Domestic Homicides and Suspected Victim Suicides 2020-2025 Year 5 Report

Appendix A – Response to Year 4 Report Recommendations

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.

The Domestic Homicide Project, supported by the NPCC leads for domestic abuse, homicide and suicide prevention have worked alongside the College of Policing to ensure policies and emerging practice is included in both the Authorised Professional Practice and within training such as DA Matters. The project team completed deep dives into five police forces regarding their response to unexpected deaths, including suspected victim suicide following domestic abuse. The work considered how the guidance is being translated into practice and two case studies are provided in the Year 5 report that highlight important themes. Developments are also evidenced within police force responses to the Year 4 recommendations.

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.

As noted in the main report, in April 2025 the College of Policing APP was updated with additional guidance on responding to unexpected deaths, including suspected suicides with a history of domestic abuse – available here. The Senior Investigating Officer (SIO) Development Programme (SIODP) is being updated and will be piloted with the new version including suicide following domestic abuse and consideration of investigation for unlawful act manslaughter (UAM). There is also relevant content in the Major Crime Investigation Manual (MCIM) and associated categories for unexpected death investigations.

Recommendation 3 [to 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.

1. Restrictions with the national DA definition:

Several forces mentioned that adhering to the statutory definition of DA limits their ability of formally record DA involving individuals under the age of 16. This represents a challenge, as many forces do not currently have mechanisms to track TRA in their current structures. Additionally, referral pathways to victim support and other services are aligned to the national definition, which limits the actions forces can take in relation to domestic abuse outside of existing child protection and safeguarding pathways.

However, most forces recognise the importance of addressing DA among young people and are working on developing a better understanding of the issue. For example, some of them have incorporated TRA into their problem profiles, while others are undertaking scoping exercises to understand the demand.

2. Data Capturing and Flagging:

Forces acknowledged that there were gaps in data, flags on systems and risk assessment tools for identifying and responding to TRA. Some forces are addressing these issues through a triaging process allowing them to identify TRA cases. For example, one force does quality assurance of Child Concern Notifications within multi-agency safeguarding hubs (MASH) to identify potential TRA and they apply a marker (different from a flag for DA) in the system to ensure the case is visible when responding to any future incidents. Another force highlighted their daily Intelligence scanning process whereby a team identifies any concerns linked to TRA and considers what support can be provided in response.

Forces also reported efforts to develop or improve flagging mechanisms within police systems for intimate partner abuse involving under-16s, including the introduction of prompts within Vulnerable Child forms to identify actual or potential harm in relationships involving young people aged 12–16.

In relation to risk assessment, one force highlighted challenges where DASH is not autogenerated in their system for TRA due to age. To address this, they have implemented workarounds to enable completion of the risk assessment form. Another force has amended their policy, to require completion of a DASH/DARA where TRA is identified. A further force reported ongoing research work to develop a specific risk assessment tool for teenagers.

3. Multi-Agency Working:

Forces reported collaboration with social care, education and health partners, often through MASHs arrangements, to support children and young people affected by DA. Some forces are developing or updating guidance and referral pathways and working on

improving information sharing with partner agencies. Some forces mentioned the consideration of referrals to MARAC for young people who are 16 and over. One force also reported undertaking regular audits of MARAC cases, including with a planned thematic focus on TRA.

While some forces reported a lack of access to specialist services such as youth IDVAs, most indicated the presence of specialist teams or partnership arrangements to support young people affected by DA. However, most of the support referred to those witnessing or experiencing abuse in the home, rather than within their own relationships. Some forces are including TRA within Operation Encompass notifications, enabling schools to provide targeted support.

Examples of wider partnership activity include the development of a tiered sexual harms behaviour pathway for children at risk of perpetrating sexual offences, commissioning of a new stalking advocacy service for young people, and the establishment of a TRA working group to map existing approaches, identify local gaps and consider process improvements.

4. Education and Prevention Activity:

Many forces highlighted education-based activity delivered in partnership with local education authorities, including awareness sessions and educational workshops across primary, secondary and higher education settings. Topics commonly covered include (un)healthy relationships, violence against women and girls (VAWG), coercive control and online harms.

Several forces are using resources from the Pol Ed platform to support work in this area. On their website, Pol-Ed states that they *"support schools in delivering expertly planned lessons designed to develop a deep awareness of risks, citizenship and the law"*. According to forces, teaching staff can access planned lessons and self-deliver as they see fit. The platform includes contents related to DA and VAWG, such as harassment, spotting coercive control and managing stages of intimacy.

Forces also reported having teams and officers working directly with schools. For example, one force has police officers working with schools to identify children and young people at risk of becoming a victim or offender, with a particular focus on the criminal and sexual exploitation of children, VAWG and DA. Another force has neighbourhood officers delivering educative sessions to young people aged 13 to18 in schools and colleges.

Additionally, forces highlighted their involvement with local prevention and education programmes, including interventions for younger perpetrators. For example, one force had commissioned youth-focused programmes addressing knife crime, coercive behaviours and sexual violence prevention initiatives for young people aged 11 and

older. In another force area, there are support services for victims and perpetrators of domestic abuse including programmes specific to young people aged 11 to 18 who have used violence or abuse towards family or intimate partners.

5. Child Protection Pathways:

Forces reported that DA within relationships involving under-16s is primarily managed through child protection and safeguarding pathways. Several forces identified Public Protection Notices (PPNs) as the main mechanism for referring concerns about young people into MASH, enabling information sharing between the police and relevant partners. Two forces also highlighted the use of secondary risk assessments conducted by specialist teams as an additional assurance measure to prevent missed referrals and to support the identification of tailored support pathways.

Where cases of TRA involve both parties being under 16, forces described a child safeguarding response, which may include engagement from social care, involvement of parents or carers, liaison with education and consultation with DA specialists. One force highlighted that when the perpetrator is under 16, they take a ‘child first’ approach, avoiding wherever possible the application of adult standards to children. This means that incidents and offences involving children under 16 sit with the wider youth justice system and they use Out of Court Resolutions and family-based interventions to prevent future harm.

6. Training:

Forces reported that TRA is being incorporated into the rollout of DA training for response officers and specialist teams, including training on identifying CCB within relationships involving under-16s.

Continuing Professional Development (CPD) training also incorporates themes emerging from reviews, which include TRA and coercive control dynamics among young people. One force highlighted the rollout of training on trauma responses and indicators of harm in early relationships, alongside the implementation of Trauma-Informed Policing across the force, supported by a period of self-assessment to embed trauma-aware practice. This approach is particularly relevant when responding to young people whose relationships may be influenced by developmental and contextual factors. Another force noted that tech-enabled abuse has featured in reviews involving young people, with learning indicating potential gaps in provision to address tech-enabled abuse due to due to long waiting times for digital device analysis.

Forces also reported plans to roll out CPD training on the Voice of the Child. This training is aimed at increasing awareness and identification of children impacted by DA, including TRA involving under-16s, and strengthening responses to children as victims

of abuse who are not currently recognised within the statutory age limits of the DA definition.

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.

- The recently published Freedom from Violence and Abuse Strategy set out the key actions the Government will take to halve violence against women and girls (VAWG), including teenage relationship abuse. The Government is clear that tackling teenage relationship abuse is a key priority, and we have introduced a first-of-its-kind package of measures to achieve this. These include improved healthy relationships education via the updated RSHE guidance, interventions for young people displaying harmful behaviours within their relationships, and a new helpline for young people who are concerned about their behaviour towards their intimate partners. To support this further, we will also ensure that we understand the current landscape around teenage relationship abuse by commissioning a major programme of research this year. This will look at how different organisations like the police, schools, and social care are currently approaching teenage relationship abuse, and what changes are required to strengthen society's response to it.
- The Home Office will keep exploring further work with the Domestic Homicide Project and other relevant stakeholders to ensure learning around fatal cases of teenage relationship abuse is captured.

In line with Year 5 Report Recommendations, the Domestic Homicide Project team will continue to report on this within future publications.

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.

The Year 5 report includes disaggregated data on protected characteristics, including by sex, ethnicity and typology within Chapter 3. Specifically, Section 3.3 focuses on the analysis of victims from minoritised ethnic groups in cases of domestic homicides and SVSDA. Additional protected characteristics are reported in the following section, such as sexual orientation, religion and pregnancy.

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.

1. Multiagency work and information sharing:

Forces highlighted approaching cases of domestic abuse through multi-agency reviews and information sharing. Most forces mentioned carrying out extensive information sharing, particularly through MARAC, MASH, and other safeguarding structures, involving mental health services, substance misuse agencies, GPs, Adult Social Care, and third-sector partners. Forces mentioned that these multi-agency forums allowed them to routinely review suspected suicides linked to domestic abuse with key partners, ensuring a multi-agency understanding of risk. Forces mentioned that MARAC plays a key role in coordinating safeguarding for high-risk DA cases, though some of them stated that partner attendance and consistency can vary, particularly in relation to Mental Health services.

Several forces highlighted the importance of the use of Public Protection Notices (PPNs) to help them identify suicidal ideation, mental health needs, and substance use risk. PPNs are also seen as a useful referral mechanism, but forces pointed out that they require auditing, consistency, and resourcing.

2. Data Integration:

Some forces are improving data systems to integrate suicide-related, DA-related, and vulnerability data to support real-time monitoring and targeted prevention. Forces acknowledge the need for shared datasets to facilitate prevention. One of them mentioned an initiative that allows them to aggregate personal datasets to identify service gaps, support targeted interventions, and create a unified understanding of serious violence across agencies. Forces are also using technology to improve risk identification, automate referrals, and ensure compliance. For example, one force implemented a new system which automates referrals to specialist support services, reducing reliance on officers to remember this step. For quality assurance, all submissions are reviewed by an experienced Detective within the MASH team, who have received specialist safeguarding training to undertake this role.

3. Strengthening referral pathways:

Forces are working to strengthen and clarify referral routes into mental health, substance misuse, and custody-based intervention services. Some of them mentioned carrying out daily triage processes which include local drug and alcohol services to enable early referrals and signposting. Some forces highlighted that officers are encouraged to make referrals or provide signposting to appropriate third-sector

organisations, especially in domestic abuse cases involving suicidal ideation. Forces mentioned the use of tools such as signposting apps and 'Z' cards to support officers in directing individuals to the appropriate services. However, consent requirements can limit referral options, especially in cases involving drug or alcohol use identified during secondary risk assessments.

Forces are increasingly embedding specialist roles to ensure MH and substance use considerations are addressed early and effectively. Across forces, mental health referral pathways remain inconsistent and often dependent on consent or external processes such as GP or self-referral routes. These constraints pose barriers to timely safeguarding and risk management, despite mitigating factors like embedded mental health triage roles. A few forces mentioned the implementation of centralised adult referral processes to improve safeguarding mirroring existing child safeguarding structures.

A few forces mentioned being part of the Domestic Abuse Protection Order (DAPO) pilots, which include positive requirements such as attending behaviour-change or substance use programmes, and require active monitoring by police, improving safeguarding and accountability. Some forces also mentioned the use of Drug Testing on Arrest as a tool to further identify individuals needing support.

Some forces also acknowledge that MH, substance and alcohol use are aggravating factors in domestic abuse and have developed training on these topics. For instance, a force mentioned having revised their DA policies and training to ensure officers consider how intoxication may affect reporting and to prevent minimisation or misinterpretation of allegations. Forces recognise the need to develop clearer, more reliable pathways, particularly for cases that fall below high-risk thresholds but still require coordinated intervention. Despite the efforts to work in collaboration with other agencies, only one force explicitly mentioned having a formal data-sharing agreement with NHS mental health trusts and substance misuse services to strengthen safeguarding.

4. Embedding Learning:

Forces emphasised the need to embed learning from DHRs and other reviews, especially around MH and substance use-related issues across their DA processes, including triage, secondary review, and supervisory oversight. This ensures that risk factors are consistently identified and acted upon within safeguarding pathways. Several forces have developed organisational learning structures that allow them to share learning and strengthen safeguarding outcomes. For example, one force established a safeguarding delivery group involving Domestic Abuse and Local Policing Support Teams. The group ensures suicide-related lessons from DHRs are shared across partnerships and that data is scrutinised for emerging trends. This reflects wider system recognition of the strong links between suicide and domestic abuse, which has also been incorporated into local DHR training for mental health and partner agencies.

Recommendation 7 [to 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.

1. Review of Suicides:

Many forces embedded processes to routinely screen and review suspected suicides, and identify potential links to DA. These reviews often form part of routine scrutiny of unexpected deaths and are used to identify learning opportunities and inform safeguarding responses. Several forces described daily reviews of suspected suicides, where cases are examined for indicators such as DA history or prior police contact. Where relevant links are identified, cases may be escalated for further review and/or referred to wider safeguarding or review mechanisms, such as Statutory Review Teams. In some forces, this activity is supported by data monitoring processes and surveillance systems that record suspected suicides and associated links to DA, which enables patterns and trends to be identified and shared with relevant teams and partners.

One force reported that a dedicated analyst reviews all suspected suicides daily and examines police records to identify any DA history. Where links are identified, the information is shared with safeguarding teams and public health partners, and cases are considered for further review through statutory safeguarding processes. Another force reported that a dedicated suicide prevention researcher reviews reported unexpected deaths and identifies cases where there is a link to DA. These findings are used to inform learning and system development. A further force mentioned the importance of closer collaboration with the Coroner's Office, so that confirmed suicide cases involving domestic abuse can be clearly identified and analysed. These insights would provide valuable learning opportunities to strengthen future safeguarding and prevention work.

2. Integration of Suicide Prevention within Governance and Safeguarding:

Several forces described ways in which they are strengthening organisational connections between DA and suicide prevention functions through governance, safeguarding structures and review mechanisms. This includes reviewing DA-related suicides through organisational learning meetings and homicide prevention boards, and embedding DA and suicide awareness into vulnerability strategies. Forces also mentioned integrating suicide prevention into police frameworks with the aim of strengthening early identification and monitoring of suicide risk within DA contexts. For example, one force mentioned the creation of a regional working group across policing, public health, and DA leads to focus specifically on preventing DA-related suicides, enhancing multi-agency alignment.

Some forces reported that learning from suspected suicides and DA-related deaths is discussed within public protection governance structures, ensuring that both DA specialists and mental health leads are involved in identifying learning and improving practice. In addition, forces frequently highlighted the role of partnership structures in supporting this work. Collaboration with public health teams, integrated care boards and local safeguarding partnerships were noted throughout the responses, particularly through real-time suicide surveillance groups or multi-agency suicide prevention groups/ boards.

Multi-Agency Risk Assessment Conferences (MARAC) were also identified as an important mechanism for identifying suicide risk in DA cases and coordinating multi-agency safeguarding responses where risks are identified. One force has established a dedicated DA and suicide prevention working group involving internal teams and external partners. The group will aim to strengthen the links between suicide prevention and DA responses across the partnership. Moreover, another force noted that they had established a DA-related suicide prevention project using problem-oriented policing methodologies, to better understand and address suicide risk among women and girls who are experiencing, or have experienced, DA.

3. Training and Awareness:

Forces have incorporated awareness of the connection between DA and suspected suicide into their training structures, reported frequently as key mechanisms for strengthening links between DA and suicide prevention work. One force said that mental health training for newly recruited officers includes explicit content on this link. Another force delivers training on PPNs and how to proactively explore whether victims may be experiencing suicidal thoughts. A further force, mentioned delivery of training to better understand the link between domestic abuse and suicidal ideation, promoting trauma-informed approaches strengthening officers' professional curiosity when assessing risk or engaging with victims.

Many forces indicated that training for response officers and specialist teams includes content on the relationship between DA, coercive control, and suicide risk. This training often focuses on recognising warning signs, understanding the psychological impact of coercive control, and identifying risk factors that may increase vulnerability to suicide. In several forces, this material has been incorporated into DA training programmes, CPD sessions or vulnerability training delivered to frontline staff.

One force reported delivering a dedicated training programme to officers, which included points on post-separation abuse, coercive control, and other risk indicators. This training aims to improve early identification of risk and ensure that appropriate safeguarding referrals are made. Some forces also reported plans to develop further

guidance and resources to support officers in recognising and responding to suicide risk within domestic abuse cases.

4. Dedicated Roles:

Some forces reported the presence of dedicated liaison roles or specialist functions to support coordination between DA and suicide prevention activity. Responses noted that these roles often sit within vulnerability, prevention or partnership teams, and may focus on reviewing suicide data, coordinating multi-agency work, or supporting operational teams.

In several forces, mental health practitioners, suicide prevention coordinators or liaison officers work closely with DA teams and safeguarding units to support information sharing and joint case review. These roles sometimes also contribute to partnership forums, data analysis or training activity to strengthen organisational responses to suicide risk.

However, other forces noted that they do not currently have dedicated suicide prevention teams or specialist DA units. In these cases, suicide prevention activity is often led through partnership arrangements with health services and third sector organisations, and coordination between DA and suicide prevention work takes place through broader vulnerability or safeguarding structures.

Several forces highlighted the specific roles that have been appointed to respond to this. For example, one force reported having a dedicated suicide prevention strategic coordinator who also supports the NPCC by working with public health suicide prevention leads in the force area. Another force appointed a liaison officer responsible for linking DA teams and suicide prevention work. Moreover, one force highlighted the presence of a dedicated mental health and suicide prevention officers within a Partnership and Prevention Hub, who works closely with officers from the public protection unit (PPU), as well as a DS role that has been created to improve coordination between the Partnership and Prevention Hub and PPU.

Recommendation 8 [to 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.

1. NFS is a High-Risk Indicator:

Across responses, forces consistently recognised non-fatal strangulation (NFS) as a significant indicator of serious harm within DA, with links to potential escalation towards domestic homicide as well as increased risk of suicide. Many reported that incidents involving NFS are graded as medium or high risk, which leads to enhanced safeguarding responses and allocation specialist investigators or PP teams. In several

forces, disclosure of NFS triggers escalation through risk management processes such as MARAC, or secondary risk assessments to ensure the risk is appropriately recognised and managed.

Risk assessment frameworks such as DASH or DARA frequently include prompts relating to strangulation, and several forces described internal policies and operational guidance emphasising NFS as a predictor of escalating violence, DH, and in some cases, SVSDA. This recognition was also reflected in investigative practices, with some forces allocating all NFS cases to specialist investigators or ensuring additional supervisory oversight.

One force has introduced a Crime Allocation Policy, which ensures that all high-risk DA cases and NFS investigations are allocated to CID, to ensure that there are routes for specialist investigation based on risk and complexity and that there is an awareness of the links between NFS, serious harm and DA.

2. Training and CPD:

Forces widely reported that NFS is incorporated within DA training and professional development packages for both first responders and specialist investigators to improve awareness. This includes coverage within initial recruit training, investigator development programmes, and ongoing CPD events. Training content commonly focuses on recognising the signs and symptoms of strangulation, understanding the medical risks (including delayed injury), evidential requirements, and the legal framework under the Domestic Abuse Act 2021 that introduced NFS as a standalone offence.

Some forces have supplemented formal training with internal resources, such as guidance pages, toolkits, briefings, and training videos to reinforce learning. Others reported learning inputs from external experts, including healthcare professionals and specialist organisations, to improve officers' understanding of the medical and psychological impact of strangulation, and appropriate safeguarding responses. Learning is also being taken from DHRs and other reviews, to strengthen understanding and awareness of NFS and its links to DA.

One force reported the development of a bitesize, accessible training video (produced in collaboration with criminal justice partners), to reinforce officer awareness of NFS, including its identification as a high-risk indicator and its links to DH and SVSDA. Another force noted how they have delivered joint training sessions with healthcare professionals to improve understanding of the clinical presentation of NFS, and the importance of early intervention.

3. **Governance:**

Forces described improvements made to the oversight and analysis of NFS cases, audits of risk gradings, and specific NFS scrutiny panels to better identify gaps, improve consistency and share learning. Several forces described governance structures which support organisational learning around NFS. These include DA strategic boards, threat management groups, and organisational learning meetings or panels where cases involving NFS are reviewed and discussed.

In some areas, forces conduct audits or dip sampling of DA cases, including those involving NFS, to look at risk assessments conducted, investigative practice, and safeguarding responses. Learning from DHRs is also shared through governance structures to inform policy, training, and operational practice. Some forces also reported the use of analytical products, problem profiles, or strategic threat and risk assessments to monitor patterns of NFS and better understand its prevalence and associated risks within DA cases.

One force has introduced enhanced scrutiny of NFS cases through internal review processes within a DA Scrutiny Panel, to ensure that learning from these cases is fed back into operational practice to improve investigative standards and risk assessment. In turn, this aims to form part of a wider strategy to raise awareness and tighten the force response to high-risk behaviours such as NFS.

4. Multi-Agency Working:

Forces reported extensive collaboration with partner agencies to raise awareness of NFS and strengthen responses. This included working with health services, public health teams, safeguarding partnerships and DA boards. The responses noted that NFS is often discussed within multi-agency governance structures such as VAWG boards, safeguarding partnerships, and DA strategy groups.

In several areas, forces reported joint training or awareness events delivered with partners, including safeguarding weeks, learning sessions, and partnership campaigns aimed at increasing awareness of the risks associated with strangulation.

Examples of partnership working were also evident in the development of clinical pathways for victims. In one area, a force reported a trial of a pathway through which victims of NFS that consented to a referral received a range of medical imaging, follow-ups, and prescription pathways. Another force detailed a trial taking place where victims of NFS were given a letter by their GP following disclosure. This allows them to attend their local hospital and provide staff with the letter to receive a CT scan with no further questions or investigations, which can then be used as evidence later in the investigation.

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.

- This Government is clear that focusing on perpetrator behaviour is key to tackling the root cause of domestic abuse, holding perpetrators to account, and keeping victims safe.
- In the Freedom from Violence and Abuse Strategy, the Government has committed to several measures that aim to tackle perpetrators in the community and reduce re-victimisation. We have been clear that disrupting the behaviour of perpetrators is central to the mission to halve VAWG, and this includes challenging the behaviour of perpetrators through perpetrator interventions.
- In the Strategy, we have committed to encouraging a coordinated community response, drawing on and sharing best practice from Police and Crime Commissioners who are already bringing together local services such as police, health, and specialist support to manage perpetrators and protect victims more effectively.
- Additionally, the Government has committed to replacing the violent and sex offender database (ViSOR) with a new Multi-Agency Public Protection System (MAPPS). MAPPS will enable the police and other agencies across the UK to more effectively manage serious offenders who pose a risk of harm to the public through upgraded technological capabilities and improved data sharing. Once delivered, we will continue to develop MAPPS to provide additional capabilities beyond the current system ViSOR such as automated information sharing, and ensuring police, prisons and probation staff have the right tools to manage the most dangerous offenders of these crimes.
- The actuarial risk assessment instruments (ARAIs) for reoffending in operational use by HMPPS have been updated, effective from 23 February 2026. The updated Serious Violent Reoffending Predictor (SVRP) provides prison and probation practitioners with an improved tool to identify those people on their caseload who are more likely to go on to commit homicide or other serious violent reoffences. SVRP scores previously formed part of the Risk of Serious Recidivism (RSR) score which also includes sexual reoffending risks. SVRP continues to form part of the Combined Serious Reoffending Predictor score – the new name for the RSR – but SVRP scores are now also displayed in their own right to

practitioners completing offender assessments for risk management and court reporting.

- A report presenting evidence of how the prediction of serious violent reoffending can be further improved, and wider recommendations about improving risk assessment across the CJS, was published in autumn 2025.

As part of its work on high-harm perpetration, the NCVPP will deliver several key initiatives. These include researching and evaluating algorithms that use police data to identify individuals who pose a significant risk of harm to women and girls. Work will also be undertaken to identify a system that enables effective local, regional and national monitoring of the highest-risk individuals. A toolkit will be developed to support the mitigation of risk, alongside activity to evaluate and support police forces in refining statutory and non-statutory intervention pathways.

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.

- The Home Office consulted on an updated version of the statutory guidance that underpins DHRs, which we plan to publish shortly. The new guidance will help ensure that DHRs are of higher quality, completed more swiftly, and that recommendations are implemented without delay.
- In addition, the legislation underpinning DHRs was amended by the Victims and Prisoners Act 2024 so that going forward, a DHR is commissioned when the death has, or appears to have, resulted from domestic abuse as defined by the Domestic Abuse Act 2021, with a view to identifying lessons to be learned from the death. The legislation also provides for DHRs to be renamed 'Domestic Abuse Related Death Reviews' to better reflect the range of the deaths which fall within the scope of a review process. The relevant provision will be commenced by regulations, with revised statutory guidance to reflect the changes.
- The Home Office will keep under review the operation of the legislative provisions, once commenced and the revised statutory guidance.

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.

The data collected on deaths involving a fall from height is included within a subsection of Chapter 3, Section 3.1. This analysis includes the overall number of deaths by this method, associated typologies, victim and suspect characteristics as well as the suspects' history of contact with the police. These findings have been shared with relevant stakeholders to inform future work.

Recommendation 12 [to the CPS and Police]: 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.

1. Early Identification of Cases:

As mentioned in Recommendation 7, forces now frequently have mechanisms to identify cases of suspected suicide linked to DA proactively, including daily reviews of sudden deaths and suicides and mandatory checks for DA. Forces demonstrate increasing focus on the early identification of suspected suicides linked to DA, with many embedding this within first response and investigative processes. Approaches include the embedding of prompts within sudden (now termed 'unexpected') death policies and procedures, reporting systems, and attendance checklists requiring officers to consider DA, including CCB, at the earliest stage.

Several forces have introduced structured mechanisms to support identification, including daily intelligence scanning, real-time, or 24-72-hour review of deaths, and oversight by dedicated review teams. In some areas, all suicides or unexpected deaths are automatically reviewed through a DA lens by specialist teams such as DA units or Review Units. For example, one force described a multi-layered real-time surveillance approach to all unexpected deaths. These deaths are recorded daily, reviewed across all commands and are also subject to review daily by intelligence analysts. Any concerns regarding DA will initiate investigation and escalation to CID for review. Another force detailed an Investigation Safeguarding Review (ISR) team, which undertakes daily scanning to identify suspected suicide cases that may have links to DA, and there is a DA Joint Operational Improvement Meeting with CPS where DA responses and case handling are reviewed.

Emerging practice includes the use of system-based prompts (e.g. within Storm logs or death reports), mandatory DA history checks across police systems, and engagement with family members beyond their partners (even if they are Next of Kin (NOK)) to identify previously unreported abuse. Some forces are also strengthening links with partners, such as ambulance services and coroners, to facilitate information sharing.

2. Escalation to Specialist Teams:

Force responses also described evidence of early escalation of identified cases to specialist teams or senior officers for further assessment and investigation. High-risk or complex cases are commonly allocated to PPUs, DA teams, or Major Crime Units, with oversight from DIs or SIOs.

A number of forces have established clear escalation pathways, including referral to specialist DA teams where DA is identified as a contributing factor, and allocation to SIO-led investigations where there is potential to pursue potential criminal offences such as manslaughter or CCB. One force highlighted the introduction of a force procedure to ensure that all deaths reported to the police are reviewed by the DHR team, and senior managers within the Complex Crime Unit (CCU).

Moreover, in one force, they reported a two-way referral process between DA and Major Crime teams referring cases into safeguarding units for consideration of a DHR when they are identified. This is supported by governance arrangements whereby senior officers maintain oversight and provide investigative direction. Some forces also demonstrated proactive approaches to re-opening cases where new information emerges, ensuring that prosecution avenues are fully explored.

3. Integration with Review Processes:

Integration within existing review and safeguarding processes is a consistent theme across responses. Many forces link suspected suicides following DA to DHRs, ensuring that cases are subject to multi-agency analysis and learning. Forces frequently utilise structured governance arrangements, including daily management meetings, bi-weekly or monthly review panels, and specialist oversight groups. For example, one force has introduced a procedure whereby all suspected suicides with links to DA are reviewed by a dedicated review team alongside senior managers within complex crime.

Another force noted a Safeguarding Governance Unit (SGU) that undertakes daily scanning of briefing documents to identify deaths that fit the criteria for a DHR, and two-way escalation between safeguarding and DA and Major Crime teams. Governance of the cases is managed via a monthly meeting between the DIs in the DA team and the Safeguarding Governance Unit (SGU), for oversight and advice. Moreover, in several cases, review units work jointly with safeguarding or public protection teams to identify cases and trigger further investigation, or referral for statutory review processes.

Emerging practice includes the development of case trackers, audit processes, and review frameworks to ensure consistency and oversight. Forces described the use of review not only for learning, but also to identify missed investigative opportunities, and re-open or conduct parallel criminal investigations. Some forces have introduced

parallel processes, where criminal investigations into DA or CCB run alongside coronial proceedings, with clear communication between investigators and the Coroner.

4. Early Engagement:

Early engagement with the CPS, particularly the Complex Case Unit, was reported by one force as critical in supporting effective investigation and prosecution. Many forces reported seeking early investigative advice (EIA) to guide investigations in suspected posthumous cases. In some forces, this engagement is embedded within formal processes, supported by strong working relationships, joint operational meetings, and co-located CPS prosecutors. Structured approaches such as case conversations, service level agreements and joint improvement meetings were highlighted as enabling timely and informed decision-making.

However, responses indicate variability in practice. While some forces routinely seek early advice and have multiple live cases supported by CPS, others described this engagement as ad hoc or still developing. Emerging practice includes the development of internal guidance to formalise processes around posthumous investigations including criteria for identifying cases and processes around early CPS engagement, as well as training to improve understanding of evidential requirements in posthumous prosecutions.

Overall, forces are making progress in embedding early identification, escalation, and review of suspected suicides following DA, alongside increasing engagement with CPS. While examples of good and emerging practice are evident, there remains inconsistency in approach and experience across forces, particularly in relation to formalising CPS engagement and achieving successful posthumous prosecution outcomes.

The CPS continues to strengthen its approach to cases where a victim has died by suicide following domestic abuse. The CPS has taken into account learning from recent casework and used these insights to provide awareness raising sessions to DA Leads, prosecutors across CPS Areas and via knowledge sharing activities that form part of the Domestic Abuse Joint Justice Plan (DA JJP) to increase capability and confidence among prosecutors.

A clear referral pathway has been established into Complex Casework Units (CCUs), enabling police forces to seek early specialist advice at the earliest stage to ensure cases are built robustly from the outset, with full consideration of the history of the relationship and any patterns of abusive behaviour. It is mandated that the Director for Legal Services is notified when such cases are received, including for early advice, to improve national oversight of this casework type.

Looking ahead, suicide following domestic abuse has been confirmed as a priority for the next phase of the DA JJP.

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.

There have been several events bringing SIOs and prosectors together to discuss cases of suspected victim suicide or unexpected death following domestic abuse. These include the annual SIO conference and online events arranged by the VKPP.

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.

- The 2025–26 coroner training programme, which is wholly a matter for the Chief Coroner, has included the sharing of experience and best practice in investigating deaths where domestic abuse is believed to be a factor.