DA perpetrators associated with SVSDA (92%, n=353/383). Indeed, statistical testing showed that SVSDA cases were significantly more known to police than AFH cases over the four-year period (z=-3.791, p<.05). Most SVSDA cases involve a victim and perpetrator being known to the police for DA before the death, in order for the case to be identified and reported to this Project. However, in some cases, the police are made aware of a history of DA only after the death, such as from family, friends or other agencies. Additionally, the visibility of these cases to the police and partner agencies (see Section 5.4) indicates a potential for intervention.

The suspects second most commonly known to the police were those associated with AFHs (81%, n=143/176), followed by unexpected deaths (81%, n=58/72), IPH (79% n=226/338), child deaths (66%, n=38/58) and deaths classified as 'other' (59%, n=17/29).

Figure 11 *Proportion of suspects known to police as a victim, suspect, vulnerable person or other circumstances (April 2020 – March 2024)*



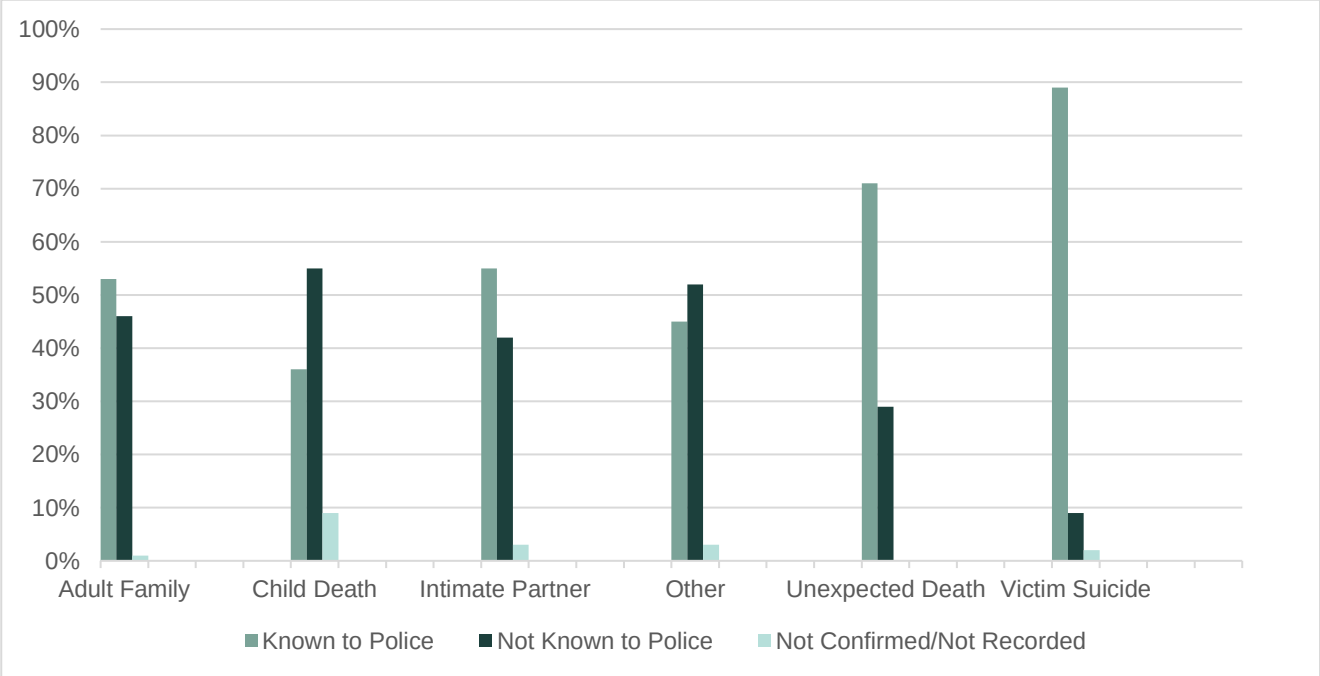
5.2 Suspect previously known to police for domestic abuse

The Project team coded a separate variable to record whether the suspect was previously known to police for DA offending (see **Figure 12**). Overall, 67% (n=705/1056) of suspects were known to the police for DA, as a suspect or perpetrator, prior to the victim's death.

Again, the inclusion of SVSDA, which most often involves police knowledge of DA perpetration prior to the victim's death (89%, n=341/383), does increase the proportion of suspects known within the overall dataset. Therefore, excluding cases of SVSDA, 54% (n=364/673) of suspects were known to the police for DA perpetration prior to the victim's death across the four-year dataset.

Across the remaining typologies, unexpected deaths had the highest proportion of suspects known to the police for DA (71%, 51/72), followed by IPH (55%, n=185/338), AFHs (53%, n=94/176), deaths classified as 'other' (45%, n=13/29) and child deaths (36%, n=21/58).[20]

Figure 12 *Proportion of suspects known to the police for DA offending by typology (April 2020 – March 2024)*



5.3 Suspect risk level and management

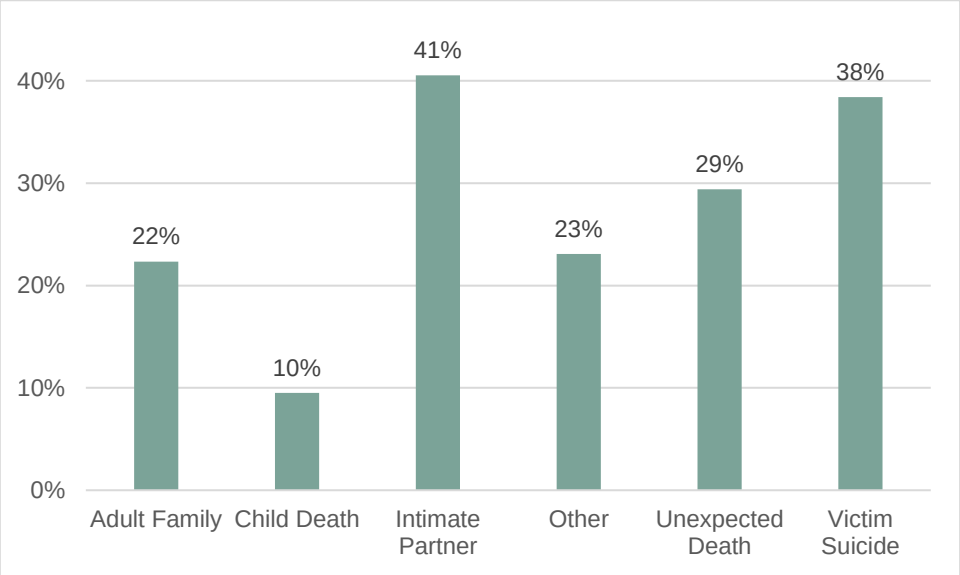
Data collection also included whether the suspect had previously been known to police as a high-risk or serial DA perpetrator, referred to MARAC, or managed by police or probation at the time of the death.

Of the suspects who were known to police for DA offending prior to the victim's death, 35% (n=247/705) were known as high-risk and/or serial perpetrators. This varied by typology

[20] Across all typologies, 27 suspects (3%) had not been confirmed to be known to police for prior DA.

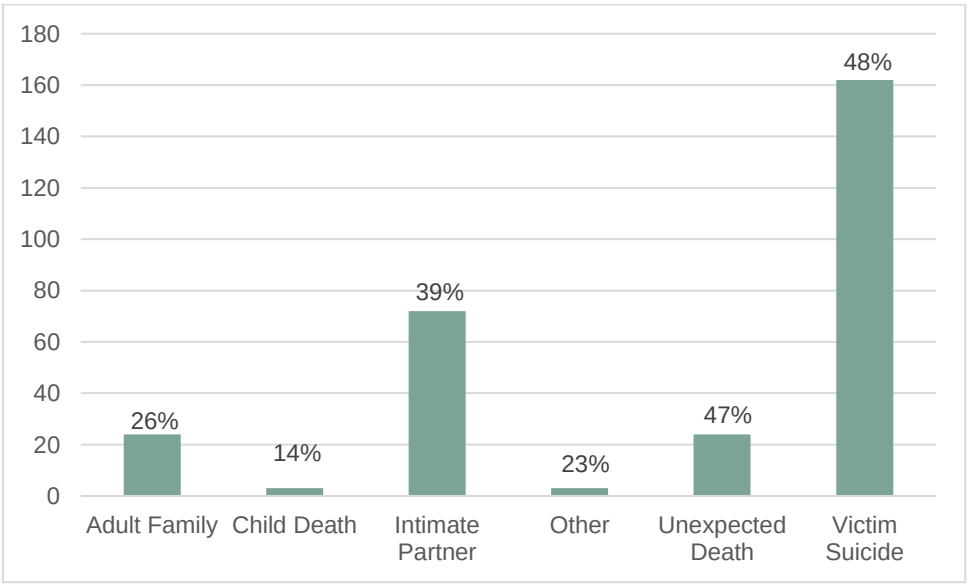
(see **Figure 13**), though primarily applied to suspects in IPH (41%, n=75/185) and prior DA perpetrators in cases of SVSDA (38%, n=131/341).

Figure 13 *Proportion of suspects known to police for DA offending and identified as high-risk or serial perpetrators by typology – April 2020 – March 2024*



Second, of the suspects who were known to police for DA (n=705) 41% (n=288) were also involved in cases which were referred to MARAC, which again varied by typology (see **Figure 14**). Consistent with previous reports (Bates et al., 2022; Hoeger et al. 2023), prior DA perpetrators in SVSDA (48%, n=162) and suspects in IPH (39%, n=72) are referred to MARAC at a higher rate compared to suspects within AFH cases (26%, n=24). Additionally, suspects in unexpected deaths had the second highest proportion of MARAC referrals (47%, n=24).

Figure 14 *Proportion of suspects known to police for DA offending and referred to MARAC by typology (April 2020 – March 2024)*



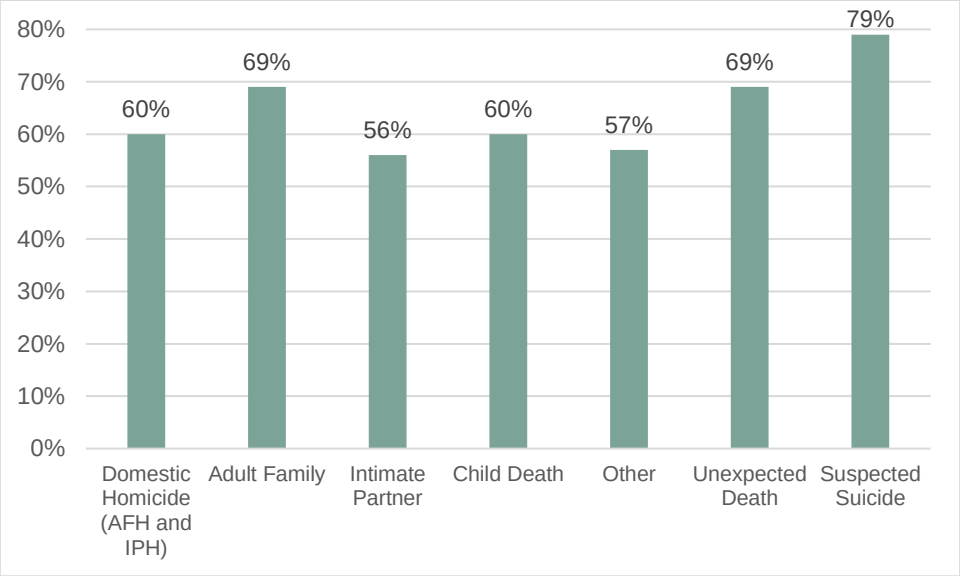
Third, across the full four-year dataset, consistent with last year's findings, 10% (n=106/1056) of all suspects were recorded as having been previously managed by police

or probation (e.g., under MAPPA, IOM, or DRIVE). Similarly, in Year 4, there were 25 suspects (9%) that were currently being managed by police or probation.

5.4 Suspect or victim previously known to other agencies

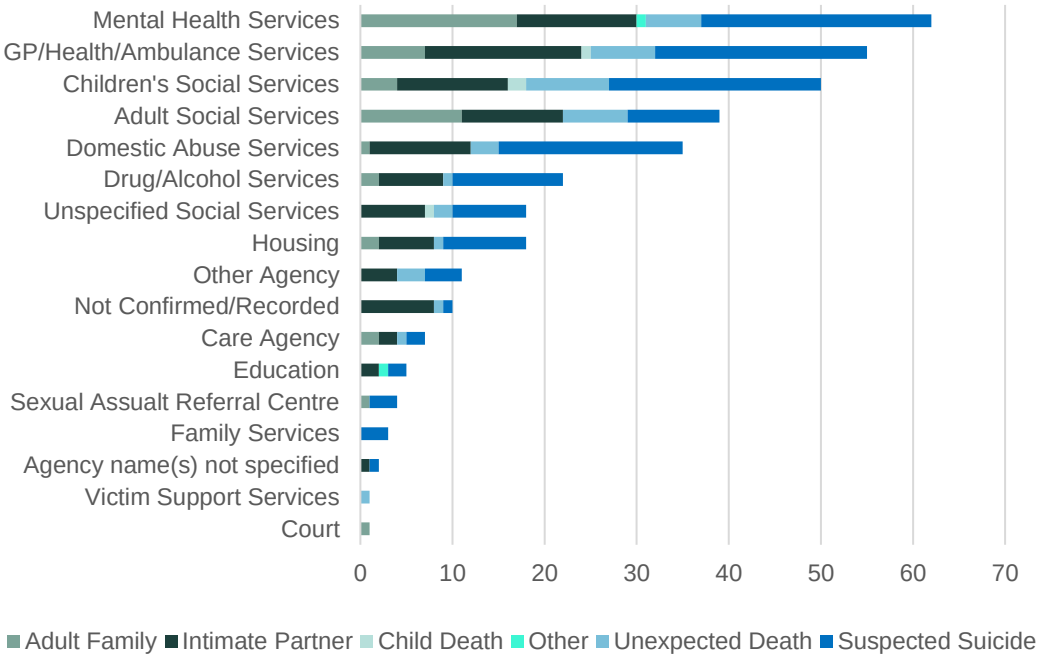
Across the four-year dataset (n=979 incidents), in 68% of cases (n=662) the suspect and/or victim was known to a partner agency, most commonly in cases of SVSDA (79%, n=281/356 – see **Figure 15**). Conversely, 22% (n=220) were not recorded as known to any partner agency and 10% (n=97) were not recorded or confirmed to be known to a partner agency. In cases where the suspect was not previously known to police for any reason (n=101), the suspect and/or victim was known to a partner agency in 30% (n=30) of cases. These findings continue to highlight the importance of multi-agency work to prevent domestic homicides and suicides following DA (Home Office, 2022).

Figure 15 *Proportion of victims and/or suspects known to other agencies by typology (April 2020 – March 2024)*



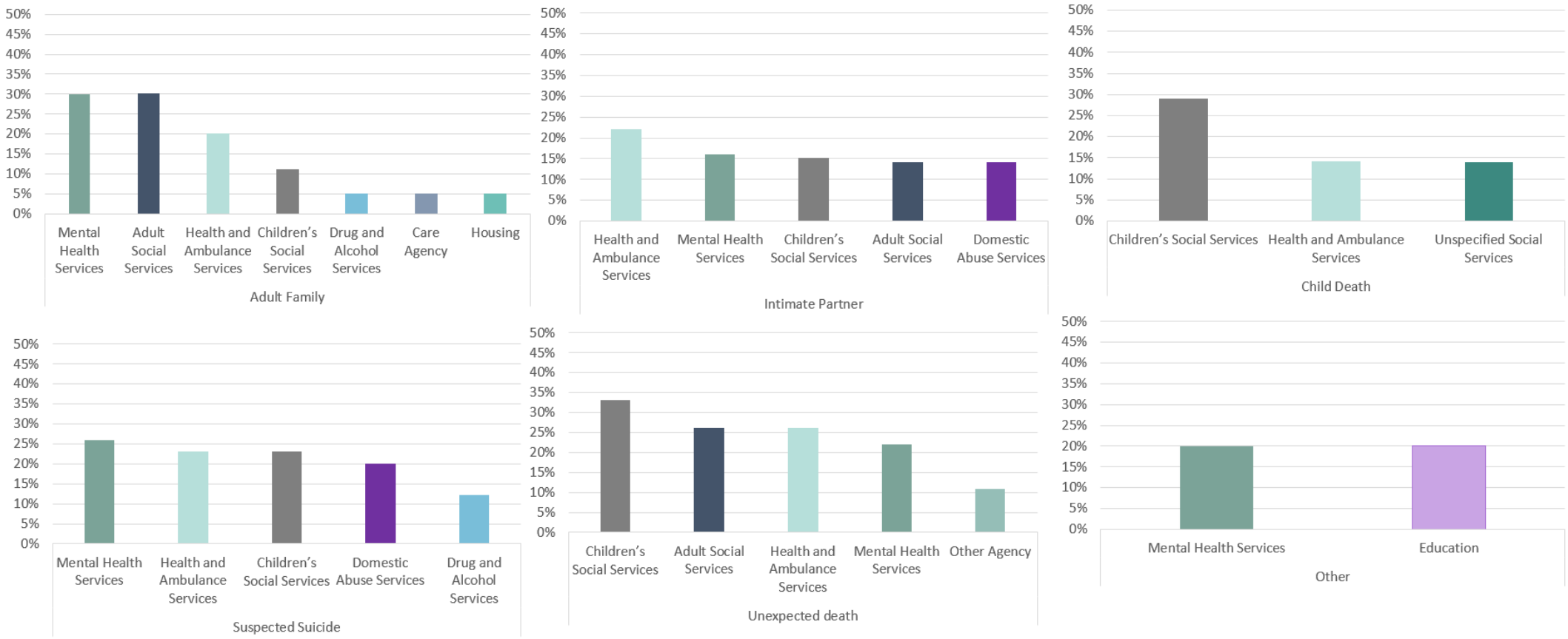
Overall, the victim and/or suspect were most known to mental health agencies (23%, n=230), followed by children's social services (20%, n=193), health and ambulance services (16%, n=156), DA services (11%, n=111) and adult social services (11%, n=105). When combining all cases known to social services (including adult, children, and unspecified services), this accounted for 37% of victims and/or suspects (n=362). Lastly, the five agencies that the victim and/or suspect were most known to within the four-year dataset were consistent with those identified within Year 4 alone (see **Figure 16**), albeit this did vary according to typology (see **Figure 17**).

Figure 16 *Number of victims and/or suspects known to other agencies by agency and typology (Year 4)*[21]



[21] 'Agency name(s) not specified' applies to cases where previous partner agency knowledge has been ticked on the submission form, though the free-text section for further detail either contains: (1) no information, (2) a generic statement without context, and/or (3) an unconfirmed acronym.
'Other Agency' refers to organisations not commonly involved in criminal justice proceedings, such the Driver and Vehicle Licensing Agency (DVLA), veteran support services, or specialised entities like agricultural societies.

Figure 17 *Proportion of cases known to other agencies by agency and typology*



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Chapter 6 – Case review referral and acceptance rates

6.1 Domestic Homicide Reviews, and other types of reviews

Every death of a person aged 16 years or older where there is a history of DA should be referred by the police or other agency to the local Community Safety Partnership (CSP). The CSP then decides whether the case meets the criteria to be accepted for a review,[22] with most cases in the Project dataset being referred for Domestic Homicide Reviews (DHR). Also note that deaths relating to abuse or neglect and involving children under the age of 16 would be subject to a Child Safeguarding Practice Review (CSPR) rather than a DHR.

In 2022 the Conservative-led government launched its Tackling Domestic Abuse Plan, where they committed to review and reform DHR procedures. Part of these changes included mandatory training for DHR Chairs and improving oversight mechanisms to ensure learning and recommendations implementation.

After a public consultation in 2023, the Conservative-led government worked on updating the circumstances when a DHR should be commissioned in order to include the statutory definition of DA into legislation. Whilst not yet enacted, the name of these reviews will be changed from DHR to Domestic Abuse Related Death Review (DARDR) in an effort to better recognise deaths by SVSDA.

The Project team requests information from the police on whether each case was being referred, by them or by another agency, to the Community Safety Partnership for a DHR (or another type of review), and whether that referral was accepted.

Overall, excluding child death and unexpected death cases (n=113), for the four-year dataset whether or not a case had been referred to the Community Safety Partnership for a DHR or other type of review was known in 91% of cases (n=789/866) (see **Table *6*** below: '% of incidents known if referred')

Of those cases that were referred, 62% (n=490/789) were accepted for a DHR or other type of review across the four year of data collection. In Year 4 the acceptance rate when cases were referred was of 50% (n=101/202). However, when cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 85% (n=490/577) overall, and to 87% (n=101/116) for Year 4. Therefore, where the referral outcome was known and recorded, only 15% (n=87/577) of cases between Year 1 and Year 4 which were referred for DHR or other types of review were not accepted.

For child deaths, out of the 43 cases recorded across the four years of data collection, 74% (n=32) were referred for a review, 7% (n=3) were not referred, and in 19% (n=8) of

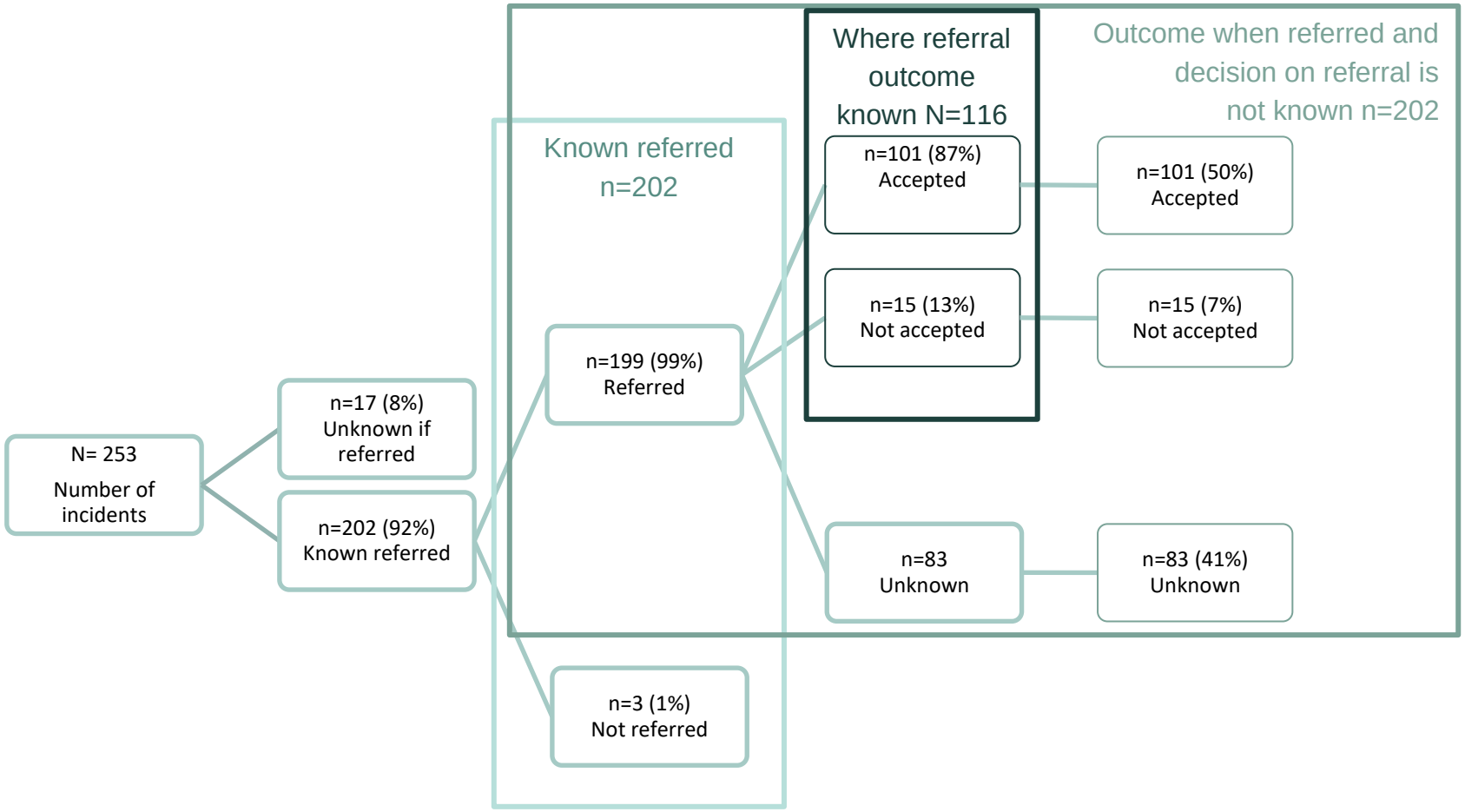
[22] DHRs focus exclusively on the deaths of victims aged 16 or over, as defined by statutory guidelines. Whilst most referrals (in all cases excluding child deaths) will be for a DHR, the Project team identified several cases which were instead referred/accepted for an SAR or other type of review process. Data cleaning will allow specific separation and analysis in future reports, but they are currently reported together.

the cases it was not known if they had been referred. Of those cases that were referred, 80% (n=28/35) were accepted for a review. When cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 85% (n=28/33).

***Table* 6** *DHR (or other type of review) referral and acceptance status – Years 1-4.*

DHR or Other Type of Review Referral and Acceptance Status (excluding child deaths and unexpected deaths)				
	2023/2024		**Total Year 1-4**	
Referral/Acceptance Status	N	%	N	%
% of incidents known if referred	202	*92%*	789	*91%*
% of incidents referred (where known)	199	*99%*	757	*96%*
% of incidents accepted (where referred)	101	*50%*	490	*62%*
% of incidents accepted (where referred and referral outcome known)	101	*87%*	490	*85%*
% of incidents not accepted (where referred)	15	*7%*	87	*11%*
% of incidents not accepted (where referred and referral outcome known)	15	*13%*	87	*15%*

Figure 18 *Flow chart example from Year 4 review referral cases to illustrate analysis process*



Focusing on SVSDA cases, **Figure 23** below presents the proportion of cases referred for a DHR (or other type of review) over the four years of data collection. **Figure 24** shows the acceptance rate when the referral outcome was known. Given the work done by the Home Office to update the name and definition used within DHR, particularly in relation to cases of SVSDA, it is worth noting that the referral rate of these cases has increased over time. However, the effects of new policies on acceptance rates for these cases will need to be assessed once changes are enacted (additionally, 11% of referral outcomes remain unknown for Year 4).

Figure 19 *DHR or other type of review referral rate for SVSDA cases, where acceptance outcome was known– Years 1 to 4*

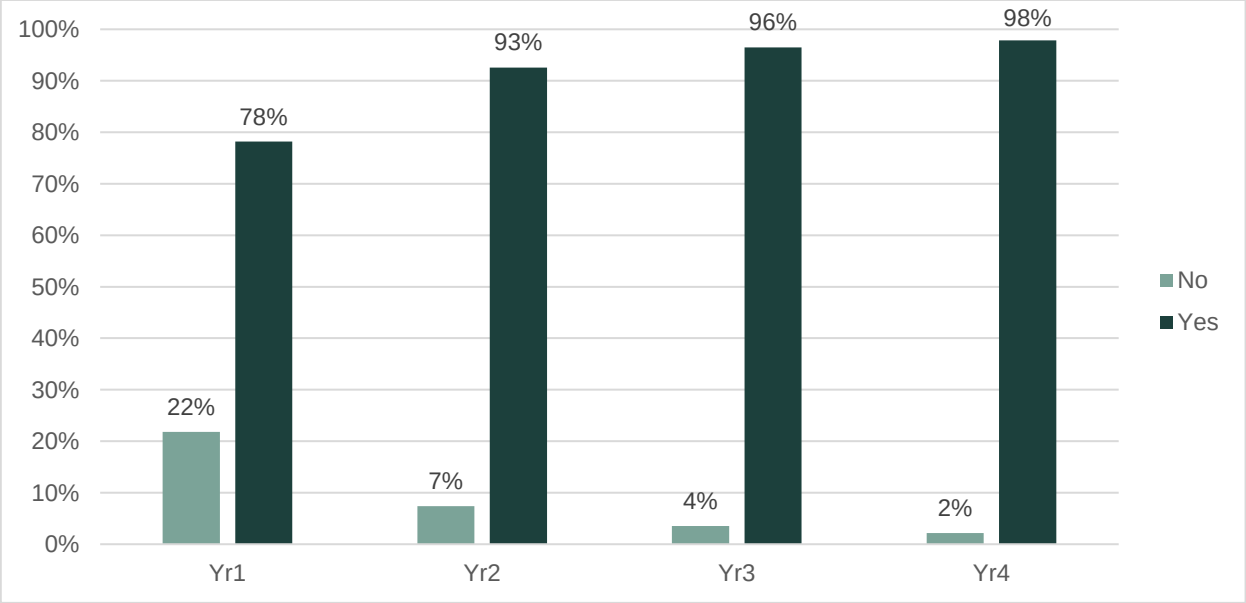
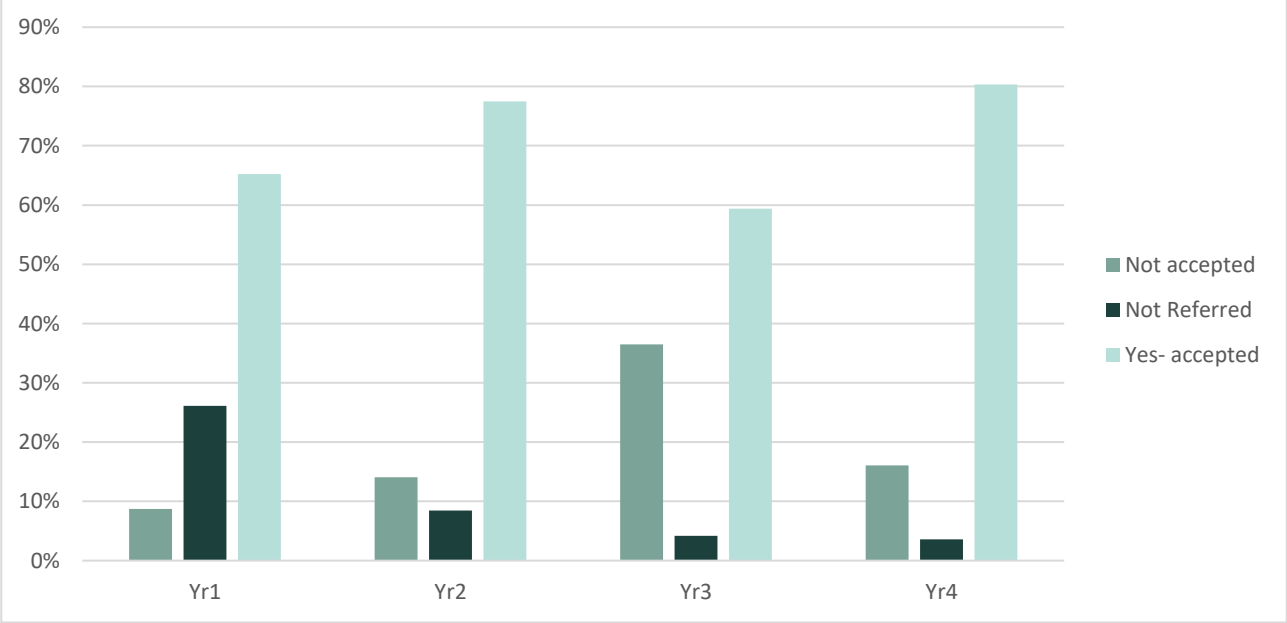


Figure 20 *Review acceptance rate for SVSDA cases, where referral outcome is known – Years 1 to 4*



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Chapter 7 – Deaths caused by a fall from height

Earlier this year the Killed Women Network led the Fallen Women - Hidden Homicides campaign, which "called for the deaths of all women who have fallen from a height to be reviewed by police to identify whether DA may have been a feature". To launch this campaign, they submitted FOIs requests to all 43 police forces in England and Wales, receiving a data return only from three of them. In this context the Domestic Homicide Project was also asked to review its data in relation to these cases. The Project team was able to identify cases of victims' deaths due to a fall from height and shared the data with the Killed Women Network. Based on this review, the project added the code 'fall from height' as a method of death to be able to keep track of these cases.

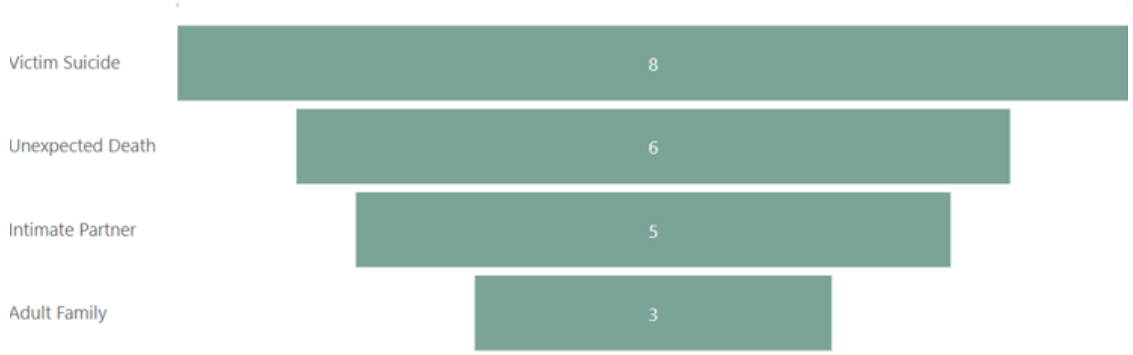
This chapter presents an analysis of the cases of deaths after a fall from height. Twenty-two cases (excluding child deaths) from 13 forces had been coded under this category between 1st April 2020 and 31st March 2024, comprising a total of 22 victims and 23 suspects[23]. The following sections will present the findings from two different analysis undertaken. First, a descriptive analysis of the victim, suspect and case characteristics was carried out. Second, a qualitative analysis of the cases was done to identify cross-cutting themes and common features of these cases.

7.1. Typology of the cases

Regarding the typologies for these deaths, they were more commonly suspected victim suicides (n=8, 36%), followed by unexpected deaths (n=6, 27%), then IPH (n=5, 23%), and finally, AFH (n=3, 14% - see **Figure 21** below). It is worth noting that these figures represent the status of the case at the moment of retrieving the data for this report, with some of them having been classified differently at other points in time. For example, of the six unexpected death cases, four had been initially recorded as SVSDA and then treated as unexpected death. The same was observed in an IPH case. Therefore, classification of cases into typologies is dynamic and changes over time as police investigations develop.

[23] The analysis presented in Chapter 7 was conducted in June 2024, whereby a total of 22 cases (excluding child deaths) of falls from height were recorded. The analysis of the wider four-year dataset was conducted in October 2024 and two cases of deaths following a fall from height were excluded from it due to updates from forces indicating the cases had been closed as non-suspicious/accidental deaths. For the purpose of the analysis of deaths caused by a fall from height presented in Chapter 7 we have included these two cases in order to gain learning from them, however they are not included within the 1012 deaths recorded from 2020-2024.

Figure 21 *Cases coded as 'fall from height' from 01/04/2020 to 31/03/2024 by typology*



The following sections will present victim, suspect, and case characteristics. Caution should be exercised in interpreting these findings; the sample is small and thus conclusions might not be generalisable.

7.2. Victim characteristics

In this sample most of victims were female. There were only two male victims, both elderly (65+) and presenting physical health issues. In both cases the death was recorded as an AFH. The third victim that was aged 65+ was also victim of an AFH, meaning all three cases within this typology involved the death of an elderly person.

In terms of age, there was a homogeneous distribution of the victims' age groups (see **Figure 22** below), although a slightly higher number of victims observed in the age group of 16 to 24, with an average age of 21.4 years.

Figure 22 *Victims' age groups*

Notably, in this sample, three victims (14%) were pregnant at the time of their death. This is a high proportion considering that for the entire four-year sample (n=1012) only five victims (0.5%) were pregnant at the time of death. Of these three cases, two were recorded as SVSDA and one as an IPH. Additionally, in the two cases of SVSDA, the pregnant victims were in the youngest age group (16-24). As findings from Bates et al. (2024) suggest, pregnancy can be a risk factor not only for IPH, but also for SVSDA.

When looking at care needs, we found that at least a third of victims (32%, n=7) had been recorded as presenting some mental health need.

Thematic finding #1
SVSDA victims recent suicide attempts
Five of the victims within the SVSDA typology had expressed suicidal thoughts or attempted suicide shortly before their death, with a timeframe ranging from three months to a few days before the death.

For example:

- Case 1: Three months before her death, the victim attempted suicide saying that she wanted to end her life due to the DA she was suffering from. She asked for the suspect to be removed from her home.
- Case 2: The victim had expressed suicidal thoughts to several people. Days before her death she had attempted suicide several times by different methods. She had been detained under Section 136 of the Mental Health Act. She was taken to hospital and then released.

7.3. Suspect characteristics

All 23 suspects were male, with a homogenous distribution of ages. However, there was a slightly higher number of suspects in the youngest age group (16-24) and the age group 45-54.

Figure 23 *Suspect age groups.*

Twenty (87%) of the suspects were or had been in an intimate relationship with the victim, which means that all the SVSDA and unexpected death cases were related to DA in the context of an intimate relationship. The remainder three suspects were involved in AFH, with two of them being the sons of the victims and one the grandson.

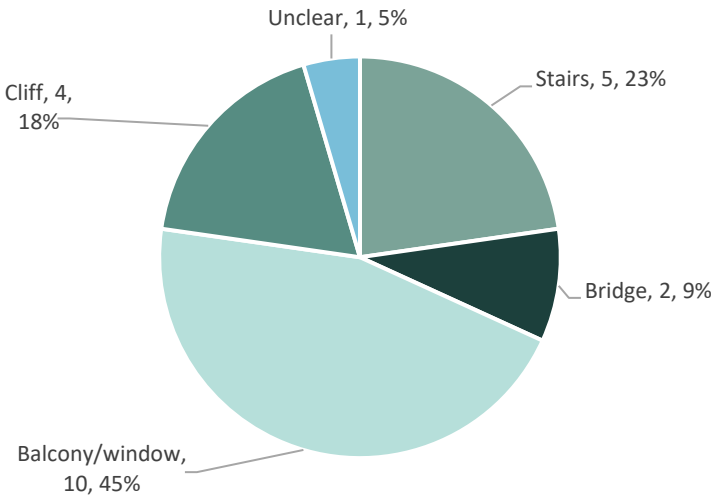
Similar as with the victims, around a third of the suspects presented some mental health issues (26%). Similar to what is observed in the general sample, in the cases of fatal falls identified as AFH (n=3), all the suspects were recorded by police as presenting mental health issues. At least two of them had been detained under the Mental Health Act in the past.

7.4. Case characteristics

7.4.1 Falls characteristics

In most of the cases (n=10, 45%) the victim fell from the balcony or window of a building. The second most recorded kind of fall was down the stairs (n=5, 23%) followed by a fall from a cliff (n=4, 18%) and falls from a bridge (n=2, 9%). In one case it was unclear how the victim fell.

Figure 24 *Number and proportion of victims by type of fall*



Of the victims that fell from a building, half (n=5, 50%) had been recorded as unexpected deaths. However, four of the cases had been initially deemed a suicide and were later investigated as unexpected deaths, potentially indicating police forces utilising updated guidance regarding the categorisation of and response to these deaths. In the case of victims that had fallen down the stairs, two were recorded as IPH, two as AFH and one as unexpected death. For victims that fell from cliffs and bridges (n=6), five were recorded as suicides and one as an IPH. The case where the kind of fall was unclear was recorded as an AFH.

Thematic finding #2

Involvement of suspects

In 15 (68%) cases the suspect was present at the time of the fall. In several cases the suspect was the person calling the emergency services, and all 15 claimed that the victim had fell or jumped. This finding is similar to what was observed by Ferguson and Sutherland (2018) who analysed twelve fall homicides (all convicted) and found that the victim's body was discovered (sic) by the offender in 75% of the cases, and in the remaining cases the body was discovered by others often after being prompted by the offender.

- In 9 out of 10 falls from a building the suspect was present at the scene. In three cases the death was considered a SVSDA and in four an unexpected death. The other two cases were recorded as IPH.
- In all the five falls down the stairs the suspect was present at the scene. These falls were more frequently considered homicides, with only one being an unexpected death.
- In only two of the cliffs falls the suspect was present at the scene, in all the remaining cliff and bridges falls the suspect was not present, with five out of six of the total of these falls being considered a suspected suicide.

7.4.2 Risk profiles

When analysing the suspect profiles, 82% (n=19/23) of all suspects were known to the police as DA perpetrators. When excluding cases of SVSDA, 79% (n=11/14) of suspects were known to the police for DA perpetration prior to the victim's death. Seven suspects (30%) were known as high-risk DA perpetrators and five of them had been MARAC subjects. In terms of the victims, 35% (n=8) were known as high-risk DA victims. From these victims, five were linked to high-risk suspect. Most of the high-risk victims' deaths (n=5) were recorded as suspected victim suicides (n=2 for IPH and n=1 for AFH).

7.4.3 Cases known to other partner agencies

In 65% of the cases, the victim and/or suspect were known to partner agencies. The agencies that most cases were known to were adult social care and mental health services, followed by child services and MARAC.

7.4.4 Review referrals.

For the 22 cases in this sample, 69% (n=15) were referred for a review, and 73% (n=11/15) of those referred were accepted. The remaining four cases were still waiting for a decision regarding the referral. All the SVSDA cases were referred for a DHR and six of them had been accepted. The other two cases of SVSDA were still waiting for a decision on the referral.

7.4.5 Risk factors

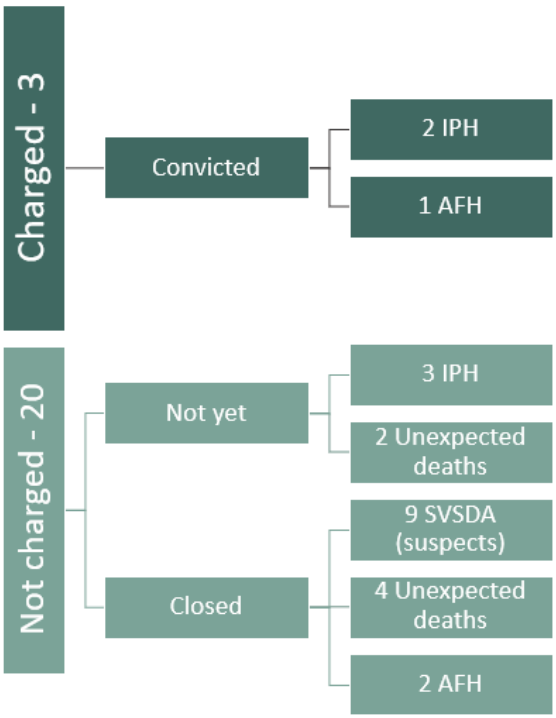
In the cases of falls from height, the most recorded risk factors for the suspects were alcohol use (n=14, 61%) and drug use (n=10, 43%), with nine (39%) suspects presenting both. Mental ill health (which includes all mental health issues) was the third more commonly recorded risk factor. These figures are similar to the most frequently recorded risk factors that were observed in the entire four-year sample. Moreover, in half of the cases the police had identified the presence of CCB.

It is worth noting that in the case of the victims, seven of them presented drug or alcohol problems. Additionally, five suspects were intoxicated with alcohol at the time of the death; four of those cases were of victims falling from a window/balcony (n=2 SVSDA; n=2 unexpected death).

7.5 Investigation and outcomes

In 16 (70%) cases the suspect had been arrested. The cases where no arrest was made were five suicides and two unexpected deaths. Of the 23 suspects, only three had been charged, and all three were subsequently convicted (See **Figure 25**). Two of these were IPH cases, with one suspect convicted for murder and the other for Unlawful Act Manslaughter (UAM). The third case was an AFH where the suspect pleaded guilty and was convicted for manslaughter. It is important to note whilst other cases had not (yet) received a charge or conviction, this does not mean they were not investigated, and in some cases were still ongoing as per additional information below.

Figure 25 *Outcomes of investigation of deaths caused by a fall from height (per suspect number)*



The cases where the offender had been convicted had either witness statements supporting the theory of a homicide, or forensic evidence to help prove it. For example:

- Case 1: 40-year-old female victim, 50-year-old male suspect (ex-boyfriend of victim). The suspect was found in distress by visiting friends, claiming that the victim had jumped from a window. The suspect was acting erratically at the scene, presenting injuries and was somewhat uncooperative with officers. There were signs of a disturbance and evidence of an attempt to clean the scene. Additionally, the post-mortem examination found that the victim had injuries inconsistent with a fall. The suspect was sentenced to 17 years for UAM.

The rest of the cases where there were no charges (n=20, 82%) can be grouped into two categories; the first group represents cases where there were no charges *yet* and the investigation was ongoing (n=5/20, 25%). Within this group, three cases were IPH and two unexpected deaths. It is worth noting that in all cases that led to a conviction and in those still being investigated (n=8), the suspects demonstrated similar crime scene engagement as outlined above in thematic finding #2, i.e., the suspect was present at the scene, claiming that the victim fell.

The second group correspond to cases closed with no charges brought, which represent the majority of this sample (n=15/20, 75%). It's worth noting that all the eight cases of SVSDA had been closed as well as four out of six unexpected deaths.

In nine of the closed cases the suspect was present at the scene with five of them claiming the victim had fallen or jumped. These deaths were primarily recorded as occurring due to a fall from a window/ balcony (n=5) and were classified as either SVSDA (n=3) or unexpected deaths (n=2).

- Case 2: 32-year-old victim, 31-year-old suspect ex-partner of victim. The victim's car was found in a parking space, later her body was found at the bottom of a cliff. Prior to her death, there are reports of DA including stalking and CCB by her ex-partner. Additionally, the suspect had a history of violent behaviour (DA and non-DA related). Just prior to her death, the victim sent her mother a text message blaming the suspect. Investigations were conducted into CCB and DA criminal damage. The police did not identify evidence amounting to CCB, so that investigation was concluded. The DA criminal damage investigation was the subject of a case file to the CPS, but this was not progressed due to evidential difficulties.

Thematic finding # 3

Family and friends coming forward alleging DA history.
In eight cases, families and friends of the victim approached the police after the death making allegations of DA between the victim and suspect. Five of these cases were SVSDA and three unexpected deaths.

- In five of these cases, the victim had fallen from a window/balcony and in the other three the victim fell from a cliff.
- In two out of the eight cases, the victim was not known to the police as a DA victim. In both cases the incident had been treated as an unexpected death, where the victim had fallen from a window/balcony and the suspect was present at the scene.
- Although forces talked to the families and investigated these allegations, all but one case were closed.

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Chapter 8: Suspected Victim Suicide Following Domestic Abuse: Coercive and controlling behaviour, posthumous prosecution efforts and third consultation with bereaved family members

8.1 Suspected victim suicide following domestic abuse involving coercive and controlling behaviour

In last year's report (Hoeger et al. 2024, see Chapter 7), the Project team continued to develop analysis of SVSDA utilising our unique dataset to provide a contribution to the growing literature in this field. The first section of this chapter presents a focused analysis of SVSDA cases with an identified risk factor of CCB.

Coercive control involves a pattern of abusive behaviour including threats, intimidation, degradation, isolation from family and friends, emotional abuse, financial abuse, jealousy, micro-regulation, monitoring and surveillance. Whilst not always overtly present, this pattern of abusive behaviour can then be (re)enforced by (threats of) physical and sexual violence (Barlow et al. 2020; Barlow and Walklate, 2022; Myhill, 2015; Stark, 2007).

It is important to provide context as to how the risk factor of CCB was identified. The history of CCB described within submissions was identified by the police in three different ways:

- Through information gathered from the victim's disclosures in previous police reports or completed risk assessments, although these disclosures do not always result in a specific report of a CCB crime.
- Through specific crime reports of the offence controlling or coercive behaviour against an intimate partner or family member.
- Through disclosures made by friends and family of the victim as part of the domestic homicide or SVSDA investigation.

The CCB risk factor was coded as 'yes' where this was indicated on the submission form, as well as being re-coded by Project team where this information was present in the 'free text' of the submission form such as within the history of previous police contact. Based on this utilisation of details available on police systems and that were selected for inclusion by the submitter, it is possible there may be additional information available that was not included on the form. Furthermore, this analysis is based on information that has been reported to the police and could also involve counter and/or false allegations of abuse that would not be possible to identify without additional context. As in the previous report (Hoeger et al. 2024), the abuse may not always be 'visible' upon police attendance and those who have experienced CCB may not necessarily be perceived as 'ideal victims' (Barlow, 2023).

Previous sections of this report have highlighted the prevalence of a history of CCB, particularly within cases of SVSDA (see Chapter 4). This section provides additional insight into these cases, with 206 victims of SVSDA from an intimate partner also involving

an identified history of CCB.[24] There were 210 prior DA perpetrators associated with these 206 deaths, which make up 58% of the 354 cases of SVSDA reported over the four-year period from 1st April 2020 to 31st March 2024.

8.1.1 Victim and suspect characteristics

Whilst the general characteristics of the victims and prior DA perpetrators in this sub-set were similar to that of the wider SVSDA dataset (e.g., sex, age, ethnicity), there are some points of note. First, five (2%) of the victims were pregnant or had given birth within the last six month prior to their death. Whilst, this number may appear small, this echoes findings from a Spotlight Briefing on young victims aged 16-25 (Bates et al. 2024) as well as the preceding analysis on deaths involving a fall from height (see Chapter 7). As there were 15 victims recorded as having been pregnant or recently given birth within the entire four-year dataset (n=1012), cases of SVSDA associated with abuse by an intimate partner that included CCB made up one in three of these cases.

Second, 51% (n=106) of victims and 40% (n=83) prior DA perpetrators were recorded as having a care need, which most commonly included a mental health care need (n=99 victims and n=71 prior DA perpetrators). This indicates that the mental ill health was recognised and recorded prior to their death by suicide.[25]

Additionally, 88% of victims and/or prior DA perpetrators were known to partner agencies (n=182). Together this indicates the visibility of the victims with potential opportunities to provide additional support, not only within the criminal justice system, but also the social care, (mental) health services and specialist DA services with whom they were in contact.

8.1.2 Risk profile: Co-occurrence

Illustrating the nature of risk in these cases, nearly half of these victims were known as high-risk (47%, n=97) and 55% (n=113) had been involved as victims in cases that were previously heard at MARAC. When considering the risk factors that co-occurred with CCB in these cases, the most common was separation (relationship ending), including 48% (n=100) of cases. This overlap was identified in the previous report (Hoeger et al. 2024, see Chapter 7) and separation has been identified as a time during which the loss of control by a perpetrator can place victims at greater risk or escalate the abuse (Campbell et al., 2007; Dobash & Dobash, 2016; Femicide Census, 2020; Monckton Smith, 2019). Additional commonly co-occurring risk factors were similar to the wider dataset, such as the prior DA perpetrator's mental ill health (45%, n=95), alcohol use (42%, n=88) and drug misuse (40%, n=85).

[24] Please note that there were four cases of SVSDA with a history of CCB in which the prior DA perpetrator was a family member. However, due to the potential differences in the dynamics of these cases, this analysis focuses on cases with a history of abuse from an intimate partner.

[25] In some cases the identification of the mental ill health may relate to a claim by their partner, family member, or report by a third party rather than a clinical diagnosis.

Notably, the next most common risk factor was the prior DA perpetrator also being known to the police as a victim of DA (33%, n=69). The previous report's analysis of SVSDA suggested that cases involving male victims were more likely than those of female victims to involve a police-recorded history of DA in which the deceased was known as the primary perpetrator of DA (Hoeger et al. 2024, see Chapter 7). However, it is important to note that this was conducted with a sample of the 28 relevant cases reported only during Year 3 (year ending 31st March 2023).

This Project's research, wider literature (Christie et al. 2023), and work by the Institute for Addressing Strangulation (McGowan, 2024) has highlighted the impact and risk associated with non-fatal strangulation, as well as its presence within SVSDA cases. Building upon this evidence, we found that non-fatal strangulation was the sixth most common risk factor in SVSDA cases involving a history of CCB from an intimate partner (27%, n=56).

The analysis also explored the simultaneous presence of CCB alongside two risk factors. One of the most common was the co-occurrence of CCB with alcohol use and drug misuse by the prior DA perpetrator (26%, n=55), followed by co-occurrence of CCB with separation and prior non-fatal strangulation (15%, n=32) and CCB with a protection order and the breach of a protection order (13%, n=27). Together, these findings suggest the types of behaviours involved and contexts within which CCB takes place that may precede a death by suicide.

8.2 Posthumous prosecution efforts in cases of suspected victim suicide following domestic abuse

This second section considers posthumous prosecution efforts across SVSDA cases across all four years of data collection (n=354 victims, 383 prior DA perpetrators).

It is important to note that updates from police forces on the status of the investigation in cases that have not (yet) achieved a charge suggest that in many cases there have been attempts to achieve a posthumous charge. Some of these cases will still be active and under investigation, which can continue beyond the six-month follow up period for this project. The free text provided by force about the status of the investigation will provide data for future analysis of SVSDA, as well as unexpected death cases. For instance, one mentions that a case was investigated with evidence of CCB presented to the CPS, but no charges were authorised, whilst another mentions that the history of DA prior to the suspected suicide is still under investigation.

At the time of submission and/or the six-month follow up process conducted by the Project team, 12 cases of SVSDA were confirmed to have successfully achieved a posthumous charge. All 12 cases also included an identified risk factor for CCB, 11 cases involved female victims and 11 involved male prior DA perpetrators. The case involving a male victim was associated with abuse from a male family member. Regarding the charges themselves, they were as follows:

Posthumous charges in cases of suspected victim suicide following domestic abuse
• Breach of harassment order   ○ Investigation for manslaughter recorded as having received no further action.
• Common assault, S 47 Assault occasioning Actual Bodily Harm (ABH), Controlling or Coercive Behaviour (CCB) and False Imprisonment
• Theft   ○ Investigation into the death itself received no further action after account given by the suspect was corroborated.
• Threatening to disclose sexual images   ○ The suspect pled guilty to the charge, but the police force was simultaneously investigating a stalking offence using forensic examination of mobile downloads, which was ongoing.
• Common assault   ○ The assault occurred two weeks prior to the victim's death.
• Two counts of S 47 Assault (ABH), Intentional strangulation, Harassment, Breach of a restraining order   ○ Investigation into the death was also recorded as ongoing.
• Stalking   ○ Investigation in the death was also recorded as ongoing.
• Harassment   ○ Considering pursuit of charge for Unlawful Act Manslaughter and in discussions with the CPS.
• Controlling or coercive behaviour against an intimate partner or family member   ○ They merged the posthumous investigation with the cases for 2 additional victims who were the perpetrator's ex-partners, which led to a conviction and custodial sentence.
• Common assault   ○ An additional common assault charge was recorded as having received no further action.
• Common assault   ○ The assault occurred three weeks prior to the victim's death.

At the time of analysis, only one case in this dataset was known to have achieved a posthumous charge for Unlawful Act Manslaughter (UAM) in a case of SVSDA. This is described in the case study below.

This case involved a female victim of SVSDA perpetrated by her male partner. At the time of her death, the force identified that there were two outstanding investigations for coercive controlling behaviour (CCB) and two reports of assault. There was a separate investigation into the previous police contact, and the initial aim was a posthumous prosecution for the outstanding reports of CCB and assault. However, a team within the force recognised the unique circumstances of the case and decided to pursue a charge for Unlawful Act Manslaughter (UAM). They utilised learning and evidential methods similar to those used in the first successful prosecution of UAM in a case of SVSDA (*R v Allen*, 2017).

The evidence gathering and investigation process included:

- Capturing more than 100 statements from family and friends that spoke to the history of CCB and general decline in the victim's mental health over the course of their relationship;
- Downloading the victim's mobile phone (with the family's consent) to identify further evidence of abuse via text/social media etc.;
- Utilising medical records relating to the victim's physical and mental health, reaching across more than 30 practitioners;
- References within the victim's suicide note about how she had been 'murdered slowly' by the suspect/perpetrator of DA;
- Use of the body worn camera footage from previous police call outs, which clearly demonstrated how the victim was feeling trapped within the relationship and was agonizing about whether or not to provide a statement to the police;
- Speaking to force areas that had also pursued posthumous prosecution for additional advice.

Some evidence of CCB within their two-year relationship included her isolation from family and friends, financial abuse (including spending the victim's money to finance his use of drugs), 'love bombing' (via gifts, signs of devotion, and a proposal following the victim's request for separation), then returning gifts following any 'arguments', degrading her, requesting her to move in with the suspect whilst he was living with his ex-partner (with whom he also had a history of DA), overtly cheating on the victim, making statements suggesting that the victim should 'end up dead' and utilising intimate knowledge of her history to target the abuse.

The CPS Complex Case Unit agreed that there was potential to achieve a charge for UAM in this case and the police worked to build an action plan on that basis. Additionally, whilst the victim's mental ill health preceded the relationship (psychiatric diagnosis, inpatient stays, suicidality), they took extra efforts to demonstrate the decline associated with the abuse from the suspect/perpetrator of DA. An expert statement provided by a forensic

psychiatrist also attested that although the victim may have died by suicide at some point, the DA constitutes the 'unlawful act', and the victim's death was directly caused by the suspect's abuse.

The suspect was charged with UAM. After breaching bail conditions, he was remanded into custody. During the trial, several defences were raised on behalf of the suspect. The defence highlighted:

- Instances of affectionate text messages between the suspect and victim, arguing that their relationship was mutual rather than coercive.
- While the victim had shared images of injuries with friends, she had also continued to send affectionate text messages to the suspect; the defence framed this as evidence of a 'toxic' but reciprocal relationship.
- Despite a lack of evidence showing injuries to the suspect or abusive messages directed towards the suspect, the defence argued that both parties were equally responsible for the relationship's dysfunction.
- One key argument centred on the victim's pre-existing mental ill health and prior suicide attempts following a previous relationship breakdown. The defence therefore argued that the victim's suicide could not be attributed solely to the suspect, as her suicidal ideation was not unique to this relationship.
- There appeared to be considerable victim-blaming throughout the trial from the defence with the victim's personal struggles and past behaviours extensively scrutinised and exposed in court; this may have consequently shifted focus away from the suspect's actions.

Although acquitted of UAM, the judge's sentencing remarks acknowledged that the evidence (including the victim's own words, actions, and psychiatric assessments) demonstrated to the jury the profound psychological impact of prolonged abuse and degradation by the suspect. It was recognised that, in the months leading up to her death, the victim had become increasingly isolated and deeply affected by the suspect's manipulation, believing herself to be worthless and without support. The suspect was convicted of CCB and ABH and sentenced to six years in prison, along with a separate six-month term for assaulting another individual 12 months after the victim's death.

The circumstances of each death will differ. The case study above demonstrates that achieving a posthumous charge in a case of SVSDA, whilst presenting challenges, is possible with support, resources, and the ability to capture relevant evidence. However, substantial barriers remain in securing convictions, particularly for Unlawful Act Manslaughter, due to the complex nature of such cases and challenges in legal proceedings that risk diminishing perpetrator accountability. Considered together with the 11 cases involving posthumous charges for other offences, whilst representing a small portion of SVSDA deaths, these cases provide initial evidence of work by the police and the CPS to hold DA perpetrators to account. The Project team aim to continue raising awareness about SVSDA and helping to facilitate the sharing of promising practice across forces.

8.3 Third consultation with bereaved family members: Perspectives from lived experience

In March 2024, the Project team held our third consultation event in partnership with Advocacy After Fatal Domestic Abuse (AAFDA) including eight family members bereaved by fatal DA, one advocate and two members of AAFDA's leadership team, including their CEO Frank Mullane. AAFDA supports bereaved families in navigating Coronial and Statutory Review processes after domestic homicides, unexpected deaths and SVSDA, providing specialist advocacy and peer support for families. We also had representation from the NPCC, the Home Office and the Domestic Abuse Commissioner, Nicole Jacobs.

Some family members in attendance had participated in all three consultation events, others had joined for two, and some were new to the consultation meeting. The Project Team's report and briefings had been shared prior to the event, with the first part of the day sharing relevant findings and providing updates on changes to policy, guidance and practice since the event in February 2023. One change was specific guidance provided to police forces about responding to unexpected deaths, including suspected suicides, that was informed by comments and concerns raised during the previous consultation.

8.3.1 Unexpected Death – Guidance in Respect of Investigating Suspected Suicides

Police enquiries in unexpected deaths, including suspected suicides, should consider any history of DA and follow these steps: (1) record all persons present in the household at the time of the death; (2) record any known history of DA associated with the victim, address or persons present in the household at the time of the death; and (3) contact close associates and others who may have information material to a history of DA, including family, friends and neighbours.

Reasonable and prompt system checks should be made for any known DA history and non-crime incidents by appropriate officers or staff. Where possible, this should be done prior to officers leaving the scene and/or within initial enquiries. At the scene, officers must always apply professional curiosity and an investigative mindset to test the obvious explanation. Research demonstrates elevated risks of both IPH and SVSDA where a history of CCB is present. Therefore, attending officers should be alert to any signs or disclosures of prior DA, especially those involving CCB. Relevant information uncovered could be included in the 'circumstances of death' section in the death report to Coroners.

Officers should also be aware that DA perpetrators may seek to inappropriately influence criminal justice and/or inquest processes after a death, especially where they are 'next of kin'. For instance, although the term does not hold a legal status, as 'next of kin', a DA perpetrator may request the victim's phone or electronic devices, which could compromise existing evidence. Additionally, whilst not an exhaustive list, DA perpetrators may attempt to interfere with the notification of the death to wider family members, the release of the body, child contact/custody arrangements, or otherwise engage in witness interference.

During the decision-making process at an unexpected death, attending officers should engage supervisors and PIP2 investigative resources. Where a suspected suicide involves

a history of DA, officers should consider the need for further investigation and PIP3 oversight.

8.3.2 Feedback from families

Throughout the second half of the day, family members shared their perspectives and experience, not only relating to the police response but also wider partner agencies. There was feedback from the family members about:

1. What gives them confidence that responses are improving:

Common themes were the sharing of data and practical experience across policing, the changes to police tools and training (e.g., DARA, DA Matters, updated guidance), and that their voices were being heard in a way that affects changes.

Some examples included comments such as, *'We can hear ourselves in the report - as a group of peers we were listened to'* and the police are *'looking at their own situation and changing culture from inside'*.

2. What still worries them:

There continue to be a number of areas of concern surrounding themes such as, young-in-service officers and their associated training, professional curiosity and standards, access to property after a victim's death, the impact on friends and family members after a death as well as burdens placed on them, and a general lack of trust and confidence in the police.

Some examples of feedback include:

- *'Family and friends dismissed – responsibility placed on them to "prove" offence has taken place'.*
- *'Collusion with perpetrators – intentional or not'.*
- *'Training on suicide prevention is needed - Need to be more proactive towards victims rather than reactive'.*
- And, *'I really feel there needs to be some thought and research into how it effects the wider family as we are now victims of this DA too and how the effects of the way police treat loved ones and the impact that has on our mental health'.*

Whilst not all points raised during the consultation are within the purview of this Project team, they have informed this report with the belief that the findings and recommendations can help improve the experiences of future victims/survivors and their families. Again, we are extremely grateful to all the families who gave their time and shared their perspectives with us. Their resilience, courage and determination to lift up the voices and honour the lives of their loved ones is remarkable.

Click here to return to the summary findings and recommendations for Chapter 8

Report Conclusion

In summary, this report has presented new analysis of domestic homicides, unexpected deaths and suspected victim suicides following domestic abuse (SVSDA), drawing on four years' worth of data collected by the Domestic Homicide Project. The first few chapters of this report shared the number of deaths by typology, victim and suspect characteristics (e.g., age, sex, ethnicity), risk factors, and police and partner agency contact associated with deaths between the 1st of April 2020 and 31st of March 2024.

The Project's recommendations for practice are informed by findings such as, changes to the reporting of SVSDA and unexpected deaths, persistent presence of specific risk factors (e.g., mental ill health, a history of controlling and coercive behaviour (CCB), alcohol and drug misuse), and prevalence of contact with the police as well as partner agencies like social services and mental health services. These recommendations provide direction for future work by the police (local forces, NPCC, College of Policing), CPS, Home Office, and multi-agency partners involved in safeguarding victims of DA.

Chapter 7 and 8 focused on analysis of the characteristics and profile of deaths involving a fall from height and what is known about the scale and response to SVSDA, particularly those cases with a history of CCB. Notably, continued attempts to pursue posthumous charges and prosecutions for Unlawful Act Manslaughter and DA-related offences, although relatively small in number, demonstrate the potential impact of awareness raising and changes to policy and practice. This signifies the importance of sharing relevant practice to inform future outcomes. Finally, consultations with bereaved family members indicate where more work must be done to prevent future deaths.

This report demonstrates the importance of continuing to collect rich data and analyse this unique dataset to track progress on, and further develop, efforts to reduce and prevent domestic homicides and suicides following domestic abuse.

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