Domestic Homicides and Suspected Victim Suicides 2020- 2024 Year 4 Report

Appendix A: Progress updates for Year 3 report recommendations

Our Year 3 report made a series of recommendations for the police, NPCC, College of Policing, CPS and the government (Home Office). The following text summarises the progress made against these recommendations:

Home Office response to recommendations:

Recommendation 1 [to the police and government]: *Police forces should build awareness of the links between domestic abuse and suicide, reflecting a more collaborative approach between police, relevant public health organisations and voluntary agencies with suicide prevention responsibilities. Similarly, the government should consider introducing communications campaigns that will improve public awareness around suicide following domestic abuse (SVSDA), utilising learning about the potential risk factors. Any campaigns should include appropriate referral information for specialist domestic abuse and suicide prevention services.*

The Home Office recently consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews (DHRs), which included additional information on domestic abuse related suicides. Additionally, the Home Office amended the legislation underpinning DHRs via the Victims and Prisoners Act 2024 so that a DHR is commissioned when the death has, or appears to have, resulted from domestic abuse as defined by the Domestic Abuse Act 2021 and amends their name to ‘Domestic Abuse Related Death Reviews’ to reflect the range of the deaths which fall within the scope of a review, including suicides that follow domestic abuse (these changes are expected to commence in 2025). Taken together, these changes will raise awareness of domestic abuse related suicides, and the Home Office will consider communications campaigns as appropriate.

Recommendation 3 [to the police and government]: *Police forces and partner agencies that work with suspects should effectively use risk assessment tools to identify key risk factors within the suspect’s history such as coercive controlling behaviour, mental ill health and drug and alcohol misuse. Multi-agency safeguarding arrangements with the relevant partner agencies, including police forces, and local health, mental health, substance misuse and specialist domestic abuse services should consider these specific factors and seek tailored interventions.*

The Home Office has committed to continue funding to SafeLives in the 2025/26 financial year to improve the multi-agency response to domestic abuse victims and engage stakeholders and victims to inform improvements to the multi-agency risk management of domestic abuse victims.

Additionally, the Government has committed to use every tool available to protect more women and girls from harm, and to relentlessly target perpetrators. Working closely with the National Police Chiefs' Council (NPCC), and the College of Policing, the Home Secretary will oversee the development of a new national approach to the use of data-driven tools – which use computer programmes to bring together and analyse a range of police data to identify and pursue offenders involved in domestic abuse, sexual assault, harassment, and stalking.

These tools, used alongside police officers' expert judgment, will help law enforcement prioritise and pursue the most dangerous offenders, enabling a more effective allocation of police resources. The technology will also assist in building risk profiles for both perpetrators and victims, enabling law enforcement and partner agencies to implement robust management plans that disrupt offenders' behaviour and enhance victim safety. This new approach will standardise the use of predictive technologies across police forces, ensuring those who pose the greatest threat are identified and managed through the criminal justice system or community-based, multi-agency interventions.

Recommendation 4 [to the government, NPCC and College of Policing]: *The government, NPPC and College of Policing should continue investigation into the identification and management of domestic abuse perpetrators by the police and probation (e.g., under MAPPA, IOM or DRIVE) to strengthen monitoring and disruption of these individuals.*

The Government is dedicated to halving violence against women and girls (VAWG) in a decade and to achieve this, current levels of offending and reoffending must be reduced alongside a preventative approach, to address and prevent the root causes of abuse and violence.

In the upcoming VAWG Strategy, the Government will set out the strategic direction and concrete actions to deliver on the manifesto commitment to halve VAWG in a decade, and a core element of this will be to improve the response to DA perpetrators.

The Home Office Domestic Abuse and Stalking Perpetrator Intervention Fund currently funds 27 PCCs to commission domestic abuse and stalking perpetrator behaviour change intervention programmes in their local areas – including the Drive Project in some areas.

In addition, from 3 February, offenders convicted of controlling or coercive behaviour, and sentenced to 12 months or longer, will be automatically managed under Multi-Agency Public Protection Arrangements (MAPPA). This law change means even more domestic abuse offenders will fall under MAPPA and recognises the significant harm this kind of offending can cause by putting controlling and coercive behaviour on par with other forms of domestic abuse.

Recommendation 5 [to the government]: *The government's ongoing consultation on the Domestic Homicide Review (DHR) process should provide additional guidance on the selection criteria for cases of suicide following domestic abuse to aid referral and acceptance decisions by police forces, partner agencies and local Community Safety Partnerships (CSPs).*

As set out above, the Home Office recently consulted on an updated version of the statutory guidance that underpins Domestic Homicide Reviews. We agree that additional information on domestic abuse related suicides was required, and this has been included in the draft guidance. Additionally, the Home Office amended the legislation underpinning DHRs via the Victims and Prisoners Act 2024 so that a DHR is commissioned when the death has, or appears to have, resulted from domestic abuse as defined by the Domestic Abuse Act 2021 and amends their name to '**Domestic Abuse Related Death Reviews**' to reflect the range of the deaths which fall within the scope of a review (these changes are expected to commence in 2025). Following the implementation of these changes, the language specific to homicides in relevant materials will be revised to reflect the range of the deaths that fall within the scope of a review, including domestic abuse related suicides.

Recommendation 6 [to the police and the government]: *Police forces and partner agencies should recognise that the prevalence of coercive controlling behaviour, non-fatal strangulation and separation is even higher in suspected victim suicides following domestic abuse than in intimate partner homicides. It has also been shown that these risk factors can co-exist in cases of suspected victim suicides following domestic abuse. The identification of these risk factors should be shared with appropriate specialist domestic abuse and mental health services.*

Most forces have now delivered Domestic Abuse Matters training for police, which covers coercive and controlling behaviour extensively. A 2020 evaluation of the programme showed a 41% increase in arrests for the offence associated with the training. In our manifesto, the government committed to strengthening training to ensure that police have the right skills to respond appropriately to victims of VAWG. The Home Office will continue to work closely with the College of Policing and NPCC to improve training for officers.

Multi-agency working to identify and share information on risk factors is critical to support and protect victims of domestic abuse. This is why the Home Office have committed to continue funding to SafeLives in the 2025/26 financial year to improve the multi-agency response to domestic abuse victims, nationally and at a local level. SafeLives engage stakeholders and victims to inform improvements to the multi-agency risk management of domestic abuse victims.

Additionally, the Home Office has provided funding to the Institute For Addressing Strangulation since it was established in 2022, with the aim of improving knowledge, awareness and data collection on the issue of strangulation.

Recommendation 8 [to the police, NPCC and government]: *The government and the NPCC should continue to collaborate with Public Health England (PHE) who lead the response to suicide prevention in line with the Suicide Prevention Strategy. Local force areas should consider ways to bolster working relationships with local mental health and children's social services, sharing information as appropriate to help identify individuals who may present a risk of suicide following domestic abuse and are known to these services.*

A five-year cross-sector strategy for suicide prevention in England was published in 2023, running to 2028. The strategy sets out areas for action to address common risk factors linked to suicide, including domestic abuse, by providing early intervention and tailored support. Partners including local police forces and NPCC should continue to work with place-based local government-led suicide prevention partnerships.

Police force response to recommendations:

Recommendation 1 [to the police and government]: *Police forces should build awareness of the links between domestic abuse and suicide, reflecting a more collaborative approach between police, relevant public health organisations and voluntary agencies with suicide prevention responsibilities. Similarly, the government should consider introducing communications campaigns that will improve public awareness around suicide following domestic abuse (SVSDA), utilising learning about the potential risk factors. Any campaigns should include appropriate referral information for specialist domestic abuse and suicide prevention services.*

Most forces mentioned that they are carrying out specialised training to raise awareness of the link between domestic abuse and suicide among response officers, detectives and other staff. Several forces are working on incorporating SVSDA into risk assessment processes and developing appropriate governance and multiagency coordination for response when risk is identified. Subsequently, they are implementing training in risk assessment related to domestic abuse and suicide. Forces have organised or are planning a series of events to share learning around this issue.

Most forces reported that they are carrying out DHR where there is a causal link to suicide. Several forces reported having a growing number of reviews for SVSDA, indicating improved capabilities in identifying such cases. They are working in partnerships to identify these cases and draw lessons from them. Although several

forces mentioned this kind of practice, the implementation of partnership meetings to learn from SVSDA appeared inconsistent.

Several forces said they have well established suicide prevention teams working with partners and led by Public Health. Some of them indicated that they use Real Time Suicide Surveillance systems for data sharing and trends analysis. However, some forces identified the lack of collaboration with Public Health and other agencies as a gap in their policy and practice.

Only a few forces mentioned carrying out suicide prevention work linking with domestic abuse teams. Despite this, several forces have review officers to go through all suicide cases and identify those with a domestic abuse link. Some forces gave examples of their ongoing efforts to enable a crossover between suicide prevention and domestic abuse. For instance, one force is linking with public health to develop training around domestic abuse and suicidality for frontline professionals, whilst another force has established a working group to develop a tool to improve identification of victims of domestic abuse at risk of suicide. One force is set to introduce police access to NHS systems, enabling flagging of relevant information, including suicide risk. Some forces highlighted how the learning from the Domestic homicide project has helped with this task.

In response to this recommendation, numerous forces said that they have updated their unexpected death policies. The updates to the policy relate to the inclusion of domestic abuse in the context of the investigation. This means that there are explicit procedures to prompt officers to consider domestic abuse or CCB in unexpected deaths or suicides and carry out system checks. More details about this can be found in the responses to recommendation 7.

Recommendation 2 [to the police]: *Police forces should ensure they have a governance structure to analyse local cases of domestic homicide, both collectively and by typology. Subsequently, all domestic homicides and cases of suspected victim suicide with a causal link to domestic abuse should be included in any 'problem profiles'.*

Several forces reported a detailed account of their governance structures, including numerous boards, for the oversight of domestic homicide cases. In some cases, they included SVSDA in these processes. Most forces reported conducting a rapid review following any domestic homicide, which includes consideration of domestic abuse as a causal link for the death. Reviews allow forces to identify cases for DHR and generate quick learning.

Only a few forces mentioned analysing their cases collectively and/or thematically. One force acknowledged that work needs to be done to develop governance structures to extend ongoing or regular analysis of local reviews collectively or by typology. Another force reported having a structure in place to hold oversight of referrals which are screened out and not considered for a DHR to maximise the potential for organisational learning.

A big number of forces reported having a problem profile that considers domestic homicide, however most of them explicitly stated that SVSDA does not feature in it. Only one force mentioned having developed problem profiles following DHRs, including SVSDA. Despite this, a considerable number of forces said that SVSDA will be considered for inclusion when their problem profiles are refreshed. One force mentioned that domestic homicide and SVSDA do not feature in their domestic abuse problem profile because the number of cases is too low to identify any patterns. Another force mentioned not having analytical capability to develop one.

Recommendation 3 [to the police and government]: *Police forces and partner agencies that work with suspects should effectively use risk assessment tools to identify key risk factors within the suspect's history such as coercive controlling behaviour, mental ill health and drug and alcohol misuse. Multi-agency safeguarding arrangements with the relevant partner agencies, including police forces, and local health, mental health, substance misuse and specialist domestic abuse services should consider these specific factors and seek tailored interventions.*

Most forces provided extensive detail in relation to their risk assessment processes, which varied considerably from one force to another. Each force has their own systems and teams in place to assess and manage risk in domestic abuse cases.

Despite the diversity of approaches, most forces mentioned the use of DASH or DARA for primary risk assessment in domestic abuse incidents. NICHE forces highlighted the IT obstacles they have faced in relation to the implementation of DARA and said they are working with the NICHE Minerva Group and preparing for implementation during 2025. NICHE forces are providing training to first responders and are hoping DARA will help them to better identify CCB. Indeed, one force that is already using DARA reported that the number of cases where CCB is identified has increased since the new risk assessment was implemented. Some forces also mentioned how they are implementing a THRIVE approach to risk assessment. Interestingly, a small number of forces pointed out how their risk assessment tools alone are not always enough to identify risk. They are therefore working hard to promote professional curiosity to identify and escalate cases where the established risk assessment tools may not necessarily reflect the risk.

Several forces mentioned secondary risk assessment (SRA) processes—including designated officers and domestic abuse specialist teams—to help them better identify risk factors and manage them. SRA procedures vary from force to force, with some of them sending all domestic abuse incidents through the process and others only doing so for high-risk cases. A small number of forces mentioned how DVDS is embedded in their SRA processes.

Forces are using a variety of tools and systems to assess offender risk, prioritise cases with high risk/high harm offenders and design offender management interventions. For example, several of them mentioned the use of the Domestic Homicide timeline. One force is scoring their SRA against the domestic homicide timeline; those cases scored stage 5 or higher are considered high risk and referred to partner agencies, including referrals through to MARAC. Another force is completing their SRA using a formula based on the domestic homicide timeline that they derived from training. Several forces stated the use of the RFG(v) (Recency, Frequency, Gravity and victims) matrix or the Cambridge Crime Harm Index (CCHI) to identify high risk perpetrators. Finally, one force referred to the development and use of their own domestic abuse Threat Assessment Tool which incorporates assessment of risk factors such as CCB, NFS and substance misuse, among others, combined with DASH, CCHI and RFG to assess risk using an algorithm developed locally.

Forces also mentioned carrying out innovative practices to enhance the risk assessment of perpetrators. For example, one force mentioned their work in the development of a structured decision-making tool for prioritisation. Another referred to their work on cohort design to identify high risk perpetrators, which included data taken from VKPP reports.

A small number of forces commented on their efforts to improve their response to stalking and the work they are doing to introduce the Stalking Screening Tool to help officers identify stalking cases and put appropriate safeguarding measures in place.

Forces risk assessments are shared with partner agencies. MARAC is the most widely named forum that allow forces to manage medium to high-risk cases and seek appropriate interventions and safeguarding strategies. A few forces reported having made changes to their MARAC process. For instance, one of them only takes “complex cases” into the conferences, whilst all perpetrators referred to MARAC go into a behavioural intervention. Another force pointed out how they added suicide to their MARAC form to ensure the link between domestic abuse and suicide is considered and discussed. Additional to the information shared via MARAC, forces also mentioned Op. Encompass referrals as a way of work with other agencies to ensure safeguarding.

A considerable number of forces are implementing (or in the process of piloting) multi-agency tasking and coordination (MATAC) to disrupt and reduce re-offending through a perpetrator focused approach. Offender management processes were also mentioned, including assessment, interventions, and close work with probation. Only one force mentioned having perpetrator management programmes for all levels of risk.

Forces are also allocating a significant number of resources into training of first responders, control room personnel and domestic abuse specialists. One of them highlighted the use of virtual reality training for the identification and impact of CCB, which was considered by staff as an excellent training tool.

Only two forces mentioned carrying out drug testing in custody for those arrested for domestic abuse, with one of them acknowledging that more work needs to be done on the link between substance misuse and domestic abuse.

Recommendation 6 [to the police and the government]: *Police forces and partner agencies should recognise that the prevalence of coercive controlling behaviour, non-fatal strangulation and separation is even higher in suspected victim suicides following domestic abuse than in intimate partner homicides. It has also been shown that these risk factors can co-exist in cases of suspected victim suicides following domestic abuse. The identification of these risk factors should be shared with appropriate specialist domestic abuse and mental health services.*

Forces responses to this recommendation generally referred either to risk factor identification and intervention in domestic abuse incidents, or identification of domestic abuse in cases of suspected suicide. Rarely forces referred to both, and only one of them clearly divided their answer in pre- and post-death procedures.

Training: Most of the forces mentioned training as a key element to help them improve their risk factor identification and domestic abuse response. Several forces have delivered Domestic Abuse Matters training and continued CPD in this area. Some of them received (or are planning to undergo) training on the Homicide Timeline which includes all three risk factors within this recommendation. A large number of forces have delivered training on identification of CCB, and a few mentioned specific training on NFS and stalking. Training participants varied from force to force, including new recruits, frontline staff, domestic abuse champions, and detectives. Two forces pointed out using the Domestic Homicide project reports for internal training and multiagency collaboration.

Some forces mentioned the importance of organisational learning. They referred to strategies for sharing learning from DHRs, with one force mentioning learning around suicide and adolescent relationships.

Risk assessment: To respond to recommendation 6, forces referred to their risk assessment processes outlined in the responses to recommendation number three. They mentioned how their primary and secondary risk assessments are designed to identify CCB, NFS and threats of or actual separation. As stated in responses to recommendation number three, forces referred to the use of DASH/DARA to help them identify risk factors. Several of them expect that the implementation of DARA in 2025 will help them to better identify CCB.

In addition to their responses to recommendation three, some forces for recommendation six referred to innovative work in progress in relation to risk assessment. For example, one of them is looking into developing a tool for automation of the screening of PPNs for referral to other agencies. Another force is piloting the CCB matrix developed by Jane Monckton-Smith. One force mentioned the use of a risk matrix for medium risk cases where CCB, strangulation and other risk factors have a higher weighted scoring, meaning that they get prioritised for review.

Only one force raised concerns in relation to DARA and the removal of the question on whether the victim is having suicidal thoughts, pointing out that this could limit the potential identification of suicide risk for victims of domestic abuse.

Multi-agency work: Forces acknowledged the relevance of these risk factors and mentioned how the process to identify them is embedded in established information sharing process with partner agencies. They mentioned how DASH/DARA, which include questions on these issues, are shared with multi agency forums to ensure risk management.

Many forces mentioned that risk in each case will be assessed holistically and on its merits. Forces are improving their ability to recognise risk factors such as CCB and NFS, allowing them to better identify high-risk cases and refer them to MARAC for multi-agency activity, information sharing and management. Other multi-agency forums, such as MAPPA and MATAC were also mentioned, although less frequently than MARAC.

Some forces highlighted that although they share information with partners such as specialist domestic abuse and mental health services, this is to a degree dependent upon risk level. In high-risk cases the information will be shared with MARAC partners, mental health or GP services. However, forces pointed out limitations within this process. For example, mental health services capacity or capability to attend MARAC

meetings or even to address the identified risks was highlighted as a challenge. In relation to information sharing with GPs, two forces highlighted the importance of improving and increasing information sharing flow both ways. A force also pointed out difficulties in the use of PPNs for adults, saying that adult services sometimes do not accept or further refer adults if they are using other services, which deems the PPNs futile.

A few forces stressed the importance of improving the quality of their risk assessment forms, to ensure that they are detailed enough for better referral processes to the right agencies. Moreover, the improvement of these processes would allow consistent information sharing, which in turn will allow partners to make more informed decisions around safeguarding.

Recommendation 7 [to the police]: *Police forces should ensure their response to unexpected deaths, including suspected suicides, embeds the College of Policing's updated guidance on categories for unexpected death investigations. Additionally, relevant force policies and guidance should reference the importance of identifying a history of domestic abuse, including speaking to family members or friends of the victim who may have information about a pattern of abuse not known to the police or other agencies.*

Almost all forces referred to having new or refreshed unexpected death policies in response to this recommendation, so they incorporate CoP guidelines. It is worth noting that the language used to name this kind of death varies considerably from force to force. For example, many forces used the concept of 'sudden death', while others expanded on it adding concepts like unexplained, suspicious, or questionable death. There was a small number of forces that mentioned how their policy/guidance was being reviewed at the time of submitting their response to the Project. Only one force acknowledged that their policy needs updating but they were not working on it. One force mentioned that the domestic homicide project is referenced in their policy.

The main changes forces have made to their death investigation policies relate to the inclusion of guidance on checking for domestic abuse history when attending unexpected deaths, including suspected suicides. This is to ensure the new policies incorporate CoP's guidance and prompt officers in cases of suspected suicide to consider whether domestic abuse is contributing factor in the death. Some forces provided more detail in relation to the steps officers should follow in these cases, including speaking with the victim's family and friends. The timeframe for the domestic abuse history check-up seems to vary from force to force, ranging from six months to five years before the death. Additionally, in most cases the policy ensures increased scrutiny with DS/DI attendance or engagement for all unexpected death cases, and in some cases, forces mentioned PIP 3 SIO oversight when a history of domestic abuse

is identified. Forces mentioned CPD and training for investigators on the topic of links between domestic abuse and suicide and applying professional curiosity when attending a scene. One force specifically mentioned policy around deaths due to a fall from height where domestic abuse is identified.

Some forces provided specific details in relation to their policies that were not seen in any other forces responses. For instance, one force referenced the National Homicide Working Group's document "Attendance at Sudden Death Review" in relation to the possibility that domestic abuse perpetrators may seek to inappropriately influence the criminal justice and/or inquest processes after a death, especially where they are 'next of kin'. Another force included specific wording for officers to consider the possibility of staged scenes, and in deaths involving a fall from height where domestic abuse is identified, to call a SIO. Finally, a force referred to a section of its policy that states that if domestic abuse has occurred within the previous 5 years *(including crime and non-crime)* a Domestic Homicide Initial Report must be completed. A couple of forces mentioned having added a tick-box to their unexpected death forms to identify if the deceased was a victim of domestic abuse or CCB. The aim is to prompt officers to consider domestic abuse and undertake the relevant checks, encouraging professional curiosity and an investigative mindset.

Only one force acknowledged the discrepancies between their policy and the CoP guidance. They mentioned that their procedure does not stipulate the PIP level of the DI who must be informed of the death, and it does not require officers to talk to family members or friends to enquire about domestic abuse history. Some forces mentioned further updates to their policies to reflect changes following the Stephen Port case inspection recommendations.

A few forces mentioned having started the N300 recording process, which includes the four classifications of death as per the NPCC and College of Police guidance.
According to forces, these updates have helped them to set clear expectations for frontline officers and investigators regarding the response and investigation of these deaths.

In terms of further work needed to improve forces response to unexpected deaths, one of them highlighted how it is unclear if the updated policy is being consistently applied. Additionally, another force pointed out the relevance of information sharing between police and the coroner's office to facilitate the investigation.

Recommendation 8 [to the police, NPCC and government]: *The government and the NPCC should continue to collaborate with Public Health England (PHE) who lead the response to suicide prevention in line with the Suicide Prevention Strategy. Local force areas should consider ways to bolster working relationships with local mental health and children's social services, sharing information as appropriate to help*

identify individuals who may present a risk of suicide following domestic abuse and are known to these services.

Most forces mentioned having strong links within local mental health services and children's social services, as well as having processes in place for information sharing and referrals. A few forces' responses focused only on monitoring deaths and quick learning to prevent future deaths, with no mention of preventative strategies.

Several forces referenced the work done by their MASH arrangements or domestic abuse partnership boards, hubs or similar panels. These were reported to foster relationship with other agencies and provide a mechanism for sharing information with local mental health and children's social services where there are established links. Most of them mentioned MARAC as a key forum to share information with partner agencies, with the caveat that only high-risk cases go into MARAC. In cases where children are involved in domestic abuse incidents, a number of forces mentioned referrals via Operation Encompass to ensure information sharing with schools and adequate support for the children.

Mental health work: Numerous forces highlighted their broader work on mental health, having mental health leads or coordinators that work closely with mental health services. Two forces made reference to their work under the Right Care Right Person framework and how it enabled information sharing between police and mental health services. A few forces stated that they have a mental health specialist in their control room to support frontline responders in mental health-related incidents.

There was also mention of information sharing agreements with mental health services to enhance multi-agency responses. One force mentioned multi-agency work that give will give staff access to both health and police systems and records to further collaboration with partners in relation to domestic abuse victims. Another stated that they have a Data Protection Impact Assessment in place to enable this flow of information sharing to continue.

Suicide prevention: Most forces mentioned their work in relation to suicide prevention, which include having a Suicide Prevention Officer (SPO), suicide prevention group/taskforce and/or a suicide prevention strategy. The main aim is to coordinate and deliver an appropriate policing response to mental health issues and suicide. Forces have in place several processes to develop effective multi-agency partnerships to approach these issues.

Although most forces work with mental health teams and Public Health to prevent suicide, only a few mentioned ongoing work linking mental health responses to domestic abuse. As an example, one force stated that they are working on the delivery

of a pilot aimed at better identifying domestic abuse victims at risk of suicide. They have a working group currently looking at data and training packages to support front line officers and others to better identify and respond to these cases. Additionally, another force pointed out that in the past year they provided all of their mental health practitioners who work on the Mental Health Joint Response Vehicles with domestic abuse training. Another force mentioned that domestic abuse is a theme addressed by their partnership response group for suicide prevention.

Some forces mentioned the use of real-time surveillance systems. Through this system, they share information with relevant partners which allows for identification of themes and emerging trends in cases of suicide.

Suicide contagion: Two forces mentioned work in relation to child suicide. They are carrying out work with schools to prevent contagion and support suicide prevention.

Another force reported piloting a multi-agency rapid review suicide group to help them identify whether any family or friends of someone that died by suicide require support. This is in recognition that grieving family members are more likely to end their lives having lost a loved one to suicide.

Work in progress: Some forces reported work in progress in relation to mental health, suicide and domestic abuse. One force has set up a task and finish group to ensure consistency across their region in the approach to support those who may be at increased risk of suicide. Another force is developing local Family Hubs. The Hubs are being designed to deliver an entire system approach to proactively intervene on vulnerability and risk identified within families. Trusted organisations including local domestic abuse services are part of the family Hub model. Lastly, one force is currently progressing a recommendation that came from a DARDR to create a protocol for recording suicide risk.

Recommendation 9 [to the CPS, NPCC and police]: *In partnership with the CPS, the NPCC and local police forces should continue supporting efforts to pursue posthumous prosecution for unlawful act manslaughter and domestic abuse-related offences (e.g., coercive controlling behaviour) following the suspected suicide of a victim of domestic abuse. Forces who have attempted, or successfully achieved, a posthumous prosecution should utilise opportunities to share promising/innovative/best practice through local and national forums.*

Forces referred to the processes for investigating unexpected deaths described in the responses to recommendation seven. They mentioned that in cases of suicide when there is a history of domestic abuse, the cases are reviewed and referred for DHR. If

it is believed domestic abuse is a contributing factor in the death, then forces consider posthumous prosecution.

Most forces said they normally conduct investigations in these cases, most with PIP 2 or 3 overseeing. At the moment of their response to these recommendations, a few of them had live investigations and were waiting for CPS advice or decision. Two forces reported having managed charges against suspects in cases of suicide following domestic abuse. Despite this, the majority of the forces said they have not been successful in bringing charges against the suspects.

Forces are developing training and taking part in working groups to share learning around this topic; suicide following domestic abuse is on their agendas and they are keen to learn from those forces that have achieved charges.

NPCC, College of Policing and CPS response to recommendations:

Recommendation 4 [to the government, NPCC and College of Policing]: *The government, NPPC and College of Policing should continue investigation into the identification and management of domestic abuse perpetrators by the police and probation (e.g., under MAPPA, IOM or DRIVE) to strengthen monitoring and disruption of these individuals.*

The NPCC DA portfolio has led a review of the DVDS processes and guidance has been reissued to forces in 2024/25, as well as work on CARA and OOCD.

The College of Policing has undertaken work to develop, launch and support the DAPO pilots – which give some statutory powers for managing suspects outside of MAPPA processes.

The VAWG Taskforce has also delivered practice sharing examples with forces which includes Project Vigilant (TVP), Railway Guardian (BTP), PPDA smarter practice guidance (Hampshire and Isle of Wight).

The VKPP have completed insight work into VAWG perpetrators – they visited 7 forces in Autumn 2024, to understand what forces were doing to manage their key perpetrators once identified i.e. how they brief staff, made use of protective orders and other high level policing tactics to tackle these perpetrators. The report from this work will be used as we write the guiding principles for forces.

The VAWG Taskforce commenced the guiding principles workstream in 2024/25 to produce guidance to forces on how to identify their cohort of VAWG perpetrators. This is underway and will link to wider work on the use of AI in policing. The College of

Policing is working with NPCC colleagues on this. From the 1st April 2025, the National Centre for VAWG and Public Protection (NCVPP) will provide governance going forward. The Strategic Delivery Plan currently contains a workstream regarding VAWG perpetrators, which includes domestic abuse.

Recommendation 8 [to the police, NPCC and government]: *The government and the NPCC should continue to collaborate with Public Health England (PHE) who lead the response to suicide prevention in line with the Suicide Prevention Strategy. Local force areas should consider ways to bolster working relationships with local mental health and children's social services, sharing information as appropriate to help identify individuals who may present a risk of suicide following domestic abuse and are known to these services.*

It is estimated that around 700,000 people die by suicide each year globally. This is a significant public health issue, and efforts to prevent suicide involve addressing mental health, reducing access to means of suicide, and providing support to those in crisis. The Office for National Statistics reports that:

- There were 6,069 suicides registered in England and Wales (11.4 deaths per 100,000 people) in 2023; this is an increase compared with 2022 (10.7 deaths per 100,000, or 5,642 deaths) and the highest rate seen since 1999.
- In 2023, suicide rates in Wales (14.0 deaths per 100,000) were higher than in England (11.2 deaths per 100,000), although rates increased from 2022 in both England (10.5 deaths per 100,000) and Wales (12.5 deaths per 100,000).
- London had the lowest rate of any region in England (7.3 deaths per 100,000); the highest rate was in the North-West (14.7 deaths per 100,000).
- In 2023, suicide rates for males (17.4 deaths per 100,000) and females (5.7 per 100,000) increased to their highest levels since 1999 and 1994, respectively.

Partner collaboration and data sharing are crucial in suicide prevention and reducing overall levels of suicide. By working together and sharing data, partners can create a more effective and coordinated response to suicide prevention, ultimately saving lives. The information and intelligence collated by the NPCC national real time suicide surveillance system (n-RTSSS) is now being shared widely with partners in suicide prevention providing a more comprehensive approach to addressing the factors that contribute to suicide. It is important that we do all we can to reduce this number as far as possible. RTSSS data on deaths occurring in the year is intended to be available earlier so that suicide prevention leads across multiple agencies can respond quickly to emerging patterns. RTSSS data is also used routinely to monitor suspected suicides

monthly and feeds into many working groups locally and national such as the Concerning Methods Working Group.

Recommendation 9 [to the CPS, NPCC and police]: *In partnership with the CPS, the NPCC and local police forces should continue supporting efforts to pursue posthumous prosecution for unlawful act manslaughter and domestic abuse-related offences (e.g., coercive controlling behaviour) following the suspected suicide of a victim of domestic abuse. Forces who have attempted, or successfully achieved, a posthumous prosecution should utilise opportunities to share promising/ innovative/ best practice through local and national forums.*

The NPCC continues to partner with the CPS on posthumous prosecution efforts and share learning from these cases within forums such as the national Homicide Working Group. Alongside the College of Policing, we continue to develop work surrounding policy and practice relating to unexpected deaths, including suspected suicides and deaths involving a fall from height.

The CPS continues to support prosecutors in the pursuit of appropriate prosecution pathways in cases of SVSDA. We have increased efforts to raise awareness of unlawful act manslaughter through our national Domestic Abuse Area Leads network, seeking to cultivate a better understanding of the legal nuances prevalent in cases, and to create increased opportunities for peer advice, expertise and best practice in this field to be shared.

Under the CPS' next Domestic Abuse Programme, domestic homicide, including SVSDA, has been identified as a priority and work will be undertaken to update the prosecution guidance and learning in this area.