Vulnerability Knowledge
& Practice Programme

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

March 2025

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Introduction

This executive summary presents the main findings and recommendations from the Domestic Homicide Project Year 4 report. The full report is available **here**.

The National Domestic Homicide Project funded by the Home Office and led by the National Police Chiefs' Council (NPCC), is delivered by the Vulnerability Knowledge and Practice Programme (VKPP) within the College of Policing. It tracks the scale and nature of domestic abuse-related deaths in quick-time, sharing learning from all police-recorded domestic homicides, child deaths, unexpected deaths and suspected suicides following domestic abuse. The project gathers detailed case information, including suspect and victim demographics, prior police and partner agency contact, and risk factors.

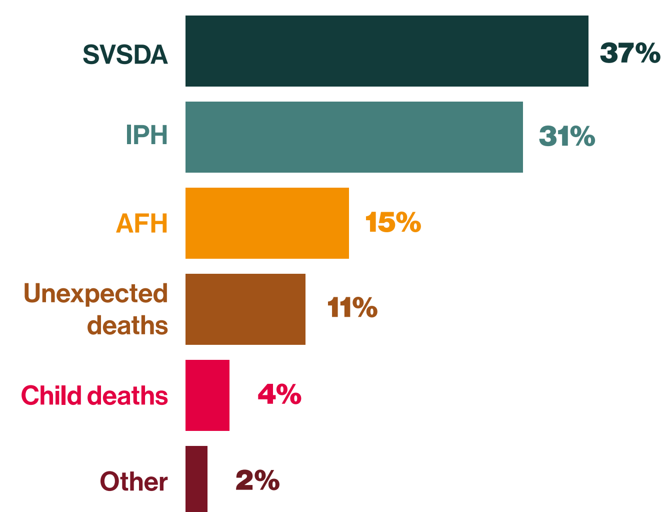
The deaths are classified into six types for analysis: adult family homicide (AFH), child death, intimate partner homicide (IPH), suspected victim suicide following domestic abuse (SVSDA), unexpected deaths, and other (whereby the victim and suspect live together but are not intimate partners or family members). Crucially, this dataset also includes cases that meet the project's definition but were not referred or accepted for a Domestic Homicide Review (DHR).

Main Findings - Year 4

1012 deaths
from April 2020 until March 2024

Across four years of data collection (from 1st April 2020 to 31st March 2024), this project has counted 1012 domestic abuse-related deaths. These include 501 domestic homicides (169 AFH and 332 IPH), 354 SVSDA, 71 unexpected deaths, 61 child deaths and 25 deaths classified as 'other'.

Overall, the most common method of death was by sharp instrument, accounting for 45% of domestic homicides. Within SVSDA cases, hanging was the most common method of death (62%).



In Year 4 (1st April 2023 to 31st March 2024), a total of 262 deaths were recorded. These deaths comprised **98 (37%) SVSDA, 80 (31%) IPH, 39 (15%) AFH, 28 (11%) unexpected deaths, 11 (4%) child deaths** and **six (2%) deaths classified as 'other'**. Therefore, as in Year 3, SVSDA was the most recorded typology in Year 4, surpassing the number of IPH deaths.

Key points

- SVSDA is the most recorded typology across the full four-year dataset. The overall increase in reported SVSDA since the start of the project likely reflects improved case identification and submission to this project, rather than an empirical rise in cases.
- IPH deaths have remained relatively stable across four years of data collection (n=87; n=84; n=81; n=80 respectively), representing around a third of the DA-related deaths per year. This highlights the entrenched issues surrounding IPH indicating the need for further work aiming to prevent future deaths.
- Across the first three years of the project, the recording of SVSDA deaths increased. In Year 4, there was a slight decrease in recorded SVSDA as compared to Year 3, alongside an increase in recording of unexpected deaths. There are several possible explanations for these changes. One possibility might be that forces are working to follow guidance by recording and submitting cases as unexpected deaths where ongoing (coronial and/or police) investigations have not officially ruled deaths as suicides. Additionally, SVSDA cases may be more likely to be submitted to the project in slower time due to the process of identification, as indicated by the increase in SVSDA cases reported within Year 3 since the previous publication.

The importance of understanding the identification and response to SVSDA and unexpected deaths have informed the project's recommendations listed at the end of this report.

Victims and suspects

Victim and suspect demographics remained similar to previous years. Across the four-year dataset, most victims (73%) were female, and most were between 25 to 54 years old (60%). Notably, within AFH the majority of the victims were older, with the most prevalent age group being victims aged 65 years or older.

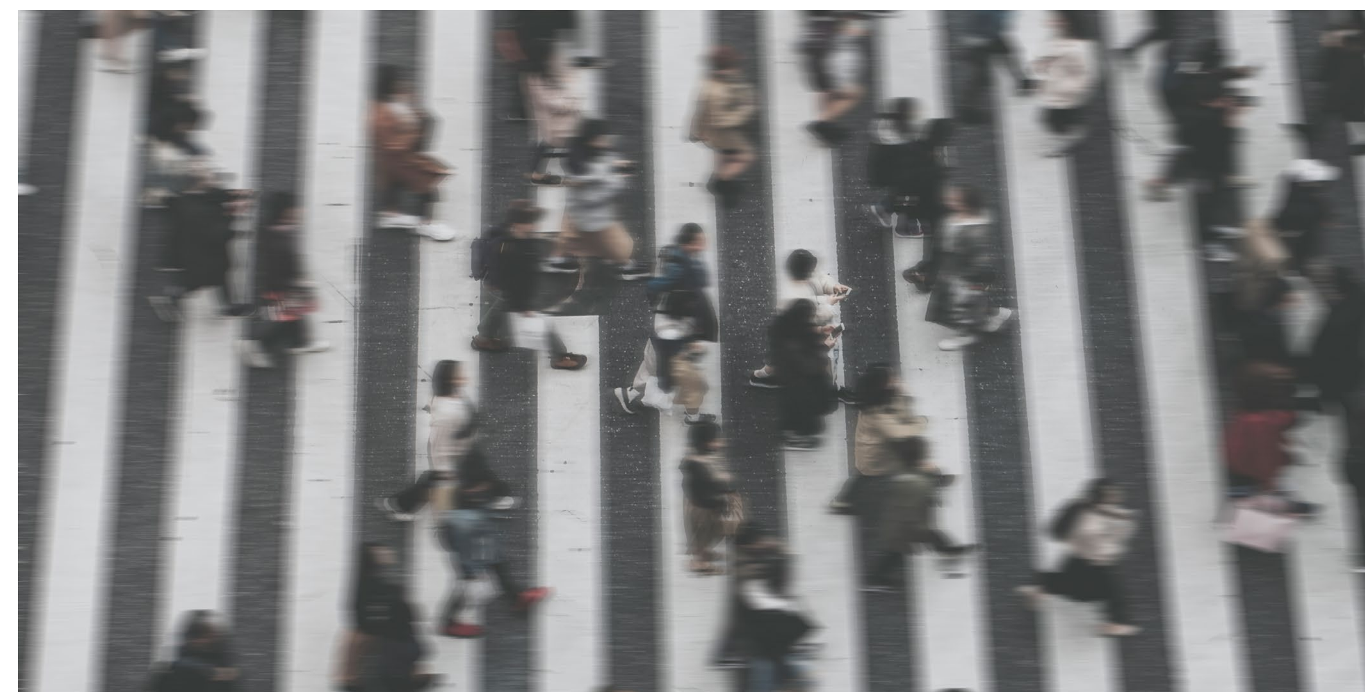
most victims
73%
were female

On the other hand, suspects (or prior domestic abuse perpetrators in cases of SVSDA) were predominantly male (80%), with the majority aged 25 to 54 years old (69%). When analysing the victim and suspect as a pair within each case, the vast majority of IPH and SVSDA cases (82% and 73% respectively) involved a female victim and male suspect (or prior DA perpetrator).

The police-recorded ethnicity of victims and suspects was predominantly White, albeit overall those from Black, Black British, Black Welsh, Caribbean or African ethnic groups remain slightly over-represented compared with their presence in the general population. Further analysis showed that 18% of victims of domestic homicide (IPH and AFH) were women from minority ethnic groups.

Notably, across the four years of data collection, 22% of victims and 43% of suspects were recorded as having mental health needs.

The overall proportion of victims identified as LGBTQ+ remained consistent with previous years. These victims were primarily recorded within cases of SVSDA—representing 68% of all LGBTQ+ victims—with this proportion marking a seven percentage-point increase from last year's report. In Year 4, for the first time the project recorded victims (n=3) and a suspect (n=1) that had undergone gender reassignment. All four were recorded within cases SVSDA. These findings suggest the importance of considering opportunities to support suicide prevention activities within the LGBTQ+ community.



Risks and response: risk factors, previous police contact and review referrals

Across the four-year dataset, the most commonly recorded risk factors in relation to the suspect were:

Mental ill health

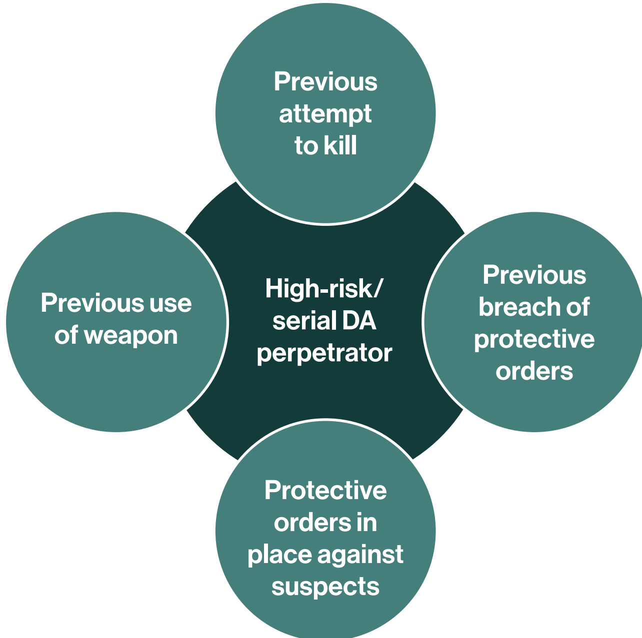
Alcohol use

A history of coercive and controlling behaviour (CCB)

Drug misuse

Some of these risk factors may co-occur, with the clearest example being that 18% of the suspects presented both alcohol and drug misuse. Although these common risk factors appear relatively consistent, there are variations between typologies. For instance, CCB was prominent in cases of IPH, SVSDA and unexpected deaths, whilst suspect mental ill health was particularly notable in cases of AFH.

Another commonly recorded risk factor, particularly within IPH and SVSDA cases was separation (threat or actual ending of the relationship), which was announced by the government as a new statutory aggravating factor for sentencing in murder cases.



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, previous use of weapon, protective orders in place against the suspect and previous breach of protective order.

Overall, 67% of suspects were known to police as a suspect or perpetrator of domestic abuse. The inclusion of SVSDA, which most often involves police knowledge of DA perpetration prior to the victim's death increases the proportion of suspects known within the overall dataset. Therefore, excluding cases of SVSDA, 54% of suspects were known to the police for DA perpetration prior to the victim's death across the four-year dataset.

68%

of cases, the victim and/ or suspect was known to a partner agency

In 68% of cases, the victim and/or suspect was known to a partner agency, which was most common in cases of SVSDA, indicating their overall visibility to agencies. In cases where the suspect was not previously known to the police for any reason, the suspect and/ or victim were known to a partner agency in a third of the cases. These findings continue to highlight the importance of multi-agency work to prevent domestic homicides and suicides following domestic abuse (Home Office, 2022).

Excluding child death and unexpected death cases, in 91% of cases across the four-year dataset (n=113) it was known whether or not a case had been referred to the Community Safety Partnership for a DHR or other type of review. Of those cases that were referred, 62% were accepted for a review. In Year 4, the acceptance rate when cases were referred was 50%. Moreover, when cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 85% overall, and to 87% for Year 4.

Deaths involving falls from height

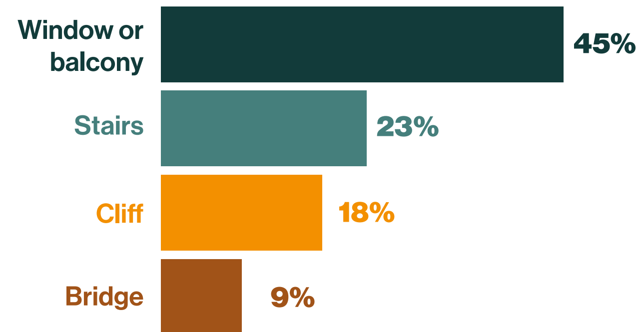
Earlier this year the Killed Women Network led the Fallen Women - Hidden Homicides campaign, utilising FOI requests to police forces in England and Wales for data collection. They received just three data returns and asked the Domestic Homicide Project to review its database for relevant information. The project team identified cases of victims' deaths due to a fall from height and shared the data with the Killed Women Network. Twenty-two cases (excluding child deaths) from 13 forces were coded under this category between 1st April 2020 and 31st March 2024, comprising a total of 22 victims and 23 suspects.

Victim and suspect characteristics

The vast majority of victims in these cases were women

Of these 22 deaths, the majority were recorded as SVSDA (36%), followed by unexpected deaths (27%), then IPH (23%), and finally, AFH (14%). The vast majority of victims in these cases were women (91%), with a homogeneous distribution of age groups. All three AFH deaths involved a victim aged 65 years or older.

Notably, three victims (14%) were pregnant at the time of their death. This is a high proportion considering that for the entire four-year sample only five victims (0.5%) were pregnant. Of these three cases, two were recorded as SVSDA, with the victims being 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.



All 23 suspects were male, with a homogenous distribution of ages. Regarding the relationship between victim and suspect, in all cases except for the three AFH deaths, the suspect was the current (61%) or ex- intimate partner (26%) of the victim.

Case characteristics

In almost half of the cases the victim was reported to have fallen from the balcony or window of a building, whilst nearly a quarter of victims reportedly fell down the stairs. In 15 (68%) cases the suspect was present at the time of the fall; most of the time they were the person who called the emergency services. All 15 of these suspects claimed that the victim had fallen or jumped. In 9 out of 10 falls from a building, the suspect was present at the scene.

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.

Risks and response: risk factors, previous police contact and review referrals

82% of suspects were known to the police as DA perpetrators, decreasing to 79% when SVSDA cases were excluded. A third of the suspects and victims were known as high-risk; with five high-risk victims linked to high-risk suspects. Most of the deaths involving victims who were identified as high-risk were recorded as SVSDA.

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

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. 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.

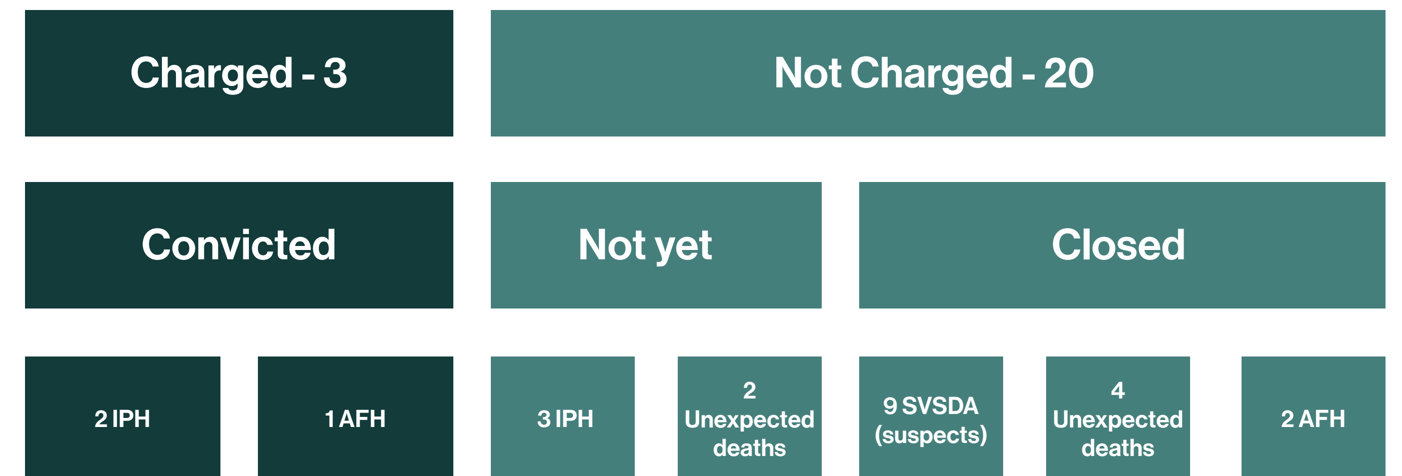
Of the 22 cases in this sample, 69% were referred for a review, and 73% of those referred were accepted. All eight SVSDA cases were referred for a DHR and six of them had been accepted at the time of the analysis.

In the cases of falls from height, the most recorded risk factors for the suspects were alcohol and drug use, with over a third of suspects presenting both. Notably, five suspects were intoxicated due to alcohol use at the time of the death and four of these cases involved victims who fell from a window/balcony.

Investigation and outcomes

In 70% of cases the suspect had been arrested. The cases where no arrest was made were five suicides and two unexpected deaths. Of the 23 suspects, three had been charged, and all three were subsequently convicted.

The cases with no charges can be grouped into two categories; the first group represents cases where there were no charges yet, and the investigation was ongoing. The second group corresponds to cases closed with no charges brought, which represent 65% this sample. In all eight cases of SVSDA and four of the six unexpected deaths, the investigation had been closed. Additional information about deaths involving a fall from height is provided in Chapter 7 of the full report.



Suspected victim suicide following domestic abuse

Coercive and controlling behaviour

206 victims of **SVSDA** with a history of **CCB**

Across four years of data collection, 206 victims of SVSDA from an intimate partner were also identified as having a history of CCB within these relationships. 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.

Victim and suspect characteristics

The general characteristics of the victims and prior DA perpetrators in this sub-set were similar to that of the wider SVSDA dataset. Notably, five (2%) of the victims were pregnant or had given birth within the last six month prior to their death.

Just over half of the victims and 40% prior DA perpetrators were recorded as having a care need, which most commonly included a mental health care need. Additionally, almost 9 in 10 victims and/or prior DA perpetrators were known to partner agencies. Together this indicates the visibility of the victims with potential opportunities to provide additional support, not only within the criminal justice system, but also within the social care, (mental) health services and specialist DA services with whom they were in contact.

Risks and response: risk factors, previous police contact and review referrals

Illustrating the nature of risk in these cases, nearly half of these victims were known as high-risk and 55% 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% of cases. Additional commonly co-occurring risk factors were similar to the wider dataset, such as the prior DA perpetrator's mental ill health (45%), alcohol use (42%) and drug misuse (40%).

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

At the time of analysis, 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. Amongst the most common posthumous charges achieved were Common Assault, Controlling or Coercive Behaviour in an Intimate or Family Relationship, S 47 Assault occasioning Actual Bodily Harm (ABH), and Harassment. Only one case in this dataset was known to have achieved a posthumous charge for Unlawful Act Manslaughter (UAM) in a case of SVSDA. A case study outlining the evidence gathering and investigation process, as well as the outcome at trial in this case can be found in Chapter 8.2 of the full report.

Third consultation with bereaved family members: Perspectives from lived experience

As in previous years, we are deeply grateful to families bereaved by fatal domestic abuse and their supporters in AAFDA for taking part in our consultation in March 2024 and sharing their valuable insights. This past year, the project team updated the participants on changes to policy, guidance and practice since the previous consultation event in February 2023. One of these changes 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. During the latest consultation, family members shared their perspectives and experience, not only relating to the police response but also wider partner agencies. They expressed their thoughts on areas of improvement within the police response and what still worries them. The themes and concerns raised during this consultation provide important areas for future work by the government, police and their partners.

Progress against our Year 3 recommendations

In the Year 3 report, we made recommendations to policing on several issues, such as how to strengthen their responses to suspected victim suicide following domestic abuse, building awareness of the link between DA and suicide, collaborating with partner agencies for suicide prevention, and the use of risk assessment tools to identify key risk factors within the suspect's history.

Overall, the recommendations made in the Year 3 report have led to significant changes by police forces across England and Wales. Some of the main updates reported by forces to our project are:

- Training to raise awareness of the link between DA and suicide. Review teams are proactively working to better identify cases of suicide with links to DA.
- Growing number of DHRs for cases of SVSDA, reflecting improved ability to identify these cases.
- Well established suicide prevention teams.
- Most forces have updated their unexpected death policies, including DA in the context of the investigation. This means that there are explicit procedures to prompt officers to consider DA or CCB in unexpected deaths or suicides and carry out system checks.
- Several forces mentioned further updates to their policies to reflect changes following the Stephen Port case inspection recommendations.
- Forces are working on improving awareness about the higher prevalence of CCB, non-fatal strangulation and separation in SVSDA, as well as their co-occurrence. Most of the forces mentioned training as a key element to help them improve their risk factor identification and DA response.
- Risk assessment processes are designed to identify CCB, NFS and threats of or actual separation. Several forces expect that the implementation of DARA in 2025 will help them to better identify CCB.
- Forces acknowledge how their risk assessment tools alone are not always enough to identify risk, thus they are working hard to promote professional curiosity to identify and escalate cases where the established risk assessment tools may not necessarily reflect the risk.
- 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.
- Forces identify MARAC as a key forum for information sharing with partner agencies, with the caveat that only high-risk cases go into MARAC.
- Forces are developing training and taking part in working groups to share learning around posthumous prosecution; suicide following DA is on their agendas and they are keen to learn from those forces that have achieved charges.

Although there have been significant improvements in the forces' response to DA, there is still work to be done, particularly in relation to the response to unexpected deaths and suspected suicides following DA. Some of the main issues identified are as follows:

- Forces have problem profiles for Domestic Homicides, however most of them do not have one for SVSDA.
- Forces acknowledge 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.
- Some forces highlighted that although they share information with partners such as specialist DA and mental health services, this is to a degree dependent upon risk level.
- Forces pointed out limitations in the process of information sharing with MH services and GPs, such as their capacity to attend MARAC meetings and challenges on information sharing flow both ways.
- 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 are carrying out suicide prevention work linking with DA teams.
- 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.

Police forces are attempting to identify the best model to measure and predict risk and identify the most dangerous perpetrators. However, the evidence base is currently limited.

- Despite the high prevalence of use of drugs as risk factor for DH and SVSDA, only two forces mentioned carrying out drug testing in custody for those arrested for DA.
- Although work is being done to improve forces response to unexpected deaths, it is unclear if the updated policy is being consistently applied.
- The majority of the forces said they have not been successful in bringing posthumous charges against domestic abuse suspects.

References

Bates, L., Hoeger, K., Gutierrez-Munoz, C., Sadullah, A., & Whitaker, A. (2024). Domestic Homicide Project Spotlight Briefing: Young Victims (No. 6). VKPP.
DHP-Young-People-Spotlight-Briefing-Final-29.10.24-2.pdf

Femicide Census. (2020). UK Femicides 2009-2018.
010998-2020-Femicide-Report_V2.pdf

Home Office. (2022). Tackling Domestic Abuse Plan. Home Office.
https://www.gov.uk/government/publications/tackling-domestic-abuse-plan

Year 4 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.

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.

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.

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.

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.

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.

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.

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.

Vulnerability Knowledge & Practice Programme

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