Vulnerability Knowledge and Practice Programme (VKPP)

Domestic Homicides and Suspected Victim Suicides 2020-2023

Year 3 Report

Dr Katharine Hoeger [1], Dr Carolina Gutierrez-Munoz[2], Adam Sadullah[3], Tegan Edwards[4], Dr Liam Blackwell[5], Dr Lis Bates[6] and Angela Whitaker[7]

"You are the voice of the dead person, and you have a huge responsibility to ensure their story is recorded correctly. How can we learn from the past if it is not represented accurately?" - Frank Mullane 2018

March 2024

[1] Senior Research Fellow, Vulnerability Knowledge and Practice Programme (VKPP)

[2] Research Fellow, Vulnerability Knowledge and Practice Programme (VKPP)

[3] Research Assistant, Vulnerability Knowledge and Practice Programme (VKPP)

[4] Analyst, Vulnerability Knowledge and Practice Programme (VKPP)

[5] Research Fellow, Vulnerability Knowledge and Practice Programme (VKPP)

[6] Senior Research Fellow, Vulnerability Knowledge and Practice Programme (VKPP) and Reader in Interpersonal Violence Prevention at the Connect Centre, University of Central Lancashire (UCLan)

[7] Project Lead, Vulnerability Knowledge and Practice Programme (VKPP) on secondment from West Midlands Police as National Domestic Abuse Coordinator and Staff Officer for AC Louisa Rolfe

A LIFE REARRANGED - By Jackie Nudd
Written February 2022 for my Daughter Louise. Died 06/11/2018 aged Just 33.

That call that night.
That feeling of dread.
That fear in my heart.
I just knew you were dead….
The click of that phone,
Here, home all alone.
The distress that I feel
This cannot be real….
Life stopped in its tracks that moment in time…
Frozen forever the 6th of November…
Nobody there, Nobody cared.
The Police didn't come.
I'd called them that morning SCREAMING a warning
My daughter's at risk from a man who I feared…
What do you do when the life that you knew is shattered in pieces,
Your life now a thesis, a mission for truth….
Life's path changed forever,
A void deep and dark,
You know somethings wrong and you have to be strong…
No-one listens.. or hears the shouts of your fears…
The facts of the case dismissed and ignored,
Doors SLAMMED in your face…
Evidence 'lost' or 'misplaced'...
No time to grieve…A battle begins..
A mission for justice in pursuit of the facts,
A struggle begins in a system that lacks.
The depth of a pain….NO pill can relieve…
A life I have lost…and cannot retrieve…
Domestic Abuse, the cruellest of crimes, one that's ignored too many times.
Challenge accepted, its time for a change, Your death now a trigger…
My life rearranged….
A fight for an inquest to list ALL the facts…
Where death by abuse ...becomes a new 'Act'

Foreword – Police Chiefs and the College of Policing

The police service remains committed to protecting victims of domestic abuse, bringing perpetrators to justice and preventing crime. The Strategic Threat and Risk Assessment of Violence Against Women and Girls (VAWG) identifies domestic abuse as a national threat alongside terrorism and serious and organised crime. Ongoing work on the Joint Justice Plan (JJP) for domestic abuse also involves a commitment by the police and Crown Prosecution Service (CPS) to hold perpetrators to account.

The NPCC and College of Policing, working with the national policing Vulnerability Knowledge and Practice Programme (VKPP), devised the Domestic Homicide Project at the start of the Covid-19 pandemic and this is the third annual report. This research provides policing with unique insights from the analysis of domestic homicides, unexpected deaths and suspected victim suicides following domestic abuse, including twenty-three key findings and nine recommendations to improve the response to domestic abuse and aim to help prevent future deaths.

Throughout this project we have been greatly supported by the domestic abuse and homicide stakeholders, alongside academics who are experts in this field. The report also provides the opportunity to remember the victims and their families who have lost their loved ones in horrific circumstances. We would like to thank the families whose contributions to this research have informed the police response to suicide following domestic abuse and will have impacts for years to come.

AC Louisa Rolfe OBE
Assistant Commissioner
National Policing Lead for Domestic Abuse

CC Kate Meynell
Chief Constable
National Policing Lead for Homicide

ACC Charlie Doyle
Assistant Chief Constable
National Policing Lead for Suicide Prevention

CC Andy Marsh QPM
Chief Constable
Chief Executive Officer
College of Policing

Foreword – Minister for Victims and Safeguarding

Domestic homicides can mark the grim culmination of domestic abuse in circumstances in which the killer is also the victim's loved one or a family member. The Crime Survey for the year ending March 2023 estimated that 2.1 million adults aged 16 and over in England and Wales were known to have experienced domestic abuse in the previous year, and we know that one in five homicides is a domestic homicide. As Minister for Victims and Safeguarding, I am committed to doing everything I can to ensure victims have the protection they need, and that perpetrators of these crimes are brought to justice.

The landmark Domestic Abuse Act became law in April 2021 and is strengthening protections for victims and ensuring perpetrators feel the full force of the law. It was followed by our Tackling Domestic Abuse Plan 2022, which includes reforms specific to domestic homicide, including improving how we learn from each tragedy through Domestic Homicide Reviews and how we manage the most harmful perpetrators of this abuse.

We are making progress on the commitments set out in this document. For example, we have added violence against women and girls to the Strategic Policing Requirement so that it is treated as seriously as terrorism and organised crime for the purposes of resource allocation and the priority given to the offence. We are also amending the legislation underpinning Domestic Homicide Reviews to ensure all deaths linked to domestic abuse – including suicides - are considered for statutory reviews so that lessons can be learnt, and future deaths prevented.

We have also looked at some of the common factors behind domestic homicide. One example being a history of coercive control, which we are legislating to include within the list of offences that requires management under multi-agency public protection arrangements.

This report shows a 7% fall in domestic homicides compared the previous year's data. We are not complacent, nor do we consider it shows a clear trend. More data will be required for that. It demonstrates that more still needs to be done to increase our understanding of domestic abuse and domestic homicide.

I am very grateful to the National Police Chiefs' Council, the Vulnerability Knowledge and Practice Programme and the College of Policing, and all those who have contributed to this project. We must work together to go even further in tackling domestic abuse.

Laura Farris MP

Minister for Victims and Safeguarding

Contents

Summary of Findings and Recommendations

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

In 2020 the Domestic Homicide Project was established by police and government[8] in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides, unexpected deaths[9] and suspected suicides of individuals with a history of domestic abuse victimisation. In the wake of the Covid-19 pandemic, the Project aimed to establish the impact of the pandemic and associated restrictions on domestic homicides and learn lessons from every tragic death to seek to prevent future deaths. Based on its unique contribution, the Project has been embedded and expanded to fill a gap in information not available elsewhere or within the same timescales.[10]

Across the three-year dataset (1st April 2020 – 31st March 2023), there were a total of 723 deaths recorded. This included 248 intimate partner homicides (IPH), 216 suspected victim suicides following domestic abuse (SVSDA), 121 adult family homicides (AFH), 74 unexpected deaths, 46 child deaths and 18 deaths classified as 'other' (see Table 2).

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

Considered by year of data collection, a total of 222 deaths were recorded in Year 1 (1st April 2020 – 31st March 2021). This included 88 IPHs, 51 SVSDA, 37 AFHs, 20 child deaths, 18 unexpected deaths and eight deaths classified as 'other'.

In Year 2 (1st April 2021 – 31st March 2022), a total of 259 deaths were recorded. This included 80 IPHs, 72 SVSDA, 53 AFHs, 33 unexpected deaths, 15 child deaths, and six deaths classified as 'other'.

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

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

[10] Please note that the Domestic Homicide Project is separate to the existing statutory process for Domestic Homicide Reviews, which 'review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself' (Home Office, 2016). As this process conducts an in-depth review to draw out learning from all agencies, not just policing, it may take years after the death for the Domestic Homicide Review (DHR) to be published. At the time of writing, reform of the DHR process by the Home Office, including the title, definition, criteria and guidance, is ongoing.

In Year 3 (1st April 2022 – 31st March 2023), a total 242 deaths were recorded. This included 93 SVSDA, 80 IPHs, 31 AFHs, 23 unexpected deaths, 11 child deaths and four deaths classified as 'other'.

Chapter 2: Domestic Homicides and Suspected Victim Suicides 2020-2023

Click here to proceed to this chapter

Findings

Finding 1: There was a 7% (n = -17) decrease in the recorded number of deaths in Year 3 compared with Year 2. SVSDA have demonstrated the greatest increase in recorded cases across years of data collection, accounting for 28% (n = 72/250) of Year 2 cases and 38% (n = 93/233) of Year 3 cases. The increase in submissions is likely to reflect better awareness and identification of these cases by the police rather than an increase in the number of deaths. This increase in identification of cases also follows from the impact of work by this Project, recent coronial judgments and relevant research on suicide following domestic abuse.

In Year 3, as compared to Year 2, there was an increase of two percentage points in the proportion of IPH cases (from 31%, n= 80/259 to 33%, n = 80/242), and a decrease of seven percentage points (from 20%, n= 53/259 to 13%, n = 31/242) in the proportion of AFHs. The small proportion of child deaths reported in Year 3 (5%, n = 11/242) may be due to a limited number of force areas reporting all child deaths in line with the project definition. The reported data is likely to reflect child deaths with a perceived link to domestic abuse or associated with a familicide.

Finding 2: Last year's report noted an increase in deaths in April, August and December 2021 compared to Year 1 data. Across all typologies, Year 3 saw an increase in the number of deaths reported in the months of August and November (primarily attributed to a rise in reported SVSDA), with decreases in October and December.

Importantly, monthly fluctuation is expected when analysing smaller samples. Additionally, the increased awareness and reporting of SVSDA in Year 3 will impact year-to-year comparisons. Further data collection may help discern a seasonal pattern, but the prevalence of SVSDA in this dataset highlights the potential links between domestic abuse and suicide, requiring continued analysis.

Recommendation

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, utilising

learning about the potential risk factors (see Chapters 4 and 7). Any campaigns should include appropriate referral information for specialist domestic abuse and suicide prevention services.

Chapter 3: Typologies and characteristics of victims and suspects

Click here to proceed to this chapter

Findings

Finding 3: Strangulation (including hanging) was the most common method of death across the three-year dataset. However, this includes SVSDA deaths by hanging, which remains the most recorded method of deaths for SVSDA across the three-year dataset (from 47%, n = 24/51 in Year 1 to 65%, n = 47/72 in Year 2 to 63%, n = 59/93 in Year 3). When considering domestic homicides only, the most common method of death remains the use of a 'sharp instrument' (such as a knife), accounting for 54% (n = 62/114) of AFHs and 43% (n = 106/248) of IPHs across the three-year dataset.

Finding 4: Across the three-year dataset there remains a high proportion of older victims (aged 65 years old and over) in AFH cases (43%, n = 16/37 in Year 1; 38%, n = 20/53 in Year 2; 45%, n = 14/31 in Year 3). The perpetrator in AFH cases was primarily the adult child or grandchild of the victim (63%, n = 79/125).

Finding 5: Across the three-year dataset, and in line with wider literature on domestic homicide and suicide following domestic abuse, the majority of victims were female (71%, n = 514/723). In Year 3, there were fewer male victims (27%, n = 65/242) compared to Year 2 (32%, n = 83/259). However, the number of male victims of SVSDA has increased between Year 1 (12%, n = 6/51), Year 2 (19%, n = 14/72) and Year 3 (26%, n = 24/93). Additional analysis of SVSDA cases by sex of the victim is included in Chapter 7.

We also conducted analysis on victim-suspect dyads by sex and typology. Most cases involved a female victim and male suspect(s) (67%, n = 483/723). Again, there are differences when comparing by typology. For example, whist 45% (n = 55/121) of AFH cases involved a female victim and male suspect(s), the vast majority of IPH cases involved a female victim and male suspect(s) (84%, n = 208/248).

Finding 6: In Year 3, the number of victims identified as LGBTQ+ (5% n = 11/242) remained the same as reported in Year 2 (4%, n = 11/259). Notably, 17 out of the 28 LGBTQ+ victims across the three-year dataset were recorded within SVSDA. This demonstrates an area for further research and work to improve the identification and response to domestic abuse involving LGBTQ+ victim and suspects.

Finding 7: Overall, the three-year dataset includes a slightly lower proportion of victims and suspects with White ethnicities and a higher proportion of victims and suspects of minority ethnic heritages compared to the general population, as measured by the 2021 Census (23% of victims and 19% of suspects were of minority ethnic heritages, compared to 18%

in the Census). This was particularly true for victims and suspects of Black ethnicities (8% of victims and 7% of suspects, compared to 4% in the Census).

The Project's previous Spotlight Briefing on Ethnicity (Perry et al., 2022) found that victims of Black ethnicities were less likely to have reported domestic abuse to the police, but equally likely to seek help from independent advocates. These findings highlight the importance of officers developing cultural competence and working in partnership with local domestic abuse services to help improve reporting and provide opportunities for support.

Finding 8: Consistent with last year's findings, victims of Polish nationality were the second most common after victims of British nationality across the three-year dataset, at 4% (n = 24/723). The Femicide Census analysis of ten years' femicide data similarly highlights Eastern European, post-communist nationalities – and especially Polish – as being relatively highly represented in terms of victim nationality (Femicide Census, 2020). Moreover, according to the 2021 Census, Polish has been the most common non-British nationality in the UK since 2007 (ONS, 2021a).

Finding 9: Overall, the findings in this chapter show the importance of analysing information about victims and suspects/perpetrators, including protected characteristics. This analysis could help to identify communities who may be over-represented or under-served, facilitating partnership working, engagement and targeted prevention programmes.

Recommendation

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'.

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

Click here to proceed to this chapter

Findings

Finding 10: Across the three-year dataset, the most commonly identified antecedent risk factors for all suspects in domestic homicides and the perpetrators of prior domestic abuse in SVSDA were:

- Coercive controlling behaviour (CCB);
- Mental ill health;
- Alcohol and drug misuse, and;

- (threat/fear of, or actual) Relationship ending/separation

These risk factors varied by typology, with mental ill health and CCB being particularly prominent in IPHs. A history of CCB was also a prominent risk factor for domestic abuse perpetrators in SVSDA, appearing to be more common than IPHs (in Year 3: 47%, n = 48/102 vs. 36%, n = 29/81 respectively). Mental ill health and alcohol and/or drug misuse were most prominent in suspects of AFHs.

Notably, the presence of CCB behaviour was significantly associated with the suspect being identified by the police as a high risk and/or serial perpetrator of domestic abuse ($p < .05$, n = 506, Phi (effect size): 0.414). This finding suggests that police officers are appropriately using the presence of CCB when assessing risk.

Finding 11: When comparing Year 2 and Year 3, there was an increase of eight percentage points in the proportion of cases where the suspect had previously been a victim of domestic abuse (17%, n = 44/265 in Year 2; 25%, n = 63/249 in Year 3), and where the suspect previously had suicidal thoughts or attempted suicide (16%, n = 42/265 in Year 2; 23%, n = 59/249 in Year 3).

Furthermore, there were increases in reported risk factors by typology between Year 2 and Year 3. For instance, within IPHs, recorded cases where the suspect had previously been a domestic abuse victim increased by 14 percentage points (15%, n = 13/82 in Year 2; 30%, n = 24/81 in Year 3).

Additionally, in cases of SVSDA, there was an increase of 11 percentage points in the proportion of cases where the suspect had previously non-fatally strangled the victim (9%, n = 7/76 in Year 2; 20%, n = 20/102 in Year 3). This increase in recording may have been influenced by the criminalisation of non-fatal strangulation by the Domestic Abuse Act 2021 and associated improved awareness.

As in previous reports (Bates et al. 2021; 2022), changes in recorded risk factors from year to year may also reflect improved data quality and or coding and follow up processes rather than an empirical rise in the presence of these risk factors.

Finding 12: Reinforcing findings from last year, this report demonstrates that risk factors present in intimate partner abuse and family member abuse can differ. To intervene effectively and introduce appropriate prevention activities, police need to understand the ‘problem profiles’ of different domestic abuse-related deaths in their force (see also Recommendation 2).

Recommendation

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 (see also Chapter 5).

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

Click here to proceed to this chapter

Findings

Finding 13: Overall, 61% (n = 457/754) of all suspects in the three-year dataset were known to the police for domestic abuse prior to the victim's death. Demonstrating potential opportunities for intervention by the police, in Year 3, the proportion of suspects/ perpetrators previously known to the police for domestic abuse was highest in cases of SVSDA[11] (83%, n = 85/102; 92%, n = 70/76 in Year 2). Contrary to last year, a larger proportion of suspects in AFHs were known to the police for domestic abuse compared to IPHs (60%, n = 18/30; 48%, n = 39/81, respectively). However, this finding may have been impacted by the decrease in reported AFHs in Year 3 as compared to Year 2.

Finding 14: The proportion of suspects known as high-risk and/or serial domestic abuse perpetrators rose from Year 2 to Year 3 within IPHs (from 34%, n = 16/47, to 49%, n = 19/39) and AFHs (from 18%, n = 4/22, to 39%, n =7/18). Consistent with previous findings, the data also suggests that IPH suspects and prior domestic abuse perpetrators in SVSDA are more likely to be referred to MARAC compared to AFH suspects.

Finding 15: Across the three-year dataset and consistent with last year's findings, only 10% (n = 75/754) of suspects (or prior domestic abuse perpetrators in SVSDA) were recorded as (currently or previously) having been managed by police or probation (e.g., under MAPPA, IOM or DRIVE). Calculated as a proportion of those suspects/perpetrators who were previously known to the police as domestic abuse perpetrators, this rose to 16%. Our previous reports highlighted that further investigation was needed to test whether this figure is accurately capturing all offenders who are being managed, or there was under-reporting to this Project. Following previous recommendations and ongoing work by the Project on the management of perpetrators, the Year 3 data mirrors previous findings; in fact, there were no suspects that were currently being managed by police or probation in Year 3. This shows that additional investigation is necessary as to whether management of domestic abuse perpetrators demonstrates any preventative effects, and if the 'correct' individuals are being identified for management.

Finding 16: Across the three-year dataset, the victim and/or suspect was known to a partner agency in 60% of cases (n = 422/701). Notably, of the 145 cases in which the individuals were not previously known to the police for any reason, 39% (n = 57) were

[11] In suspected victim suicide cases, 'suspect' refers to the perpetrator of the prior domestic abuse. Where we discuss suspected victim suicide cases only, we use the term 'prior domestic abuse perpetrators'.

known to one or more non-police agency. In Year 3, victims and suspects were most commonly known to mental health services (25%, n = 59/233) and child social services (18%, n = 41/233). These findings show that effective multi-agency partnerships are vital to identify those most at risk and put in place appropriate interventions.

Recommendation

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.

Chapter 6: Domestic Homicide Reviews

Click here to proceed to this chapter

Findings

Finding 17: In Year 3, the overall number of domestic homicides and SVSDA referred and accepted for Domestic Homicide Reviews (DHRs), or other types of review, decreased from 76% (n = 148/195) in Year 2 to 60% (n = 305/511) in Year 3. When cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 84% (n = 305/511) overall. The relatively high proportion of SVSDA cases that were not accepted for a review in Year 3 (41%, n = 19/46) is notable given the increased sample size.

Recommendation

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).

Chapter 7: Suicide following domestic abuse

Click here to proceed to this chapter

Findings

Please note that all findings within Chapter 7 focus on SVSDA reported in Year 3.

Finding 18: In Year 3, 28% (n = 28/102) of domestic abuse perpetrators associated with SVSDA were also previously known to the police as a victim of domestic abuse. Whilst this included an equal split (n = 14) of both male and female domestic abuse perpetrators, the dynamics of the abuse appeared to differ. Specifically, male perpetrators of domestic abuse who were previously known to the police as victims of domestic abuse were more

often identified as the primary perpetrator of the abuse. In contrast, female perpetrators of domestic abuse who were previously known to the police as victims of domestic abuse were more often identified as the primary victim. As noted, additional analysis of the prior perpetration of domestic abuse by both parties (the deceased and the associated prior domestic abuse perpetrator) would be necessary to draw further conclusions.

Finding 19: Year 3 did not see another increase in younger victims of SVSDA, with just 10% (n = 9/93) of victims aged 16 to 24. Additionally, decreasing slightly from Year 2 (13%, n = 9/72), 6% (n = 6/93) of victims of SVSDA were recorded as being LGBTQ+ in Year 3, with associated prior perpetrators of domestic abuse including both current and ex-intimate partners (n = 4 cases) as well as family members (n = 2 cases).

Finding 20: A history of CCB was the most common risk factor in SVSDA (47%, n = 48/102) in Year 3, again being more common in these cases than any other typology. In addition to their separately identified prevalence within SVSDA (see Chapter 4), the co-occurrence of the risk factors of relationship ending/separation and CCB (56%, n = 27/48), as well as non-fatal strangulation and CCB (27%, n = 13/48), were relatively common.

Finding 21: In Year 3, contact with (non-police) partner agencies in cases of SVSDA most often involved mental health services (28%, n = 26/93) and children's social services (18%, n = 17/93). Thematic analysis of cases of SVSDA with a history of CCB highlighted the impact of abuse on the victim's mental health, and the perpetrator's use of children and the Family Court system to further abuse the victim.

Finding 22: At least one case of SVSDA in Year 3 achieved a posthumous charge for domestic abuse-related offences, and a further six were identified as having attempted or initiated a posthumous investigation for CCB, rape, non-fatal strangulation and unlawful act manslaughter. This indicates some progress in the police response to SVSDA, with attempts to hold the prior domestic abuse perpetrator to account even after the death of the victim.

Finding 23: Family members bereaved by SVSDA who were consulted by the Project raised important points, not only about the response to these deaths, but how the police and their partners can work to prevent future deaths. The key practice points and themes raised during this consultation provide important areas for future work by the government, police and their partners (see Section 7.2).

Recommendations

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.

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.

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.

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.

MAIN REPORT

Chapter 1 – Introduction

1.1 Definitions and terminology

For the purposes of data collection, in order to capture as accurate as possible a picture of the scale of domestic abuse related deaths in quick-time, the Project adopted a wide definition of relevant deaths. In addition to domestic homicide by a (current or ex) partner or family member, the Project also counted child deaths in a domestic setting, as well as unexpected deaths or suspicious deaths and suspected suicides of individuals with a known history of domestic abuse victimisation. This is a wide definition which does not require a causal link to be made between the death and the previous domestic abuse, nor does it specify a time period within which the abuse must have occurred. As such, there is a degree of flexibility as to how police interpret which cases to submit to the Project, with an emphasis on including cases if in doubt.

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

- Adult Family Homicide (AFH) – homicide of an individual aged 18 or over by an adult family member who is not an intimate partner.
- Child Death – homicide of a child aged under 18 by a family member.
- Intimate Partner Homicide (IPH) – homicide of an adult aged 18 or over by a current or former intimate partner.
- Other – where the relationship is not intimate partner or familial but the victim and suspect live together, e.g., lodger or flatmate.
- Suspected Victim Suicide Following Domestic Abuse (SVSDA) – suspected suicide of a person aged 16 or over following known domestic abuse against them.
- Unexpected death – sudden, unexplained or unexpected deaths under investigation but not yet deemed a homicide, suspected suicide or non-suspicious death (see Section 1.2 for updated coding and analysis).

Counting of domestic homicides in this report will therefore differ from Home Office Homicide Index (HOHI) numbers on domestic homicides, based on differences in definition, inclusion criteria and data collection:

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

domestic homicide, our definition includes individuals that are living together but are not related or in an intimate relationship.

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

3. Because we gather information on deaths in quick-time (pre-charge and pre-inquest), we include deaths that are, at the time of initial report to us unexpected - but may not yet been formally deemed a homicide or suicide. If, following further investigation, the police deem these cases to be non-suspicious deaths by natural causes they are excluded from our dataset before analysis.

Where we present analysis of the whole dataset in this report and use the umbrella term 'suspect', in cases of SVSDA this refers to the perpetrator of the prior domestic abuse. Where we only discuss SVSDA, we use the term 'prior domestic abuse perpetrators'.

1.2 Our Year 1 and 2 reports

In 2021 and 2022, the Project published its first two annual reports examining every death identified by police as meeting the Project definition between 1st April 2020 and 31st March 2022. The Year 2 report made recommendations: to policing, government, the College of Policing, and to this Project. Appendix A contains a list of these recommendations with an update of progress against each one.

The primary change from reporting and analysis from previous annual reports is the separation of unexpected (previously termed 'unexplained' or sudden) deaths as its own category. In the annual reports published in 2021 and 2022, the Project team coded these deaths within the typologies of AFH, IPH, or child death according to the relationship between the victim and suspect. This year, to ensure clarity between findings associated with each broader category (of homicide or suspected suicide), unexpected deaths still under investigation by the police are considered separately. The updated approach to coding and analysis of unexpected deaths has been taken across all three years of data from the Project, and so observations in this report about changes in numbers of deaths between Years 1, 2 and 3 are comparing like with like.

Unexpected deaths will be investigated by the police, may undergo post-mortem examination, and often receive a coronial inquest. Through these processes the death will be formally determined to be a homicide, suicide, or death by accident or natural causes. At the point of six-month case follow up with forces by the Project team, if the death has been re-classified by police as non-suspicious (e.g., due to accident or natural causes) it will be excluded from analysis for this Project. Similarly, if coronial processes have deemed the death to be a suicide, it will be re-coded by the Project team as a suspected victim suicide following domestic abuse. Further details about findings relevant to unexpected deaths are provided in Chapter 2 to Chapter 7.

1.3 About the data

This report provides analysis of three years of data from 1st April 2020 to 31st March 2023, focusing on previously unreported data from 1st April 2022 to 31st March 2023 (Year 3). Updated information and relevant comparison are also provided from the first two years of data collection.

As in previous reports, the Project team coded the data quality and completeness of each submission, both using a three-point grading system. In Year 3, 91% of submissions were assessed to be fully or mostly complete. In terms of data quality, it was assessed as good or excellent in 83% of cases (see Table 1). Importantly, where any data quality or completeness issues are identified these are rectified by the Project team following initial and 6-month follow up processes.

Table 1 *Data quality and completeness of submissions (April 2022 – March 2023)*

	Quality					
Completeness	**Excellent**	**Good**	**Fair**	**Not Recorded**	**Total**	***%***
Complete	62	101	11	-	**174**	***72%***
Largely incomplete	-	1	13	-	**14**	***6%***
Mostly complete	7	28	12	-	**47**	***19%***
Not Recorded	-	-	-	7	**7**	***3%***
Total	**69**	**130**	**36**	**7**	**242**	***100%***
% Total	**29%**	**54%**	**15%**	**3%**		

Source: Domestic Homicide Project

In Year 3, three forces provided a nil return to indicate they had not identified any relevant deaths occurring in their force area for the reporting period. The Project team completed data reconciliation exercises to confirm that this information was correct. Thus, the Project received submissions from 40 of 43 (93%) police forces in England and Wales in Year 3. Across the first three years of data collection, only one of 43 territorial forces had not submitted any cases to the project. Over the three-year reporting period, 20% (n = 142) of submissions came from one force area, with 67% of submissions coming from 25 force areas. The remaining forces (n = 16) submitted an average of six cases during the timeline of the Project.

Additionally, across the three-year dataset, 36 initial submissions were later excluded from the analysis. In almost all cases, the exclusion arose from further information coming to light which meant the incident was deemed not to be a crime (in formal terms, 'cancelled') or found on further investigation not to be domestic-related. These exclusions also include sudden or unexplained deaths that are determined upon follow-up to no longer fit within the Project definition.

Finally, the Project team also completed data reconciliation exercises with the cases collected by Counting Dead Women and the ManKind Initiative. Data reconciliation with the Counting Dead Women website identified a further 10 submissions. Reconciliation using the ManKind website identified one case not already submitted to our Project. We

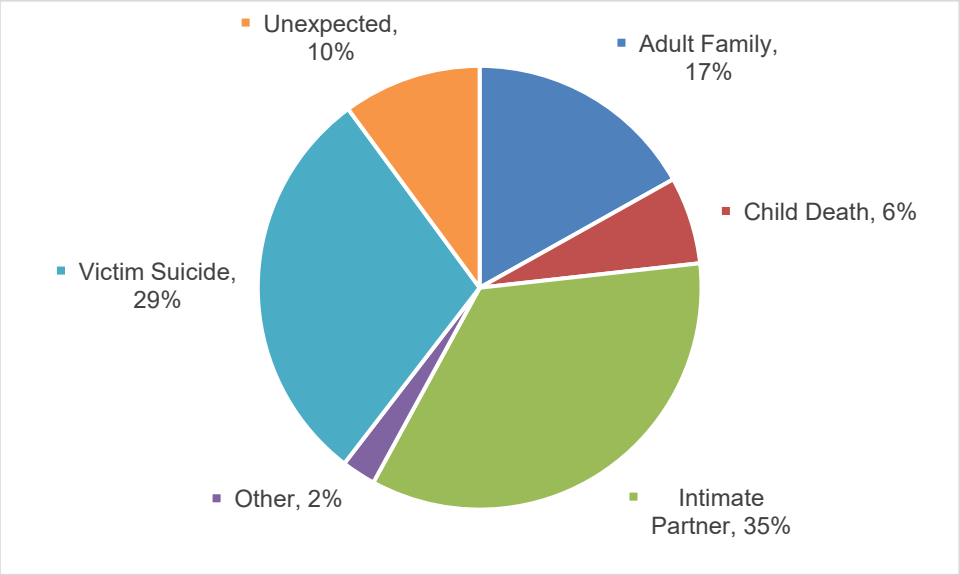
are grateful to these organisations for their work to identify and collate this information, as well as their generosity and co-operation in helping triangulate the cases.

Chapter 2 - Domestic Homicides, Unexpected Deaths and Suspected Victim Suicides Following Domestic Abuse April 2020 - March 2023

2.1 Overall deaths April 2020 - March 2023

Across the three-year dataset, this Project has counted 723 total deaths in 701 incidents. These 723 deaths are spread across the following typologies: 248 IPHs, 216 SVSDA, 121 AFHs, 74 unexpected deaths, 46 child deaths, and 18 deaths classified as 'other' (see Figure 1 below).

Figure 1 *Proportion of deaths by typology (April 2020 – March 2023)*



Source: Domestic Homicide Project

2.2 Comparison of Years 1, 2 and 3

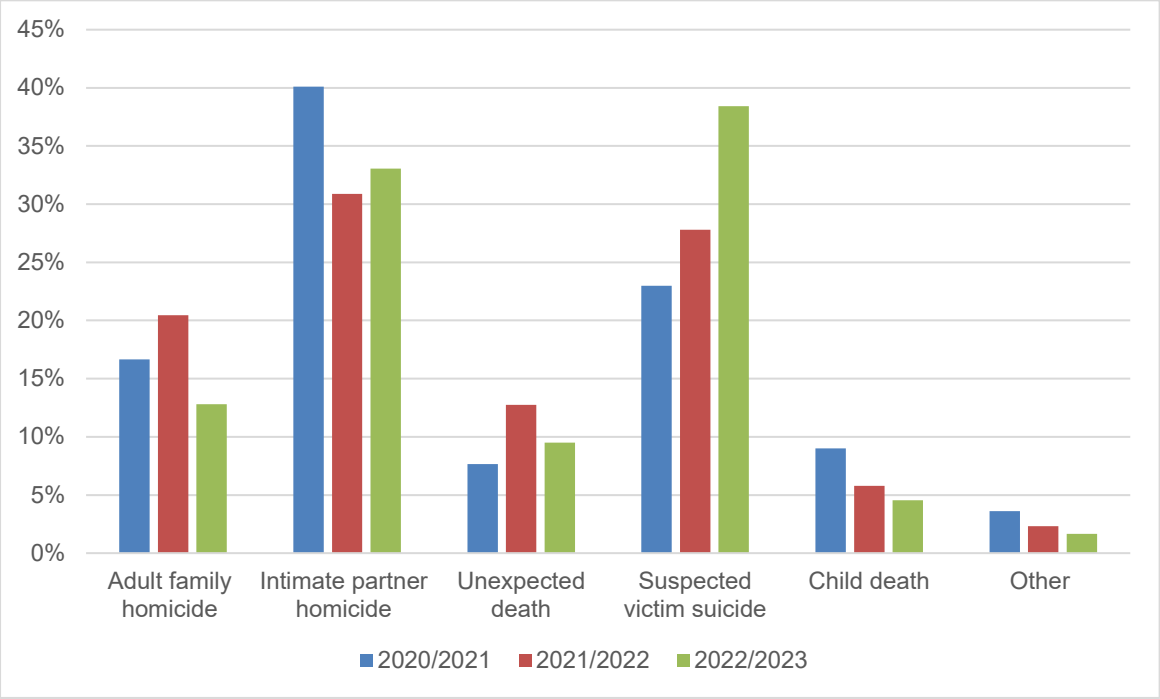
In Year 3, the Project counted a total of 242 deaths out of 233 incidents across all case types (see Table 2). Updated figures for the Year 1 dataset now show 222 deaths, whilst updated Year 2 figures show 259 deaths.[12] This means that Year 2 now represents an increase of 37 deaths (+16% change) compared to the Year 1 dataset. In contrast, the Year 3 data shows a decrease of 17 deaths (- 7% change) compared to the Year 2 dataset, and an increase of 20 deaths (+9% change) compared to the Year 1 dataset. However, as mentioned in previous reports, these figures are liable to change as more deaths are reported to the Project, or additional information results in an exclusion from the dataset. Additionally, data from the second and third year of the Project may be more accurate than the first year based upon embedding of the process by police forces and implemented data quality and integrity work by the Project research team. Moreover,

[12] Revised figures for Year 1 and 2 of data collection are utilised throughout this report.

domestic homicide data varies from year to year, and the Project data would reflect this fluctuation (Bates et al. 2022; ONS 2023).

Regarding the typology of the 242 deaths in Year 3, this was most commonly suspected suicide of a victim following known domestic abuse (hereafter, SVSDA, 38%, n = 93), followed by the homicide of a(n) (current or ex) intimate partner (hereafter IPH, 33%, n = 80). The third most common typology was the homicide of an adult family member by an adult (hereafter, AFH, 13%, n = 31), followed by the unexpected death of a(n) (current or ex) intimate partner, adult family member or child (hereafter, unexpected death, 10%, n = 23), the death of a child (5%, n = 11), and, finally, 'other' deaths involving individuals who live in the same household but are not intimate partners or family members (2%, n = 4).

Figure 2 *Proportion of deaths by typology – Years 1, 2 and 3*



Source: Domestic Homicide Project

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

	Total Deaths							
	2020/2021		2021/2022		2022/2023		Overall	
	N	%	N	% (% point difference)	N	% (% point difference)	N	%
Adult family homicide	37	17%	53	20% (+3)	31	13% (-7%)	121	17%
Intimate partner homicide	88	40%	80	31% (-9%)	80	33% (+2%)	248	34%
Unexpected death	18	8%	33	13% (+5%)	23	10% (-3%)	74	10%
Suspected victim suicide	51	23%	72	28% (+5%)	93	38% (+10%)	216	30%
Child death	20	9%	15	6% (-3%)	11	5% (-1%)	46	6%
Other	8	4%	6	2% (-2%)	4	2% (n/a)	18	2%
Total per year	222	100%	259	100%	242	100%	723	100%

* The % difference refers to the change in percentage points from the immediately preceding year (e.g., Year 2 compared to Year 1 and Year 3 compared to Year 2 etc.)

Source: Domestic Homicide Project *(click here to return to the Executive Summary)*

The continued rise in SVSDA in Year 3 likely reflects better identification and submission of these cases to this Project, rather than an empirical increase in cases. Potentially enabling the identification of cases by the police, there has been increased public awareness of the link between suicide and domestic abuse in the last few years, including within the Coroner's Prevention of Future Death (PFD) Report following the death of Jessica Laverack (Harris, 2022).This greater awareness has led to a significant milestone, whereby the inquest into the death of Kellie Sutton was the first to conclude that a suicide by a victim of domestic abuse was in fact an unlawful killing (Cooper, 2023). Further supporting the recognition of these links, in 2017 the first conviction for unlawful act manslaughter was achieved in the case of *R v Allen* following the suicide of Justene Reece after domestic abuse from her ex-partner (McGorrey & McMahon, 2019) (For an additional analysis of cases of SVSDA see Chapter 7).

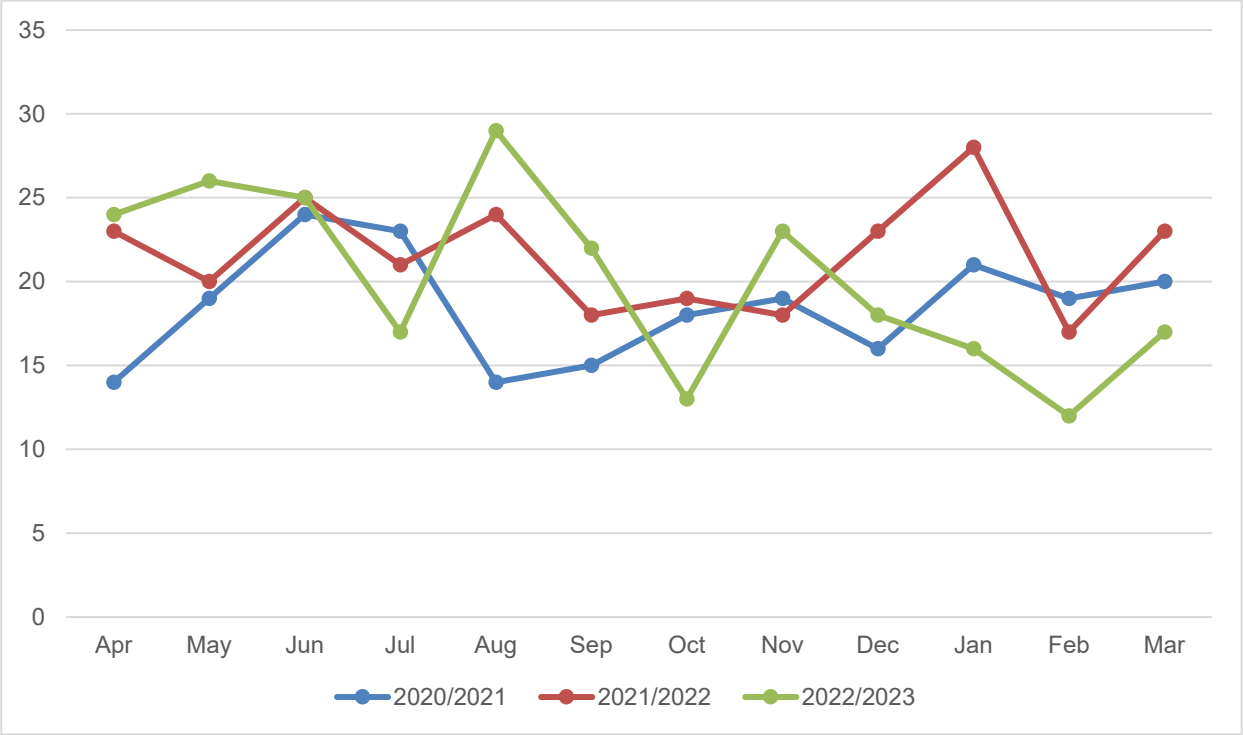
Regarding the small number of reported child deaths (n = 11) in Year 3, the Project team's discussions with forces suggest that not all areas continue to report all child deaths according to the project definition. Instead, this data is more likely to reflect child deaths with a perceived link to domestic abuse or associated with a familicide (killing of an (ex or current) intimate partner and one or more children). For this reason, disaggregated data in the remaining chapters focuses on analysis of AFH, IPH, unexpected deaths and SVSDA.

Importantly, because domestic homicide figures do fluctuate from year to year, this report's comparison of three years' worth of data may reflect this general fluctuation. At least five years of data collection is needed to assess patterns or trends in significance.

2.3 Monthly variance

Year 3 data shows that the monthly figures across all typologies remained relatively steady and followed the trend of previous years. However, compared to Year 2, an increase in deaths was observed in the months of August and November, and there were decreases seen in the months of October, and from December to March (See Figure 3):

Figure 3 *Number of all deaths by month – Year 1, 2 and 3*



Source: Domestic Homicide Project

The observed increases were mainly accounted for by a rise in SVSDA. In the month of May, the number of SVSDA was considerably higher compared to the previous years (n = 4 in Years 1 and 2 and n = 15 in Year 3). The same was observed for the variation in August (n = 4 in Year 1, n = 6 in Year 2 and n = 15 in Year 3), although in August AFH deaths also showed an increase compared to the previous years (n = 1 in Year 2, n = 3 in Year 2 and n = 7 in Year 3).

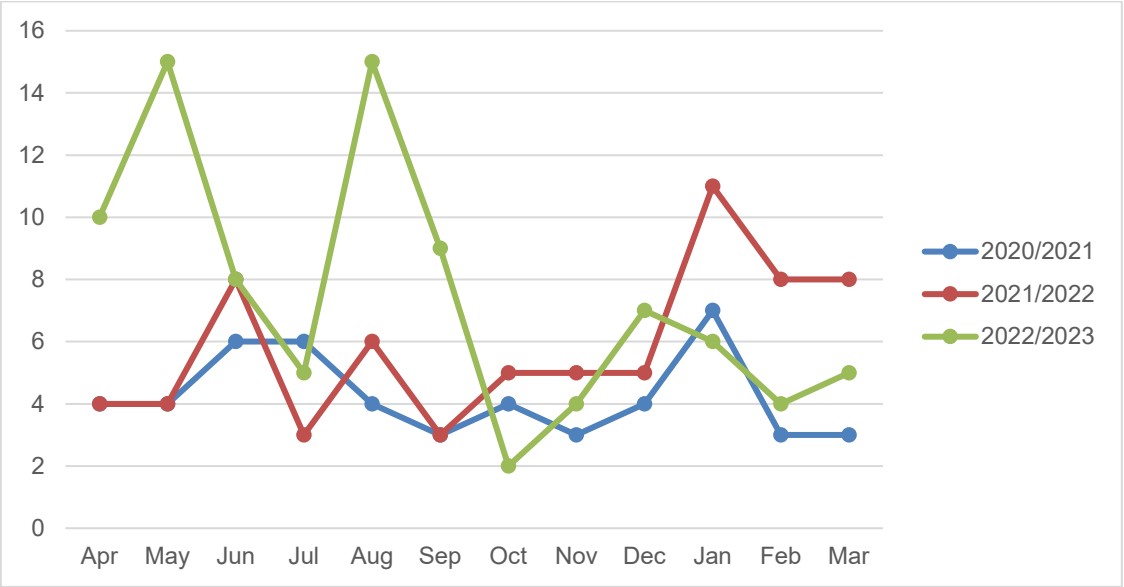
In the Year 2 report, the analysis of monthly variance raised the possibility of an increase in SVSDA in January (Bates et al. 2022). The report cited established research showing increases in police-reported domestic abuse incidents around Christmas and New Year (Card & Dahl, 2011; ONS, 2021b, fig. 2; Verney, 2021; West Midlands Police and Crime Commissioner, 2021). Additionally, the evidence base for links between domestic abuse (victimisation) and (attempted) suicide or suicidal ideation continues to grow (Aitken & Munro, 2018; Asad et al., 2010; Cavanaugh et al., 2011; Chang et al., 2015; Devries et al.,

2013; Hassanian-Moghaddam et al., 2016; Kafka et al., 2022; Keynejad et al., 2022; MacIsaac et al., 2017; McLaughlin et al., 2012; McManus et al., 2022; Munro & Aitken, 2020; Walby, 2004).

However, previous research on patterns or trend within suicide deaths more generally (not only those following domestic abuse) showed peaks in spring (March, April) and smaller peaks in summer and early autumn (August, September), with suppressed rates in the winter months (Christodoulou et al., 2012; Hofstra et al., 2018; Oladunjoye et al., 2020; White et al., 2015; Woo et al., 2012).There is little, if any, existing work specifically on the seasonality of SVSDA. Last year, the identified 'peak' in reported SVSDA in January led to a recommendation stating the 'possibility of an elevated risk of suicide amongst domestic abuse victims in the Christmas and New Year period' and recommending that 'when carrying out domestic abuse communications campaigns in the Christmas and New Year period, forces and partners consider signposting to suicide prevention services as well as domestic abuse support' (see Bates et al. 2022).

Highlighting a potential for year-to-year fluctuations in small samples, in Year 3 there were fewer SVSDA in January compared to the previous year (Year 1 = 7, Year 2 = 11, Year 3 = 6). In Year 3, the peaks were seen in May and August, with a small relative increase in December (see Figure 4). Further years of data collection may help discern a seasonal pattern but based on the potential links between domestic abuse and suicide, communications campaigns referring to support for domestic abuse victim/survivors as well as suicide prevention services remain relevant.

Figure 4 *Number of SVSDA by month – Year 1, Year 2 and Year 3*



Source: Domestic Homicide Project

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

Chapter 3 – Typologies and characteristics of victims and suspects

3.1 Case characteristics

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

3.1.1 Method of death

Overall, the most common method of death across the three-year dataset was strangulation (including hanging), representing 26% (n = 181/701) of all cases (see Table 3).[13] The predominance of strangulation represents a change from the previous years where the use of a sharp instrument was the most common method of death. However, strangulation includes death by hanging in SVSDA. When excluding these cases, deaths as a result of sharp instruments were most common, accounting for 59% of IPHs (n = 106) and 54% of AFHs (n = 62). In Year 3, the use of a sharp instrument was reported in 21% of cases (n = 49/233), raising the total of death by sharp instrument across the three-year dataset to 25% (n = 179/701).

Considering the method of death in relation to typologies, of the 181 cases reported as death by strangulation (including hanging) across the three-year dataset, 72% (n = 130) were SVSDA. Within cases of SVSDA, strangulation (including hanging) has remained consistent as the most commonly reported method of death over time (47%, n = 24/51 for Year 1; 65%, n = 47/72 for Year 2; and 63%, n = 59/93 for Year 3). Notably, IPHs also represented 20% (n = 37/181) of the total of deaths by strangulation.

Moreover, looking at the method of death by typology over the three-year dataset, 54% (n = 62/114) of AFHs and 43% (n = 106/248) of IPHs involved sharp instruments. This supports findings from general homicide, domestic homicide, and femicide data, which all indicate that sharp instruments, such as knives, have remained the most common method of killing (Femicide Census, 2020; Home Office, 2022a; ONS, 2023). This reflects in large part the fact that knives are readily available, especially in domestic settings. New changes to knife crime legislation are being progressed by the Home Office, giving the police power to seize, retain and destroy knives found in private premises if they have grounds to believe it will be used in serious crime (Home Office, 2023). Future analysis should consider these changes, if they are indeed passed by parliament.

Returning to the overall dataset (n = 701), the next most common methods of death were the use of poison or drugs (11%, n = 75), ‘other’ method of death (10%, n = 67), blunt instrument (5%, n = 38) and kicking or hitting (5%, n = 36). Also note that in one percent of

[13] In this report, we will be understanding strangulation as “asphyxia by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck” (Sauvageau, 2011, p. 1), with three main forms of strangulation, namely, hanging, ligature strangulation and manual strangulation. When we refer to hanging, we will be including both complete hanging (with complete free suspension of the body) or incomplete or partial hanging (where part of the body supports the victim’s weight).

cases (n = 9) the method of death was recorded as shooting. In 10% (n = 71) of cases the method of death was 'not known'.

Table 3 *Number and proportion of incidents by method of death – Year 1, 2 and 3*

	April 2020/ March 2021		April 2021/ March2022		April 2022/ March2023		**April 2020-March 2022**	
	N	%	N	%	N	%	**N**	**%**
Blunt Instrument	11	6%	14	6%	13	6%	**38**	**5%**
Burning or scalding (Incl. Arson)	7	3%	3	1%	3	1%	**13**	**2%**
Drowning	4	2%	8	3%	2	1%	**14**	**2%**
Kicking or hitting	22	10%	8	3%	6	3%	**36**	**5%**
Other	16	7%	26	12%	25	11%	**67**	**10%**
Poison or Drugs	24	11%	23	9%	28	12%	**75**	**11%**
Sharp instrument	59	27%	70	29%	49	21%	**178**	**25%**
Shooting	3	1%	4	2%	2	1%	**9**	**1%**
Strangulation (Incl. Hanging)	39	18%	64	24%	78	33%	**181**	**26%**
Suffocation	4	2%	8	3%	7	3%	**19**	**3%**
Not Known	29	13%	22	9%	20	9%	**71**	**10%**
Total	**218**	**-**	**250**	**-**	**233**	**-**	**701**	**100%**

Source: Domestic Homicide Project

3.1.2 Suspect's relationship to the victim

Across all three years, in 67% (n = 505) of the 754 suspects (or prior perpetrator of domestic abuse in cases of SVSDA) were the current (48%, n = 363) or ex- (19%, n = 142) partner or spouse of the victim. Consistent with the previous years, these incidents related to IPHs as well as SVSDA and unexpected deaths. It was most common for suspects of IPHs to be recorded as the victim's current partner or spouse (81%, n = 208/258).

Within unexpected deaths (n = 77), the suspect was most commonly recorded as the victim's current partner or spouse across all three years (49%, n = 38). For SVSDA, there was an increase in 17 percentage points from last year in the proportion of cases whereby the prior domestic abuse perpetrator was the victim's ex-partner (from 33%, n = 25/76 in Year 2 to 50%, n = 51/102 in Year 3).

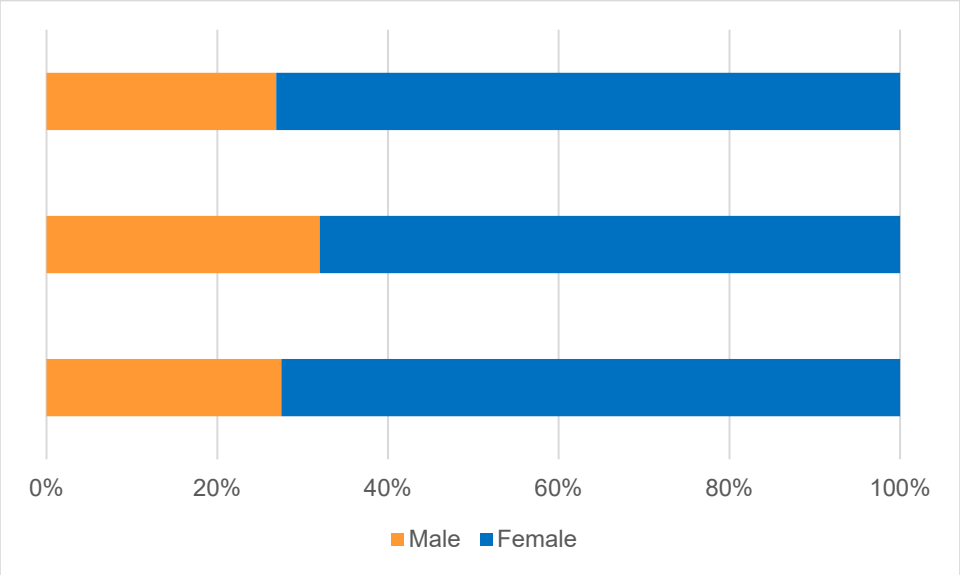
The suspect was the (adult) child of the victim in 13% (n = 97/754) of cases across all three years. This included the majority of AFH cases (63%, n = 79/125). The remaining suspects across all three years were the parent (8%, n = 62/754), other family member (4%, n = 33/754), or sibling (4%, n = 27/754). The relationship between the suspect and victim was recorded as 'other' in 3% (n = 21/754) of cases, and 'not known' or not recorded in 1% (n = 9/754) of cases.

3.2 Victim demographics

3.2.1 Sex

In Year 3, 73% (n = 177) of the 242 victims were recorded as female, whilst 27% (n = 65) were recorded as male. This highlights a slight decrease in male victims compared to Year 2, where 68% (n = 176/259) of victims were female, whilst 32% (n = 83/259) were male. The overall breakdown in sex of the victim across all three years was 71% (n = 514/723) female and 29% male (n = 209/723; see Figure 5 below).

Figure 5 *Proportion of victims by sex – Year 1, 2 and 3*



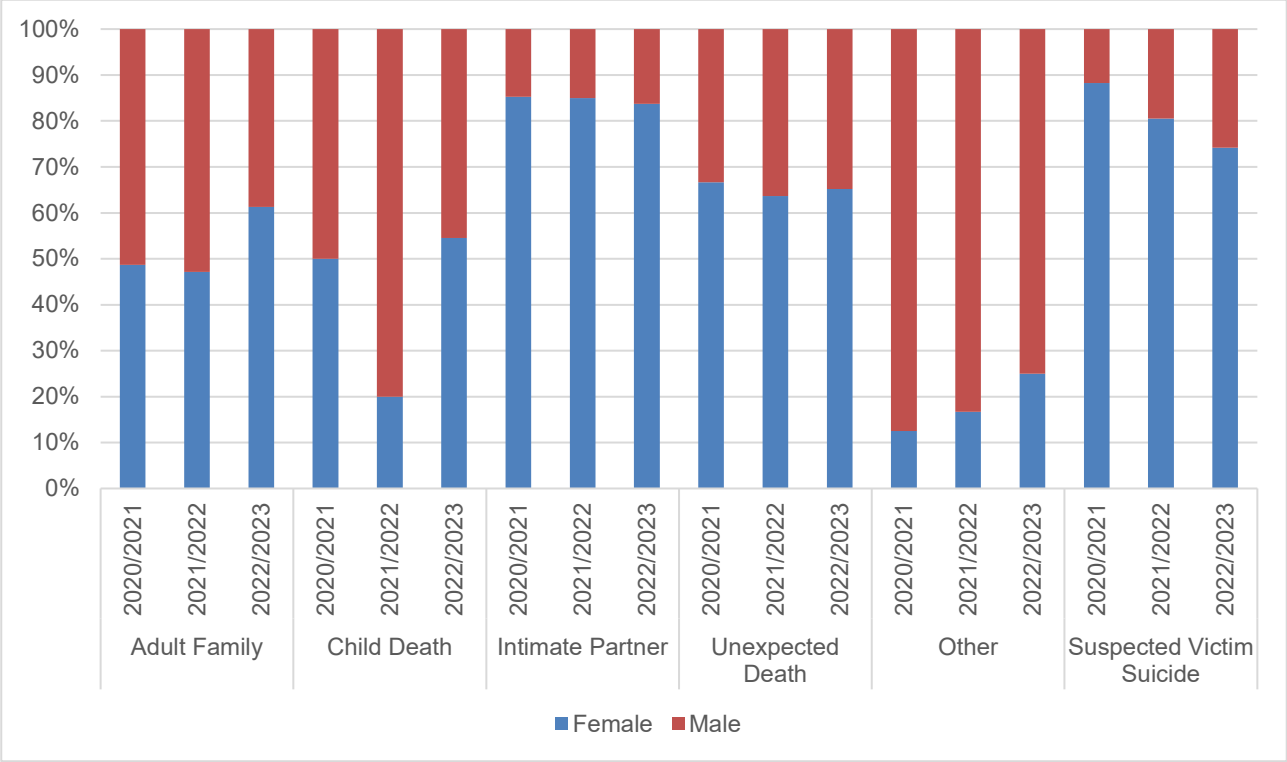
Source: Domestic Homicide Project

SVSDA have demonstrated the greatest increase in recorded cases across years of data collection. Whilst the data continues to indicate that most victims of SVSDA are female (80% across all three years, n = 172/216), the number and proportion of male victims of SVSDA have increased across each year (12%, n = 6/51 in Year 1; 19%, n = 14/72 in Year 2; 26%, n = 24/93 in Year 3). Chapter 7 discusses cases of SVSDA in more depth.

With regards to AFHs, the split between female and male victims remained more evenly distributed than other typologies in Year 2. In Year 3, there was an increase in the proportion of AFHs involving female victims (61%, n = 19/31) compared to Year 2 (47% n = 25/53) and Year 1 (49%, n = 18/37). However, the decrease in the number of AFHs between Year 2 and Year 3 may impact this change.

Finally, within unexpected deaths, most victims were female across the three-year dataset (65%, n = 48/74).

Figure 6 *Proportion of victims by typology and sex – Year 1, 2 and 3*



Source: Domestic Homicide Project

We also conducted analysis on victim-suspect dyads by sex and typology. Most cases involved a female victim and male suspect(s) or prior domestic abuse perpetrator in cases of SVSDA. Across all 723 recorded victims, 67% (n = 483/723) involved a female victim and male suspect(s), with 4% (n = 29/723) involving a female victim and female suspect(s). Additionally, 14% (n = 98/723) involved a male victim and female suspect(s), whilst 15% (n = 108/723) involved a male victim and male suspect(s).[14]

As highlighted, there are differences when comparing by typology. For example, whist in AFHs 45% (n = 55/121) of cases involved a female victim and male suspect(s), the vast majority of IPH cases involved a female victim and male suspect(s) (84%, n = 208/248). Additionally, within SVSDA, 75% (n = 161/216) of cases involved a female victim and male prior domestic abuse perpetrator(s).

Based on the nature of the submissions to this project, there are cases which involve multiple suspects (n = 43). The three most common breakdowns were cases involving, a female victim and two male suspects (30%, n = 13/43), a male victim and one male and one female suspect (26%, n = 11/43), and a female victim and one male and one female

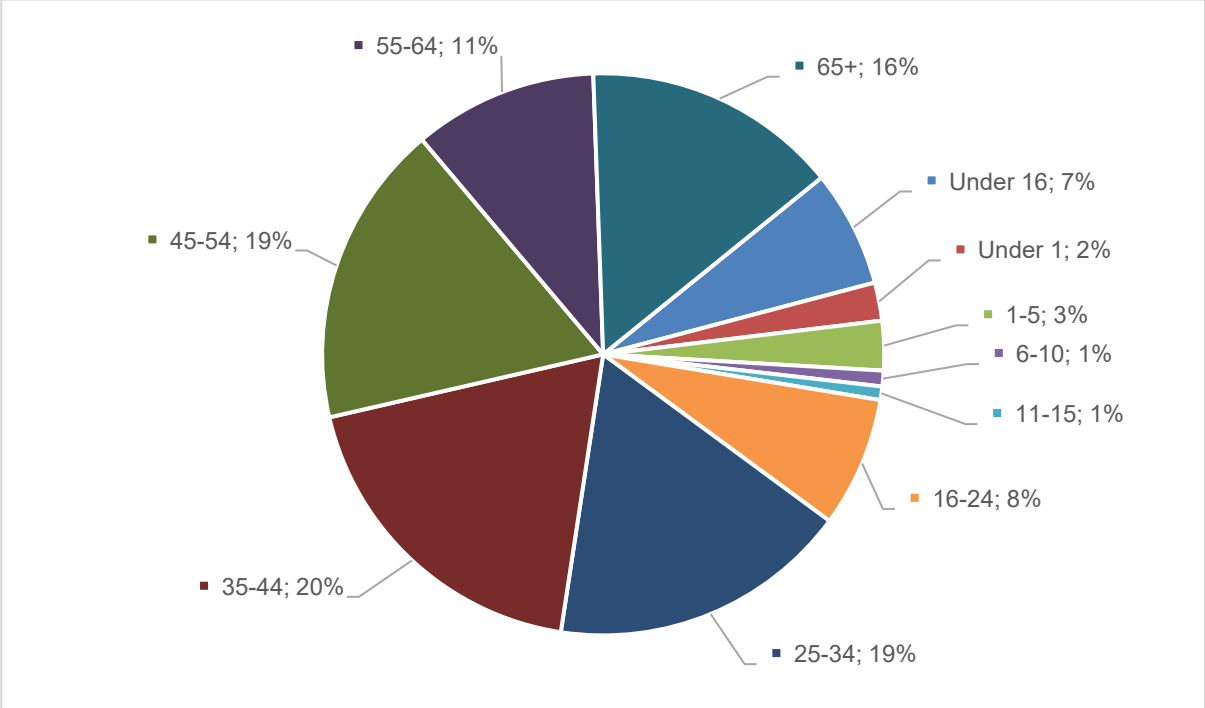
[14] There were five cases in which the sex of the suspect(s)/prior domestic abuse perpetrator(s) was not recorded. See full analysis in Appendix B Data Tables 22 to 26 (separate document).

suspect (19%, n = 8/43).[15] For additional information about recorded sex of the suspect/prior domestic abuse perpetrator see Section 3.3.1.

3.2.2 Age

Across the three-year dataset, 58% (n = 416) of 723 victims were aged 25 to 54 years old, with 16% (n = 114) being 65 years or older, as per Figure 7 below:

Figure 7 *Proportion of victims by age group (April 2020 – March 2023)*

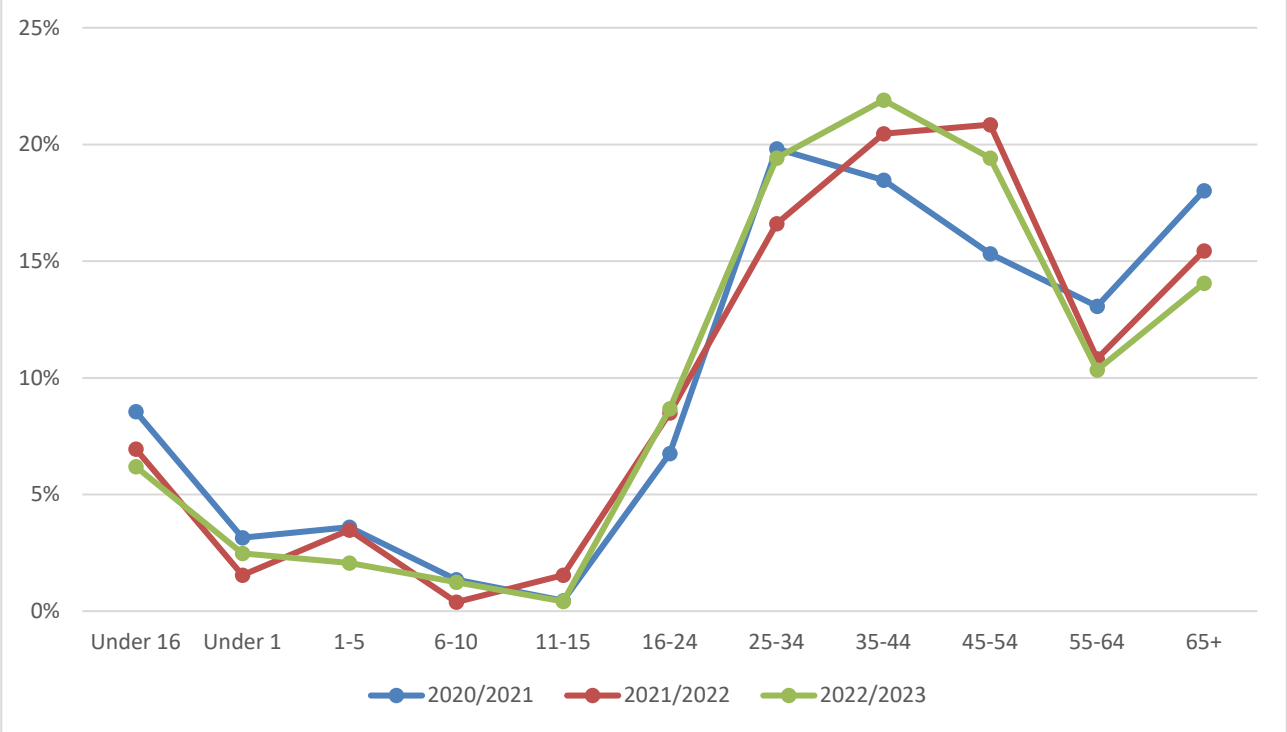


Source: Domestic Homicide Project

The proportion of victims by age group remained relatively steady when considering all typologies. For instance, the proportion of older victims (aged 65+ years) in Year 3 (14%, n = 34/242) was similar to that of Year 2 (15%, n = 40/259) and slightly lower than in Year 1 (18%, n = 40/222; see Figure 8).

[15] The calculations shown in Appendix B – Data Table 23 includes cases in which the suspects/prior domestic abuse perpetrators belonged within two or more separate typologies (e.g., an intimate partner and a family member). The figures presented here include only the overall number of victims to avoid any double counting.

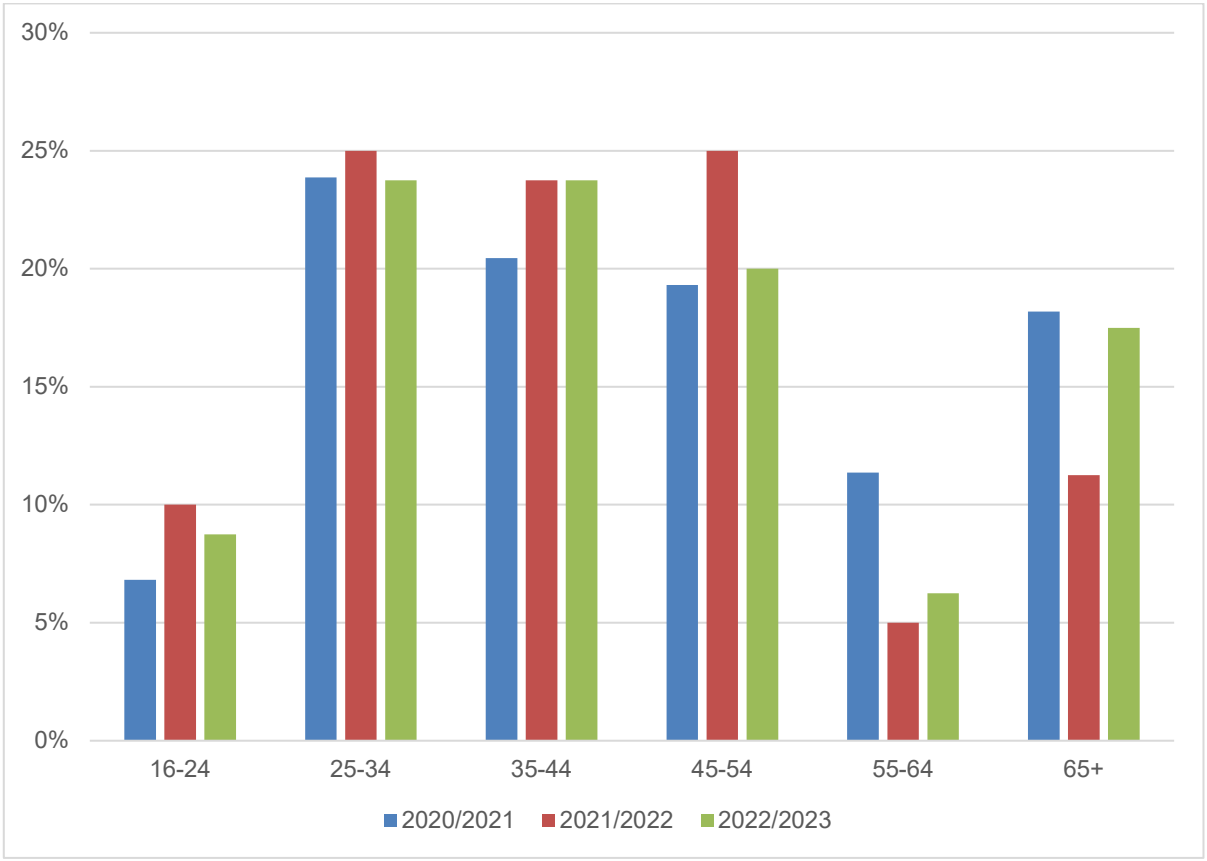
Figure 8 Proportion of victims by age group – Year 1, 2 and 3



Source: Domestic Homicide Project

First, within the typology of IPH, the overall age distribution appears to match that of the broader dataset, with the majority of victims aged 25 to 54 years old across the three years (68%, n = 169/248; see Figure 9). However, it is important to note that in Year 2, 11% (n = 9/80) of IPH victims were aged 65 years or older, whereas this increased by seven percentage points (18%, n = 14/80) in Year 3, more closely resembling the figure obtained in Year 1 (18%, n = 16/88). The Project's Second Spotlight Briefing on domestic homicides involving older victims provides additional insight regarding previously published data from the first year of the Project, including the potential impact of Covid-19-related restrictions on older victims (Hoeger et al., 2022).

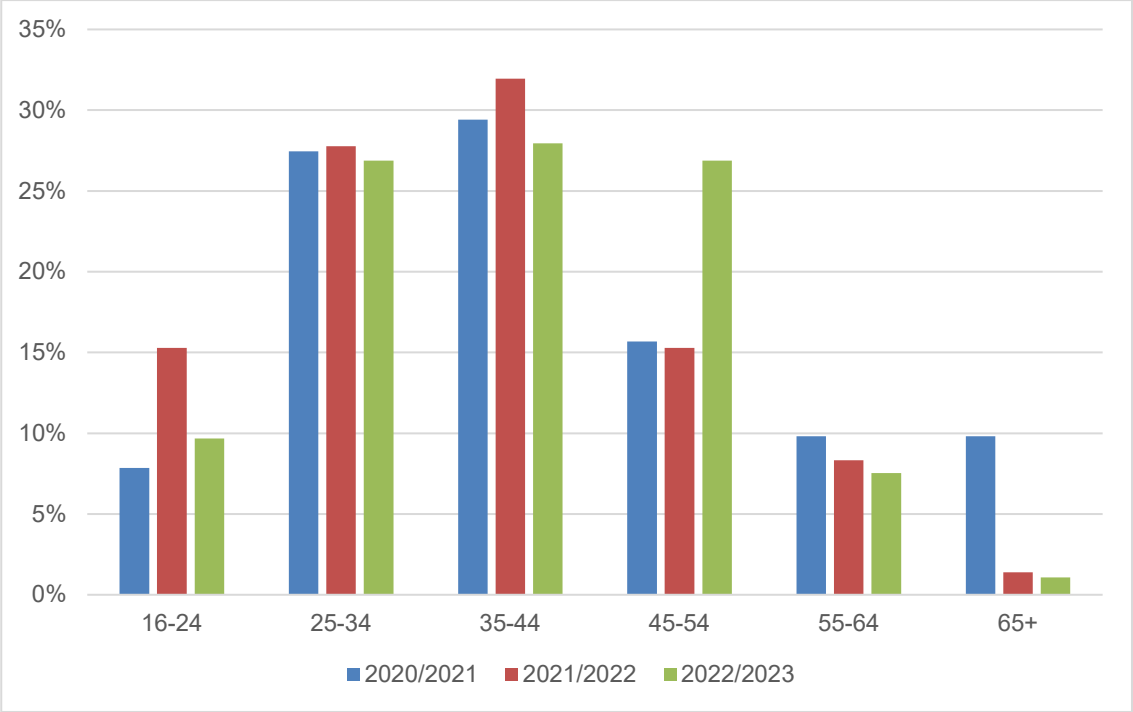
Figure 9 Proportion of IPH victims by age group – Year 1, 2 and 3



Source: Domestic Homicide Project

Second, within SVSDA, victims were slightly younger, with the majority aged between 25 to 44 years old across the three-year dataset (57%, n = 123/216; see Figure 10). When comparing across years, whilst numbers were small, there was an increase of 12 percentage points in victims aged 45-54 between Year 2 (15%, n = 11/72) and Year 3 (27%, n = 25/93).

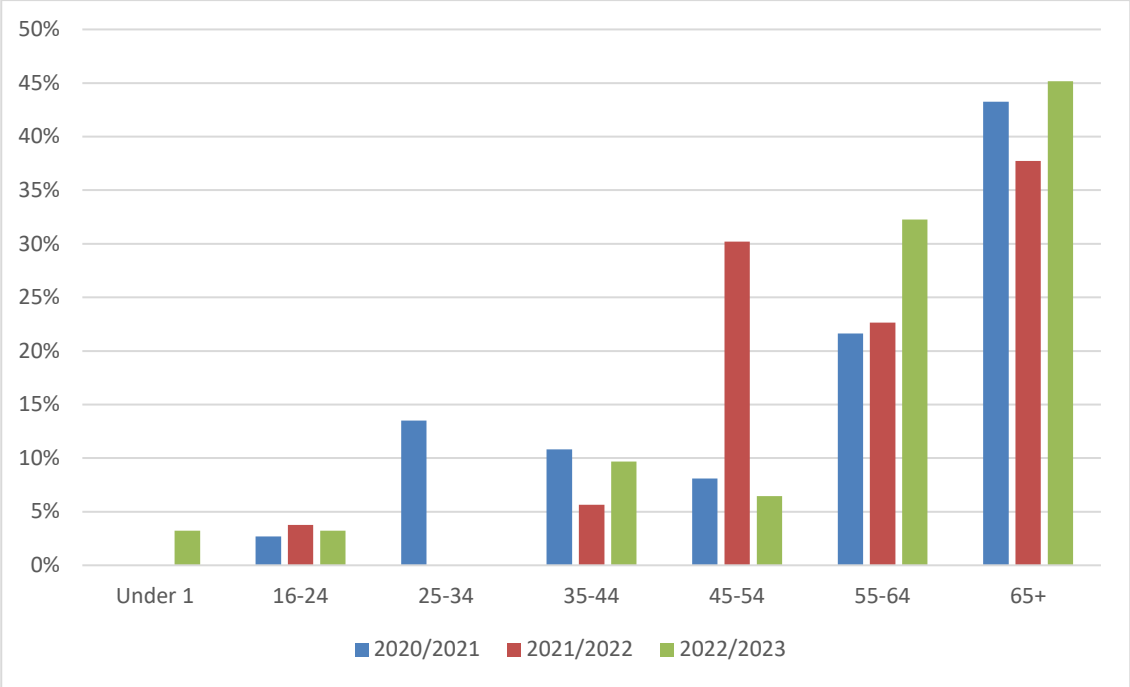
Figure 10 *Proportion of SVSDA victims by age group – Year 1, 2 and 3*



Source: Domestic Homicide Project

Third, within AFH deaths, as seen in previous years, the proportion of victims increased with age. Across all three years, the highest proportion of victims within this typology were aged 65 years or older (41%, n = 50/121; see Figure 11), with the second highest being aged 55 to 64 (25%, n = 30/121). There was an increase of seven percentage points in the proportion of victims aged 65 years or older from Year 2 (38%, n = 20/53) to Year 3 (45%, n = 14/31). Whilst the proportion of victims aged 55 to 64 increased by nine percentage points between Year 2 (23%, n = 12/53) and Year 3 (32%, n = 10/31), the proportion of AFH victims aged 45 to 54 decreased by 24 percentage points from Year 2 (30%, n = 16/53) to Year 3 (6%, n = 2/31), returning to a similar figure seen in Year 1 (8%, n = 3/37).

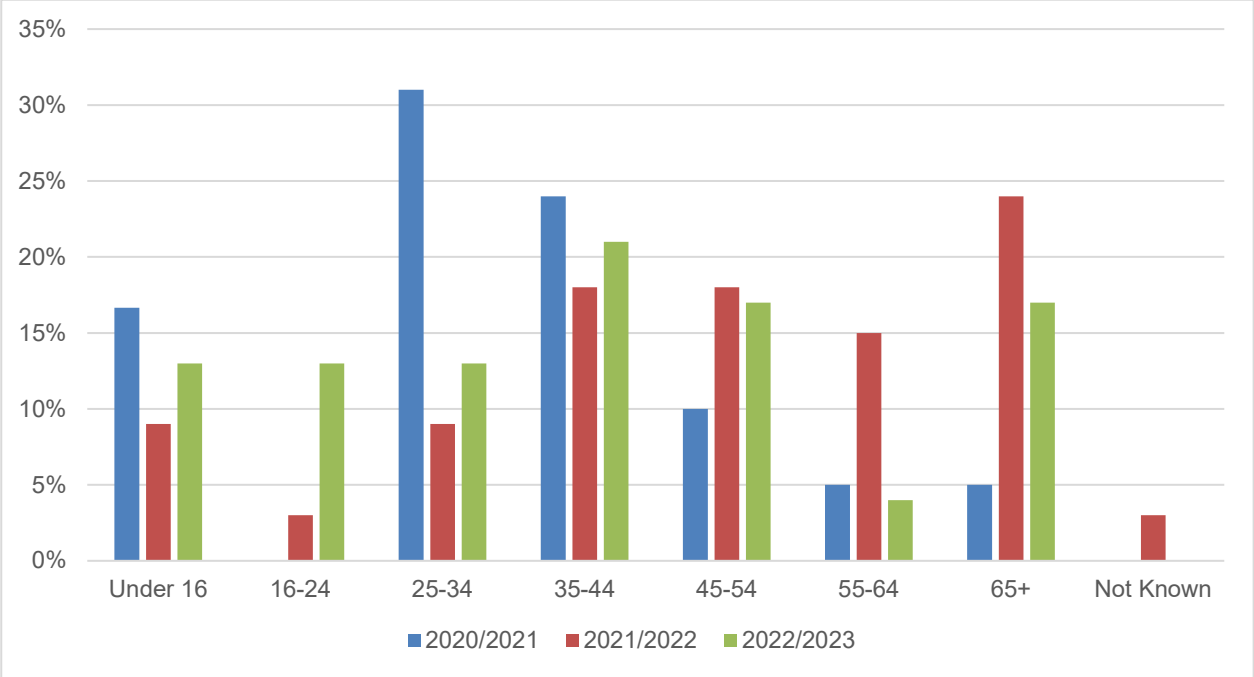
Figure 11 Proportion of AFH victims by age group – Year 1, 2 and 3



Source: Domestic Homicide Project

Lastly, for unexpected deaths, in Year 3, just under half (48%, n = 11/23) of victims were aged between 16 and 44 years old, compared to 30% in Year 2 (n = 10/33) and 39% in Year 1 (n = 7/18). Fluctuations within age groups by year of data collection are expected based on the relatively small sample sizes. For instance, there was a decrease in the proportion of victims aged 55 to 64 from Year 2 (15%, n = 5/33) to Year 3 (4%, n = 1/23). Additionally, around 17% (n = 4/23) of victims of unexpected deaths were over the age of 65, marginally decreasing from the proportion obtained in Year 2 (24%, n = 8/33; see Figure 12).

Figure 12 *Proportion of unexpected death victims by age group – Year 1, 2 and 3*

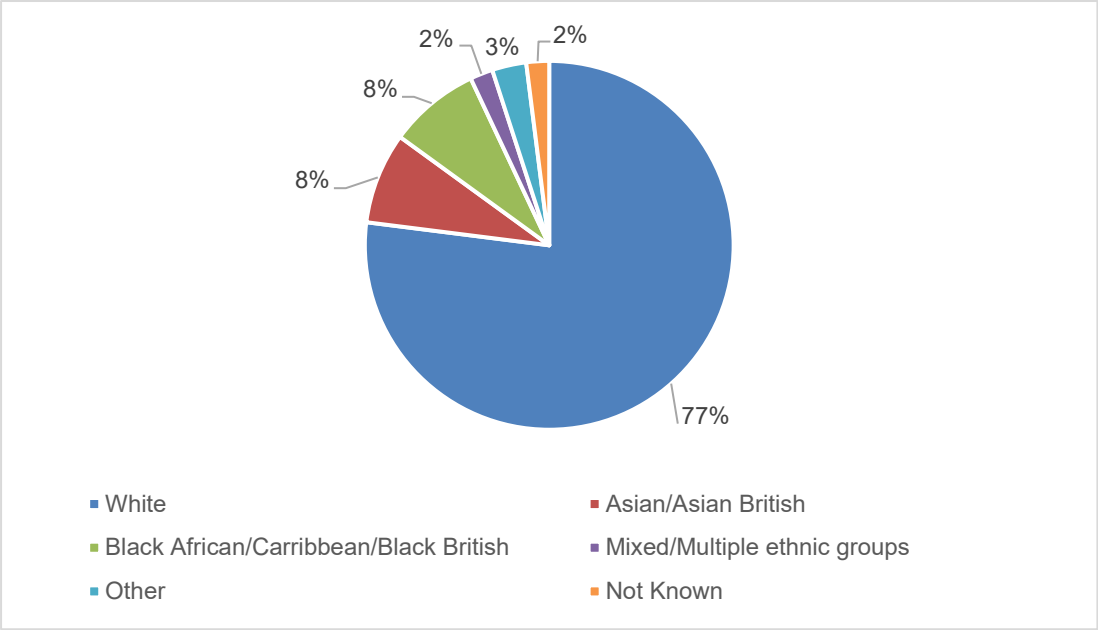


Source: Domestic Homicide Project

3.2.3 Ethnicity and Nationality

Submitters were asked to record, where known, the ethnicity of the victim and suspect/perpetrator, using the same ethnicity categories used by the Census. Across the three-year dataset, a total of 77% (n = 514) of the 723 victims were recorded by officers as being of White ethnicities. Additionally, across the three-year dataset 8% (n= 57) were recorded as being of Black ethnicities, 8% (n = 60) of Asian ethnicities, 2% of mixed ethnicities, and 3% (n = 19) of 'other' ethnicities. In 2% (n = 15) of cases the victim's ethnicity was not known or not recorded (see Figure 13). Taken together, those of minority ethnic heritages (other than White ethnicities) therefore comprised 23% of the combined three-year Project dataset.

Figure 13 *Proportion of victims by ethnicity (April 2020 – March 2023)*



Source: Domestic Homicide Project

The 2021 Census lists the following: 82% of the population was of White ethnicities, 4% of Black ethnicities, 9% were of Asian ethnicities, 3% of mixed or multiple ethnicities, and 2% of other ethnicities (ONS, 2022). Taken together, those of minority ethnic heritages (other than White ethnicities) comprise 18% of the general population as measured by the 2021 Census. Consistent with last year's report, the Project dataset therefore appears to include a lower proportion of victims of White ethnicities and a higher proportion of victims of minority ethnic heritages than the general population as measured by the 2021 Census (23% compared to 18%), and in particular, slightly higher proportions of victims of Black ethnicities (8% compared to 4%).

The Project's Third Spotlight Briefing on ethnicity (Perry et al., 2022) found that Asian (11%), Black (8%) and white (10%) victims were similarly likely to have been involved with Independent Domestic Violence Advisors (IDVA), Independent Sexual Violence Advisors (ISVA) or other domestic abuse services. However, fewer Black victims were previously known to police as victims of domestic abuse: 41% compared to 52% of Asian victims and 54% of white victims. This suggests that, whilst Black victims were less likely to have previously reported domestic abuse to police, they did seek help from independent advocates in equal numbers to victims of other ethnicities.

Across all three years of data collection, the completion rate for the ethnicity variable was surprisingly high given findings of missing ethnicity data in previous police research (Gangoli et al., 2019). Ethnicity was not recorded or not known in just 2% of cases across the three-year dataset (n = 723). However, this data is likely to reflect the seriousness of these incidents and more information being known and recorded about the victim where a death has occurred, compared to other police-recorded crimes.

Police forces were also asked to provide the nationality of the victim and suspect. Of the 723 victims across the three years, 22% (n = 162) did not have a recorded nationality. Of

the 561 cases in which the nationality of the victim was known, the most commonly recorded nationality was British, at 83% (n = 464). The was followed by 4% of victims recorded as Polish (n = 24), 2% recorded as Indian (n = 9), and 1% recorded as Welsh (N = 6). Additionally, 1% of victims were recorded to have Romanian and Lithuanian nationalities (n = 5). The Femicide Census analysis of ten years' femicide data similarly highlights Eastern European, post-communist nationalities – and especially Polish – as being relatively highly represented in terms of victim nationality (Femicide Census, 2020). Moreover, according to the 2021 Census, Polish has been the most common non-British nationality in the UK since 2007 (ONS, 2021a).

All other recorded nationalities related to one to four deaths each. It is important to note that data completion for nationality of the victim increased by five percentage points compared to the figures published in the Year 2 report, which suggests some potential improvement in the collection of this data within police systems. However, in some cases, submitted data on nationality was recorded by region rather than by country, which can obstruct in-depth analysis.

3.2.4 Other protected characteristics and additional factors

In the combined three-year dataset, 28 of the 723 victims (4%) were recorded as being LGBTQ+. For 34% (n = 245) of victims this characteristic was listed as 'not known' or was not recorded, whilst it was recorded as 'no' for 62% of victims. In Year 3, the number of victims identified as LGBTQ+ remained the same as reported in Year 2 (n = 11). As in the previous report none of the victims within the three-years dataset are recorded as having undergone gender reassignment, although this characteristic was 'not known' or not recorded for 19% (n = 138) of victims.

The above figures might be related to difficulties for the police of identifying the relationship as LGBTQ+, but also to the challenges of identifying domestic abuse within a LGBTQ+ relationship. Indeed, research suggests that police may see domestic abuse within LGBTQ+ relationships as 'mutual' because the partners are seen as equals in terms of power dynamics and physical strength. But also, police may be more dismissive of the seriousness of the events when responding to domestic abuse in LGBTQ+ couples and more responsive to physical violence than other forms of domestic abuse, missing particular dynamics within LGBTQ+ relationships (Butterby & Donovan, 2023).

Notably, 61% (n = 17/28) of LGBTQ+ victims across the three-year dataset were recorded within SVSDA (see Chapter 7 for more detail on Year 3 cases). These figures might be linked with findings in the literature indicating that LGBTQ+ victims of domestic abuse are less likely to look for support from mainstream agencies, including the police, with distrust on help providers being a key element (Donovan & Barnes, 2020; Donovan & Hester, 2014; Donovan & Hester 2011).

Only 2% (n = 27) of the 723 victims were recorded as having a known religion, with the remaining 98% being 'not known' or not recorded. Finally, 1% (n = 10) were recorded as being pregnant or having given birth within the previous six months.

Furthermore, in Year 3, 23% (n = 55) of the 242 victims were recorded as having care needs related to their mental health. Additionally, 11% (n = 27) of victims were identified as having care needs in relation to their physical health. There were also three victims with a learning or developmental need, and five victims recorded as having dementia. It is worth noting than for each of these four categories, a high percentage of the cases were recorded as 'not known' or not recorded, with an average of 114 cases per category.

Table 4 *Victims with disabilities and/or care needs, (April 2022 – March 2023)*

	Physical health care needs		Mental health care needs		Learning or developmental needs		Dementia	
	N	%	N	%	N	%	N	%
Yes	27	11%	55	23%	3	1%	5	2%
No	104	43%	95	39%	114	47%	110	45%
Not known	111	46%	92	38%	125	52%	127	53%
Total	242	100%	242	100%	242	100%	242	100%

Source: Domestic Homicide Project

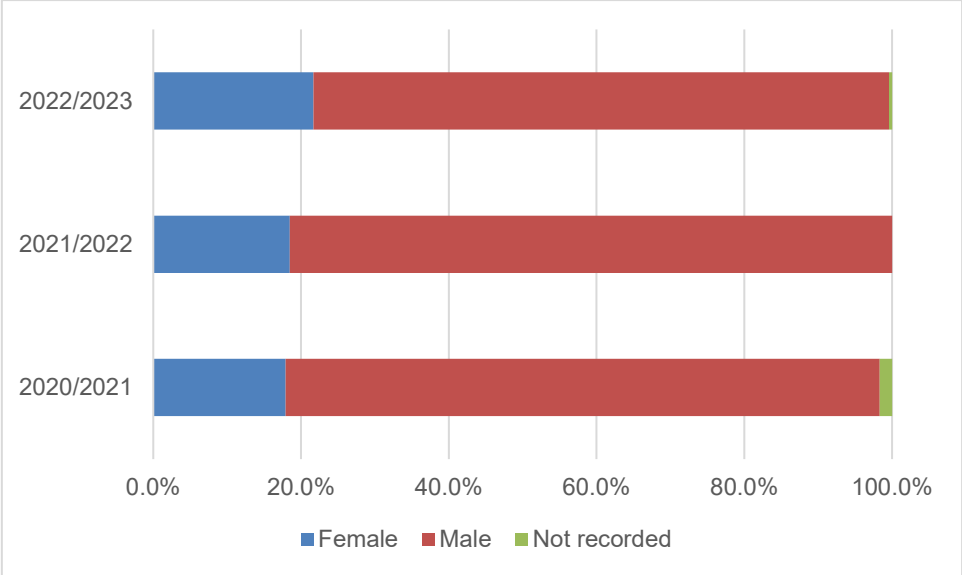
3.3 Suspect demographics

3.3.1 Sex

In contrast to victims, in Year 3, 78% (n = 194) of the 249 suspects (or prior domestic abuse perpetrators in the case of SVSDA)[16] were recorded as male, whilst 22% (n = 54) were female. Although the proportion of female suspects is slightly higher in Year 3 as compared to previous years, this is similar to the overall breakdown in sex of the suspect across all three years, with 80% (n = 603) male and 19% (n = 146) female suspects. Note that the sex of the suspect was not recorded in less than 1% of cases (n = 5) across the three-year dataset (n = 754; see Figure 14).

[16] A reminder on terminology: where, like here, we present analysis of the whole aggregated dataset, we use the umbrella term 'suspect'. In suspected victim suicide cases this refers to the perpetrator of the prior domestic abuse. Where we discuss suspected victim suicide cases only, we use the term 'prior domestic abuse perpetrators'.

Figure 14 *Proportion of suspects by sex – Year 1, 2 and 3*



Source: Domestic Homicide Project

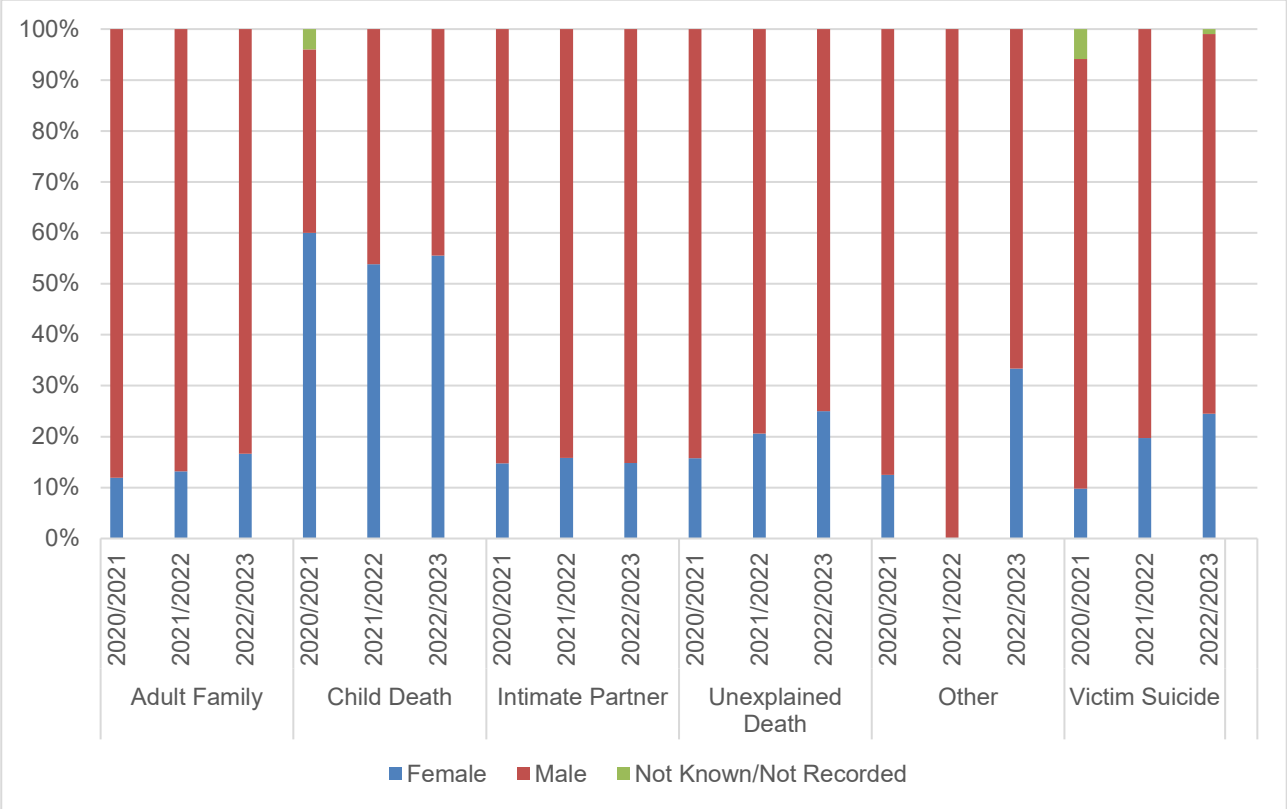
Considered by typology, within IPHs (n = 258), the proportion of male and female suspects remained relatively stable across all three years, with around 85% (n = 219) of suspects recorded as male, whilst 15% (n = 39) were female (see Figure 15).

As in IPHs, cases of SVSDA were also unequally represented by sex. Of the 102 prior perpetrators of domestic abuse associated with SVSDA recorded in Year 3, around 75% (n = 76) were male, whilst 25% (n = 25) were female and 1% (n = 1) not recorded. Compared to the Year 2 data, this shows a slight percentage increase in the proportion of female perpetrators associated with SVSDA, where 20% (n = 15/76) of suspects were female (see Chapter 7 for more detail).

In Year 3, the vast majority of suspects in AFHs (n = 30) were male (83%, n = 25), whilst 17% (n = 5) were female. Similarly, across all three years (n = 125), 86% (n = 108) of suspects were recorded as male, whilst 14% (n = 12) were recorded as female.

For suspects in unexpected deaths in Year 3 (n = 24), 75% (n = 18) were recorded as male. Though males have consistently remained the prominent suspects in unexpected deaths, there have been marginal percentage point increases in the proportion of female suspects across the three years (16% in Year 1, n = 3/19; 21% in Year 2, n = 7/34; 25% in Year 3, n = 6/24).

Figure 15 *Proportion of suspects by typology and sex – Year 1, 2 and 3*

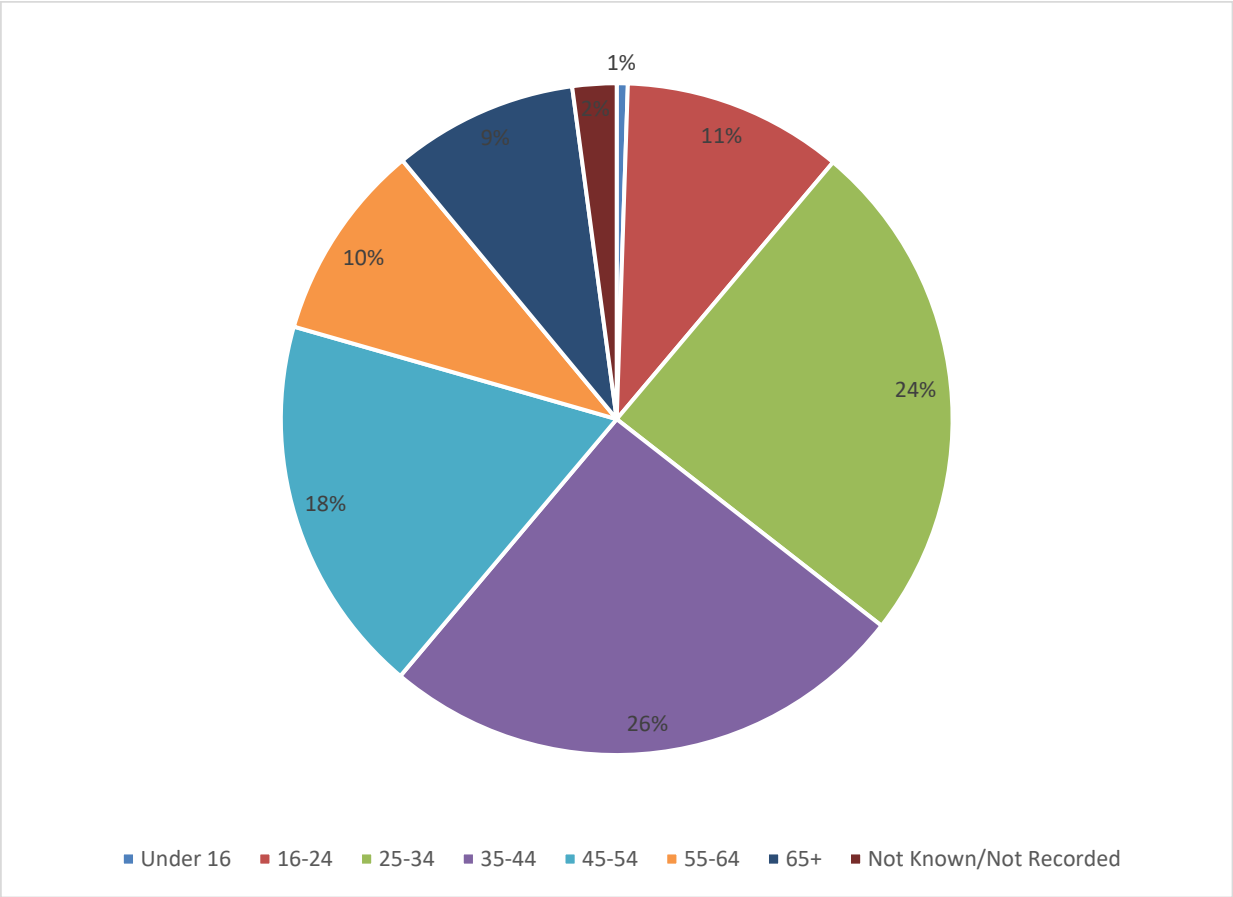


Source: Domestic Homicide Project

3.3.2 Age

Across the three-year dataset (n = 754), the majority of suspects were aged 25 to 54 years old (68%, n = 515), with an additional 18% (n = 139) being 55 years or older. About 11% (n = 80) of suspects were aged 16 to 24 years, whilst less than 1% (n = 4) were below 16 years old (see Figure 16 below):

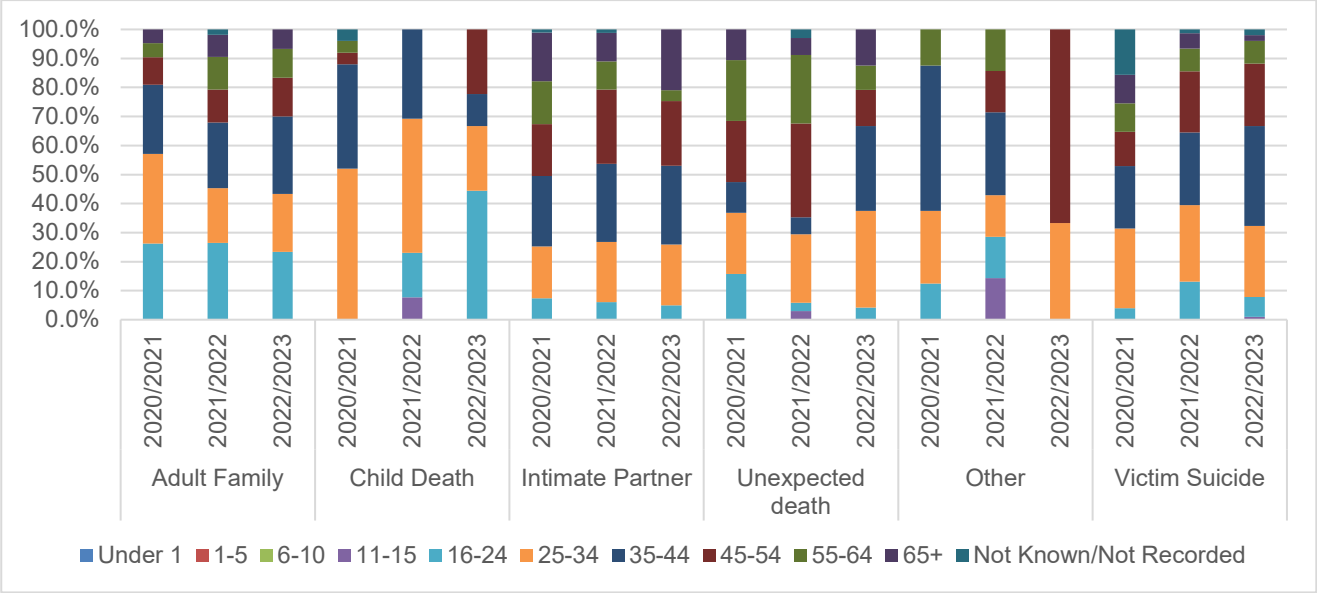
Figure 16 *Proportion of suspects by age group (April 2020 – March 2023)*



Source: Domestic Homicide Project

When comparing Year 3 to Year 2, the proportion of suspects across age groups remained relatively stable. The changes being a slight increase in the proportion of suspects aged 35 to 44 (23%, n = 61/265 in Year 2; 29%, n = 73/249 in Year 3), and a decrease in suspects aged 55-64 (11%, n = 29/265 in Year 2; 6%, n = 16/249 in Year 3). In Year 3, in less than 1% of cases (n = 2/249) the suspect's age was 'not known' or not recorded (n = 2). Figure 17 outlines the proportion of suspects by age group and typology across all three years.

Figure 17 *Proportion of suspects by age group and typology – Year 1, 2 and 3*



Source: Domestic Homicide Project

First, within IPHs, the age distribution of suspects within this typology appears to match that of the broader dataset and associated victims, with the majority of suspects aged 25 to 54 across the three-year dataset (67%, n = 174/258). In Year 2, 10% (n = 8/82) of IPH suspects were aged 65 years or older, which rose to 21% (n = 17/81) in Year 3. The proportion of IPH suspects aged 55 to 64 decreased by six percentage points from Year 2 (10%, n = 8/82) to Year 3 (4%, n = 3/81) in Year 3 (see Figure 18).

Figure 18 Proportion of IPH suspects by age group – Year 1, 2 and 3

Source: Domestic Homicide Project

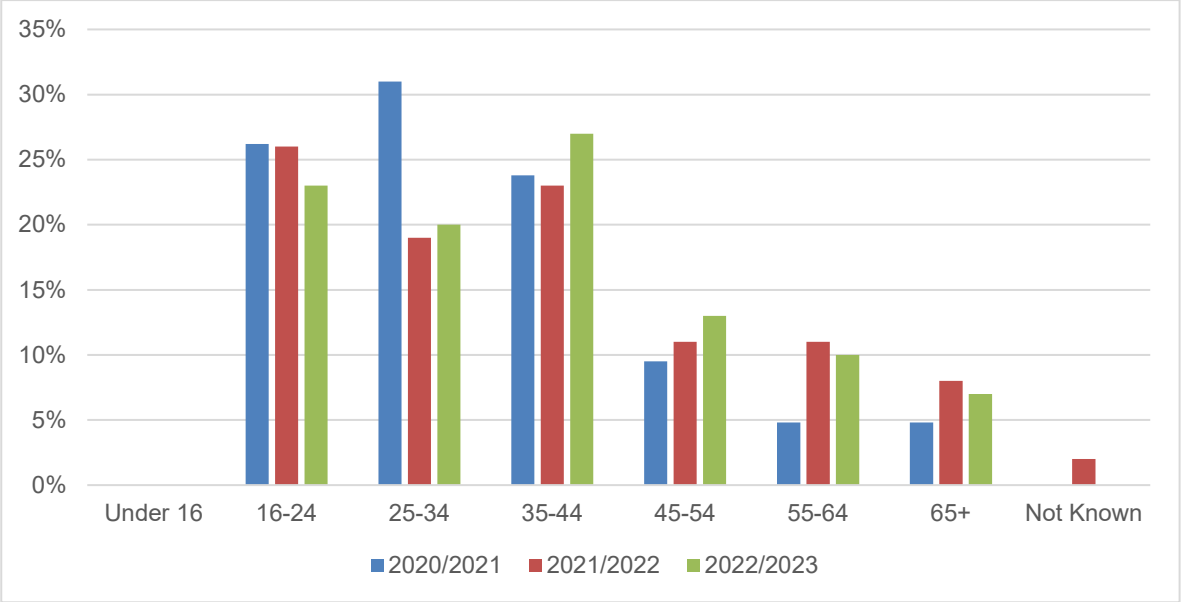
Second, within SVSDA, the age of associated prior domestic abuse perpetrators was similar to the distribution of victims, with the majority aged between 25 to 54 years old across the three-year dataset (73%, n = 168/229). When comparing by year, there was a greater proportion of domestic abuse perpetrators aged 35 to 44 in Year 3 (n = 35/102, 34%) compared to Year 2 (n = 19/76, 25%). Again, the sample within each sub-group is small, which will influence changes in proportion. Finally, in 2% (n = 16/229) cases across the three-year dataset, the age of the domestic abuse perpetrator was 'not known' or not recorded (see Figure 19).

Figure 19 *Proportion of prior domestic abuse perpetrators in SVSDA by age group – Year 1, 2 and 3*

Source: Domestic Homicide Project

Third, within AFH deaths, the suspects were generally younger than the victims. As in previous years, in Year 3, 70% (n = 21/30) of suspects were aged 16 to 44 years old (see Figure 20). The proportion of suspects aged 45 to 64 has remained stable from Year 2 (23%, n = 12/53) to Year 3 (23%, n = 7/30). Whilst, as in previous reports (Bates et al., 2021, 2022), this data is commensurate with the suspects being the child, grandchild or, in some cases, sibling of the victim, it is also reflective of a sizeable number of older adult children and older siblings in this year's dataset.

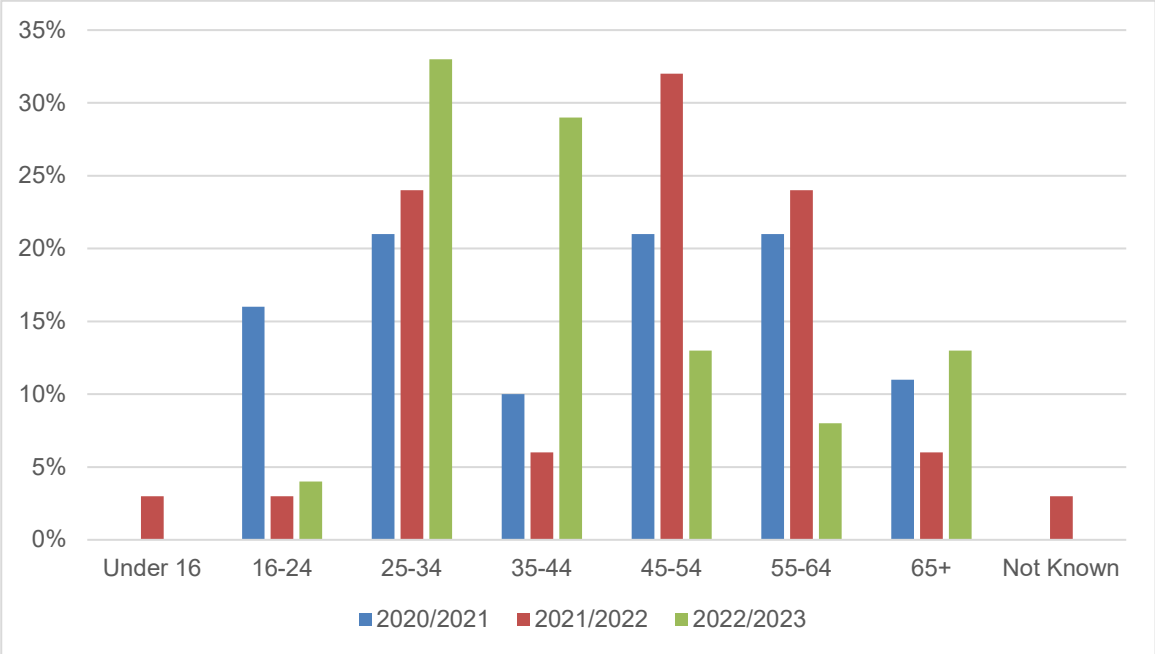
Figure 20 Proportion of AFH suspects by age group – Year 1, 2 and 3



Source: Domestic Homicide Project

Fourth, within unexpected deaths in Year 3, suspects were aged 16 to 44 in the majority of cases (66%, n = 16/24, see Figure 21). From Year 2 to Year 3, there was a decrease in suspects aged 45 to 54 (32%, n = 11/34 to 13%, n = 3/24), and those aged 55 to 64 (24%, n = 8/34, to 8%, n = 2/24). On the other hand, there was an increase of nine percentage points in suspects aged 25 to 34 between Years 2 and 3 (24%, n = 8/34, to 33%, n = 8/24), and in suspects aged 35-44 from 6% (n = 2/34) in Year 2 to 29% (n =7/24) in Year 3. As the sample size is relatively small and the types of cases involved change from year to year, these proportions may reflect expected fluctuations.

Figure 21 *The proportion of unexpected death suspects by age group - Year 1, 2 and 3*

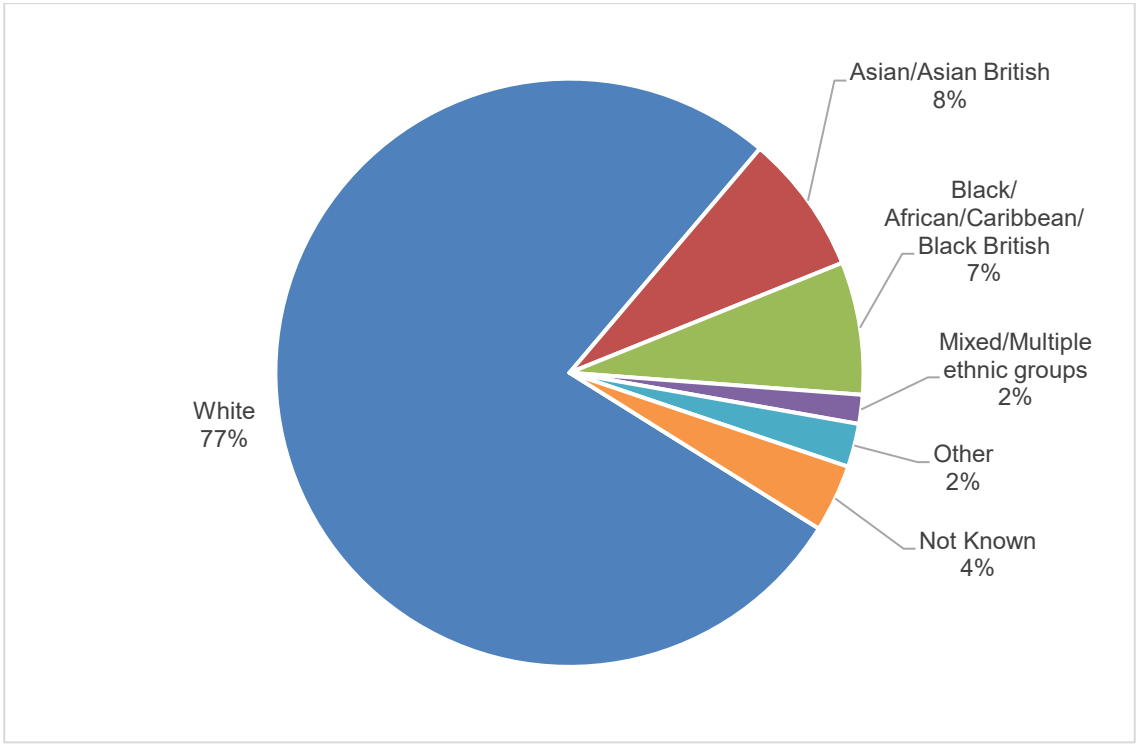


Source: Domestic Homicide Project

3.3.3 Ethnicity and Nationality

Across the three-year dataset, the ethnicity of the suspects (or prior domestic abuse perpetrators in cases of SVSDA) was similar to the victims described in the previous section. Of the 754 suspects, 77% (n = 583) were recorded as being of white ethnicities, 7% (n = 55) of Black ethnicities, 8% (n = 58) of Asian ethnicities, 2% (n = 12) of mixed ethnicities, and 2% (n = 18) of 'other' ethnicities. In 4% (n = 28) of cases the suspect's ethnicity was not recorded (see Figure 22). Those of minority ethnic heritages (other than white ethnicities) therefore comprised 19% (n = 143) of the three-year dataset.

Figure 22 *Proportion of suspects by ethnicity (April 2020 – March 2023)*



Source: Domestic Homicide Project

As mentioned in the victims' section, the 2021 Census lists the following: 82% of the population were of white ethnicities, 4% of Black ethnicities, 9% were of Asian ethnicities, 3% of mixed or multiple ethnicities, and 2% of other ethnicities (ONS, 2022). Taken together, those of minority ethnic heritages (other than White ethnicities) comprise 18% of the general population. Consistent with last year, our Project dataset therefore appears to include a similar proportion of suspects of minority ethnic heritages to the general population as measured by the 2021 Census (19% compared to 18%). However, the Project dataset includes a higher proportion of suspects of Black ethnicities than recorded in the general population (7% compared to 4%).

Police forces were also asked to provide the suspect's nationality. Similar to data on victim nationality, of the 754 suspects, 21% (n = 158) did not have a recorded nationality. Therefore, of the 596 cases in which the suspect's nationality was known, 83% (n = 493) were recorded as British. As with victims, Polish was the next most commonly recorded nationality, including 25 suspects (4%), followed by eight (1% of) suspects recorded as

Romanian, seven (1%) as Welsh, and five (1%) as Indian. All other recorded nationalities related to one to four suspects. As noted in relation to victims, when comparing to the general population in England and Wales, according to the 2021 Census, Polish has been the most common non-British nationality in the UK since 2007 (ONS, 2021a).

Data completion for nationality of the suspect increased by 12 percentage points between Year 2 (78%, n = 206/265) and Year 3 (90%, n = 223/249), again suggesting some potential improvement in the collection of this data within police systems.

3.3.4 Other protected characteristics and additional factors

In the overall dataset, 27 of the 754 suspects (4%) were recorded as being LGBTQ+. Notably, for 40% (n = 299) of suspects this characteristic was listed as 'not known' or was not recorded, whilst it was recorded as 'no' for 57% (n = 428) of suspects. Comparing Year 3 to Year 2, there was an increase in the number of suspects recorded as being LGBTQ+ in cases of IPH between Year 2 and Year 3 (from n = 0/82 to n = 4/81). As in the previous report, none of the suspects were recorded as having undergone gender reassignment; however, this characteristic was 'not known' or not recorded in 24% (n = 181/754) of suspects.

In Year 3, 4% (n = 9) of the 249 suspects were recorded as having a known religion, with the remaining 96% being 'not known' or not recorded. Finally, less than one percent of suspects (n = 2) were recorded as being pregnant or having given birth within the previous six months, and both were suspects in child deaths.

Furthermore, in Year 3, 29% (n = 71) of the 249 suspects were recorded as having care needs in relation to their mental health (see Table 5). This is the same proportion of suspects with care needs in relation to their mental health care needs in the previous year (29%, n = 77/265). However, this characteristic was 'not known' or not recorded in 42% (n = 105//249) of suspects. Comparing Year 2 and 3, there was a slight increase in prior domestic abuse perpetrators with mental health care needs in cases of SVSDA (from 5%, n = 13/265 in Year 2 to 8%, n = 19/249 in Year 3) and a slight decrease in AFH suspects with special mental health care needs (from 12%, n = 31/265 to 7%, n = 17/249). Just a small number of suspects presented any other disability (i.e., a learning or developmental need, or dementia).

Table 5 *Suspects with disabilities and/or care needs (April 2022 – March 2023)*

	Physical health care needs		Mental health care needs		Learning or developmental needs		Dementia	
	N	%	N	%	N	%	N	%
Yes	6	2%	71	29%	7	3%	2	1%
No	107	43%	73	29%	101	41%	111	45%
Not known	136	55%	105	42%	141	56%	136	54%
Total	249	100%	249	100%	249	100%	249	100%

Source: Domestic Homicide Project

Click here to return to the summary findings and recommendations for Chapter 3

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

4.1 Overall risk factors

Where it was known to them, police forces were asked to identify the presence of 23 potential risk factors relating to the suspect (or prior domestic abuse perpetrator in a case of SVSDA). These risk factors were identified by the Project team through a rapid review of existing academic and research studies on domestic homicide (see Year 1 report, Bates et al., 2021, p. 52 for further explanation). Whilst the factors may not necessarily predict, or cause, domestic homicide or suicide following domestic abuse, they have been commonly identified within academic research, as included in the reviewed literature in the Year 1 report (Bates et al., 2021). The team also conducts follow-ups with forces for clarification on the presence of risk factors. Even so, the presented figures are likely to be under-estimates, as the police may not have access to all this information, particularly early in the investigation.

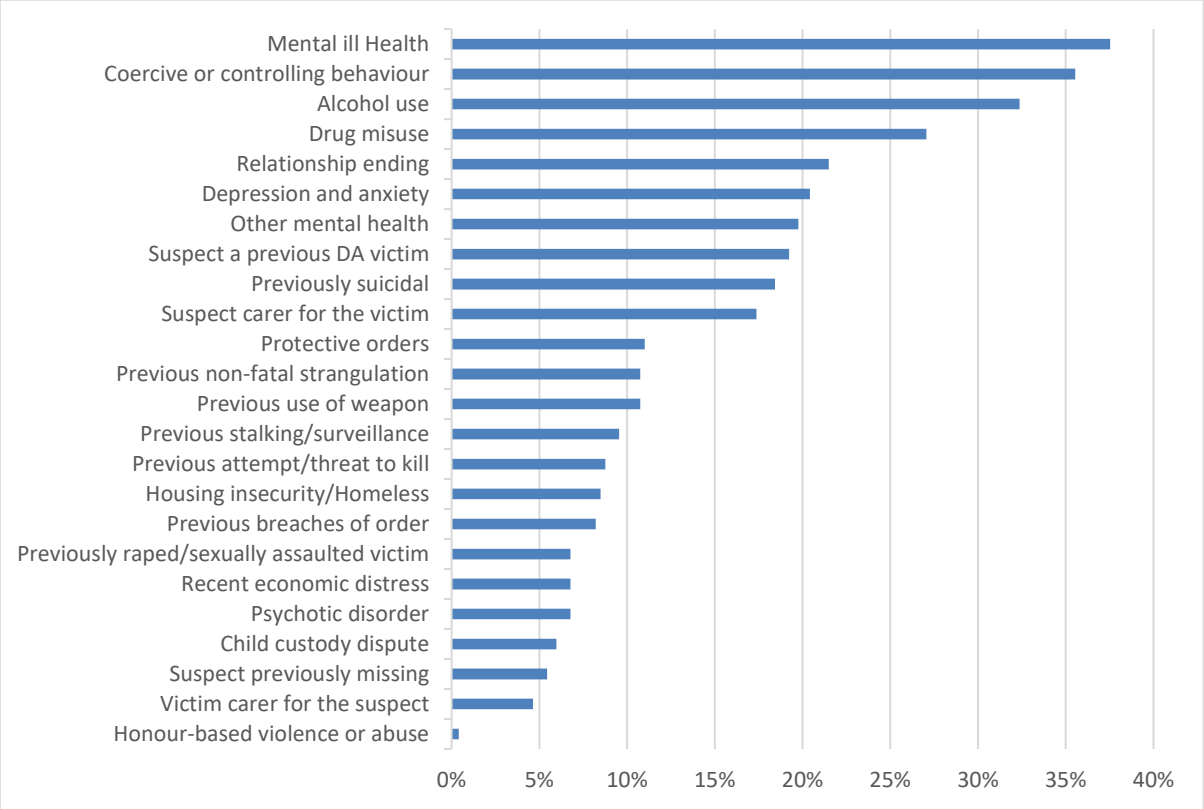
As shown in Figure 23 and 24, across the three-year dataset (n = 754), the top five most commonly recorded risk factors in relation to the suspect were identified as: any mental ill health[17] (38%, n= 283), a history of CCB (36%, n= 268), alcohol use (32%, n= 244), drug misuse (27%, n= 204) and (threat/fear of, or actual) relationship ending/separation (22%, n= 162). Importantly, some of these risk factors may co-occur.

Within these top five factors, alcohol misuse (35%, n = 92/265 in Year 2; 35%, n = 87/249 in Year 3), mental ill health (n = 105/265, 40% in Year 2; 37%, n = 92/249 in Year 3), and CCB (38%, n = 101/265 in Year 2 and 38%, n = 94/249 in Year 3) remained steady in Year 3 compared to Year 2. Additionally, the recording of drug misuse decreased by seven percentage points (33%, 87/265 in Year 2 to 26%, n = 87/249 in Year 3), whilst the recording of relationship ending/separation increased by seven percentage points (21%, n = 56/265 in Year 2 to 28%, n = 69/249 in Year 3). Notably, the presence of CCB was significantly associated with the suspect being identified by the police as a high risk and/or serial perpetrator of domestic abuse ($p < .05$, n = 506, Phi (effect size): 0.414). This finding suggests that police officers are appropriately using the presence of CCB when assessing risk.[18]

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

[18] Additional risk factors significantly associated with high risk or serial domestic abuse perpetrators ($p <0.05$) included: alcohol use, drug misuse, suspect previously suicidal, housing insecurity, relationship ending/separation, child custody dispute, previous attempt/threat to kill, previous use of weapon, previous non-fatal strangulation, stalking/surveillance, previously raped/sexually assaulted the victim, protection order, previous breach of protection order, suspect being a previous victim of domestic abuse and

Figure 23 *Proportion of suspects with recorded risk factors (April 2020 – March 2023)*

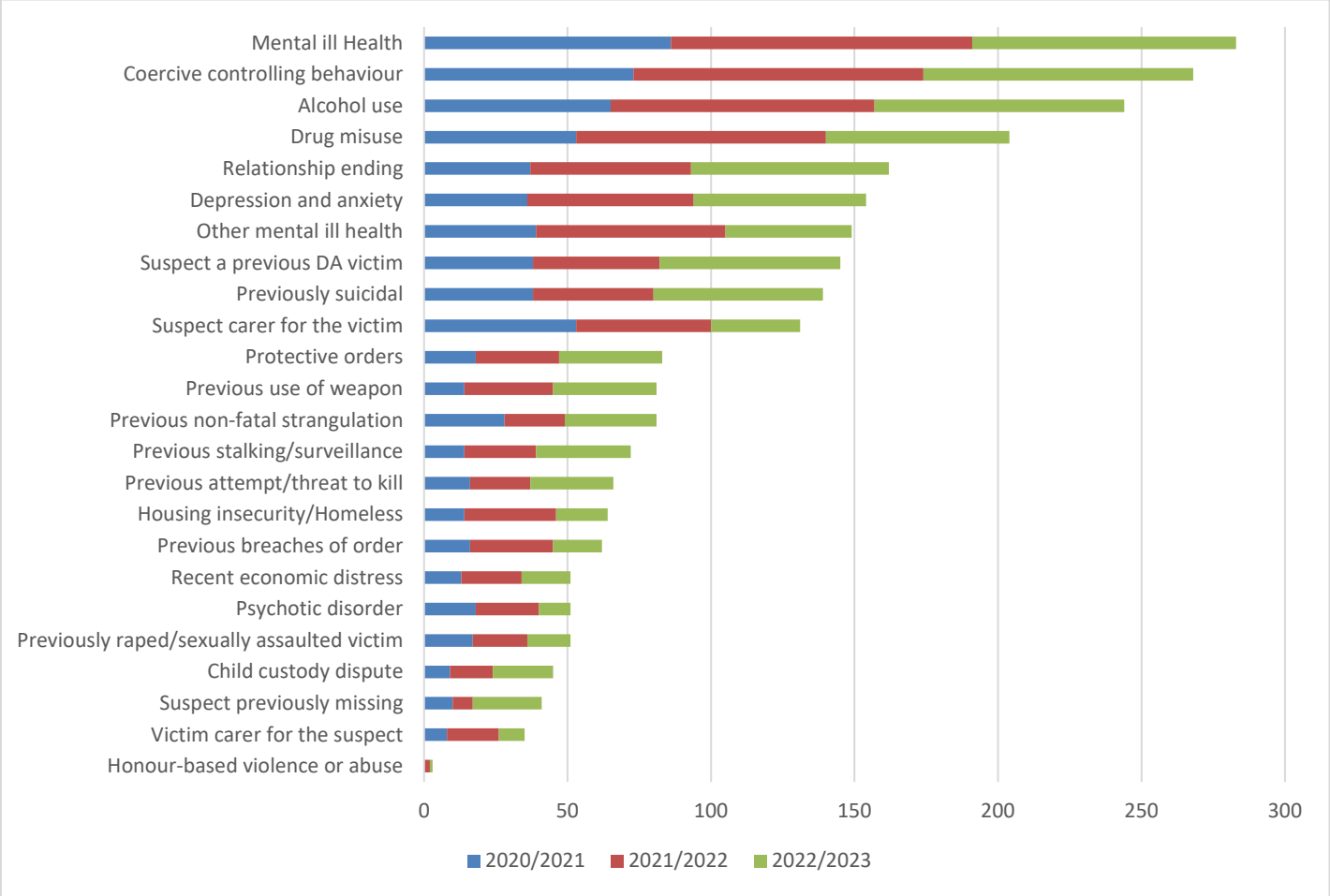


Source: Domestic Homicide Project

Additionally, some factors were more commonly reported in Year 3 when compared to Year 2 (see Figure 24). For instance, there was an increase of eight percentage points in the proportion of cases where the suspect had previously been a domestic abuse victim (17%, n = 44/265 in Year 2 to 25%, n = 63/249 in Year 3). Cases where the suspect had previously had suicidal thoughts or attempted suicide also showed an increase of eight percentage points from Year 2 (16%, n = 42/265) to Year 3 (24%, n = 59/249).

suspect a carer for the victim. However, the effect size in these cases was weak rather than the medium to strong association that was observed for coercive controlling behaviour. See Chapter 5 for analysis of high risk/serial domestic abuse perpetrators.

Figure 24 *Number of suspects with recorded risk factors by year of data collection*



Source: Domestic Homicide Project

4.2 Risk factors by case type

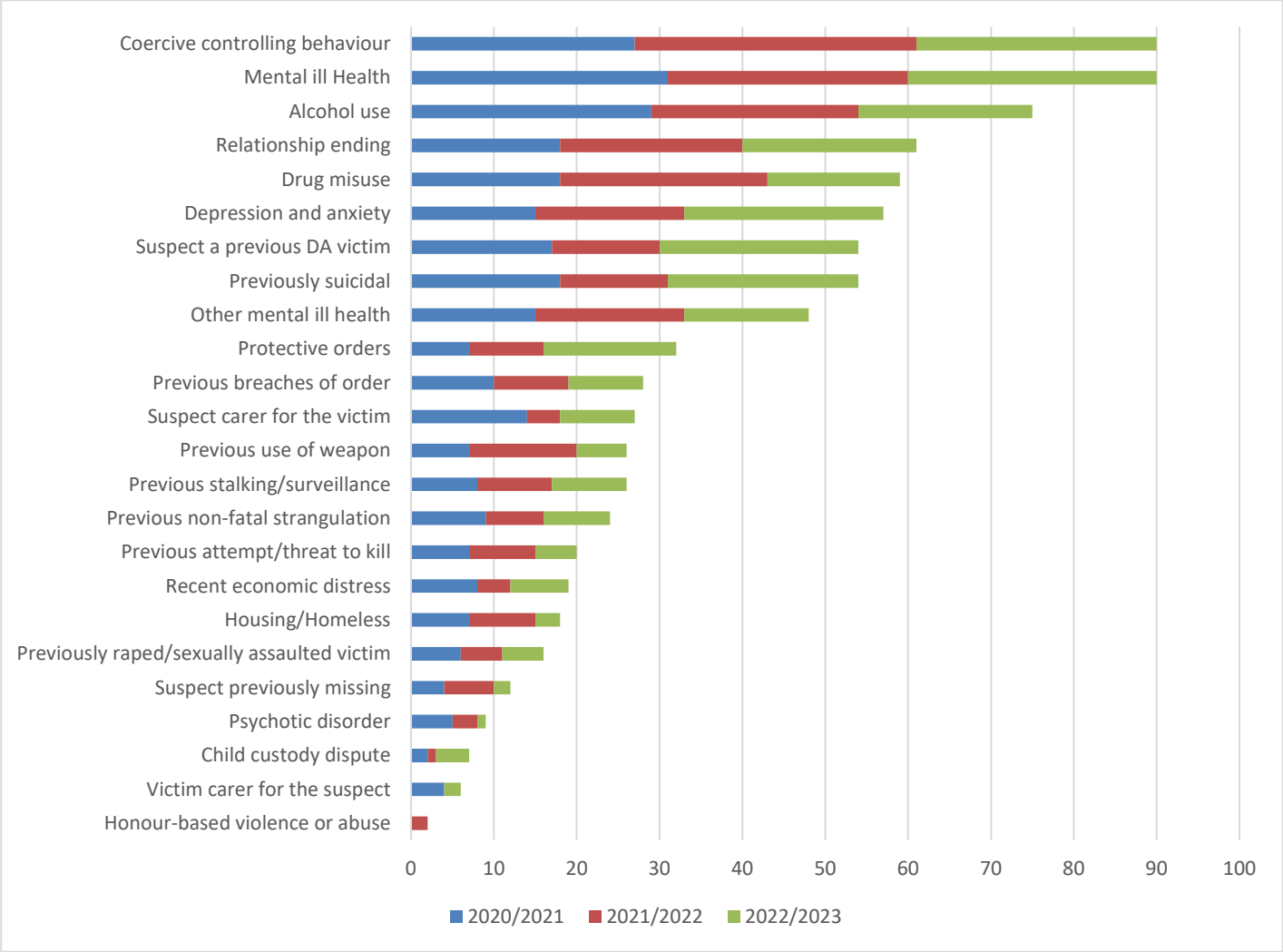
Risk factors identified did vary between typologies. First, within IPHs, the most commonly identified risk factors in Year 3 (n = 81) were: any mental ill health (n = 30, 37%), a history of CCB (n = 29, 36%), the suspect being known as a previous victim of domestic abuse (n = 24, 30%)[19], alcohol use (n = 21, 26%) and (threat/fear of, or actual) relationship ending/separation (n = 21, 26%) (see Figure 25).

When comparing Year 3 (n = 81) to Year 2 (n = 82), there was an observed increase in the proportion of IPH cases where the suspect was known as a victim of domestic abuse (16%, n = 13 to 30%, n = 24). Furthermore, there was an increase in cases where the suspect had been suicidal (16%, n = 13 to 28% to n = 23), and where suspects had currently or previously had protective orders in place against them (11%, n = 9 to 20%, n = 16). On the other hand, there were observed decreases between Year 2 and Year 3 in

[19] This category is based on police-recorded data on crimes and non-crime incidents flagged as being domestic abuse related. The submitter should flag this risk factor on the form, though the project team will also review each case to code for any risk factors that were otherwise not identified.

recorded cases where the suspect had a history of substance abuse (31%, n = 25 to 20%, n = 16), where the suspect had a history of CCB (42%, n = 34 to 36%, n = 8) and where they had previously used a weapon (16%, n = 13, to 7%, n = 6).

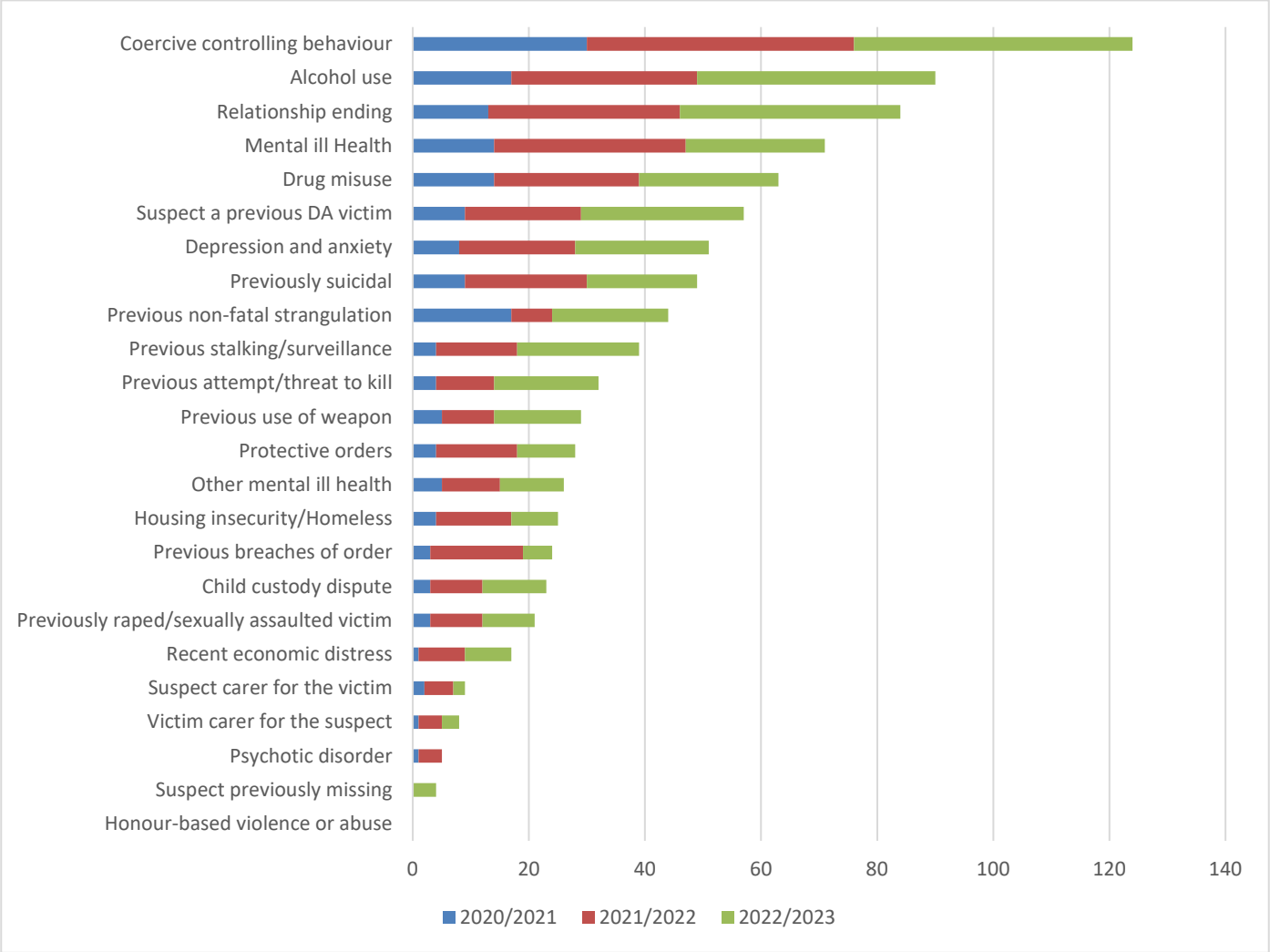
Figure 25 Number of suspects in IPHs with recorded risk factors – Year 1, 2 and 3



Source: Domestic Homicide Project

Next, within SVSDA, a high proportion of cases in Year 3 were identified as having a history of CCB (n = 48/81, 47%) (see Figure 26 and Chapter 7). Moreover, as noted in previous reports (Bates et al., 2021, p. 58), the identification of CCB was higher in SVSDA as compared to IPHs (47%, n = 48/102 vs. 36%, n = 29/81 in Year 3, respectively). Notably, in Year 3 there was an increase of 11 percentage points in the proportion of cases recorded where there had been previous non-fatal strangulation (20%, n = 20/102) when compared to Year 2 (9%, n = 7/76, see Chapter 7). After a peak in Year 2 of cases where there was a breach in protective orders (21%, n = 16/76), the figure in Year 3 returned to the levels presented in Year 1 (5%, n = 5/102 and 6%, n = 3/51 respectively).

Figure 26 *Number of SVSDA with recorded risk factors relating to the prior domestic abuse perpetrator – Year 1, 2 and 3*



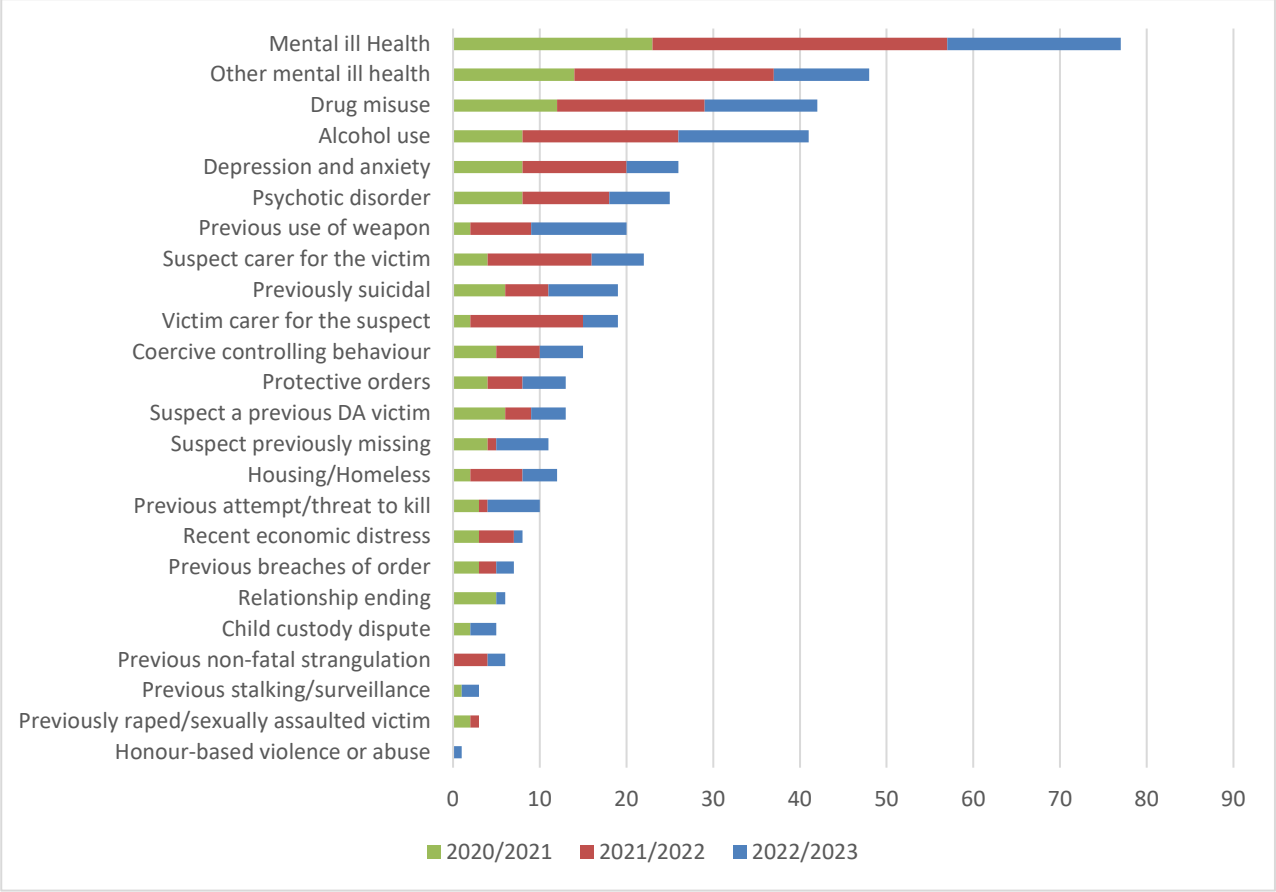
Source: Domestic Homicide Project

Turning to AFHs, any mental ill health and substance misuse were the most commonly identified risk factors in Year 3 (see Figure 27). In fact, of the 30 AFH cases during this year, any police-recorded mental ill health was identified in two thirds of the suspects associated with AFH cases (67%, n = 20). Furthermore, misuse of alcohol was present in half (50%, n = 15) of the cases in Year 3, followed closely by drug misuse by the suspect (43%, n = 13).

These findings provide further support for the analysis presented in previous reports (Bates et al., 2021, 2022) and the Project's Spotlight Briefing on AFH (Nguyen Phan et al., 2022). Additionally, other factors were more commonly reported in Year 3 when compared to Year 2. For instance, there was an increase of 24 percentage points in the proportion of cases where the suspect had previously used a weapon (13%, n = 7/53 in Year 2; 37%, n = 11/30 in Year 3).

AFH cases where the suspect had previously attempted or threatened to kill the victim and those where the suspect was previously missing, both showed an increase of 18 percentage points between years of data collection (2%, n = 1/53 in Year 2 to 20%, n = 6/30 in Year 3 for both). Finally, a similar rise was observed in the cases where there was alcohol use (34%, n = 18/53 in Year 2; 50%, n = 15/30 in Year 3) and those where the suspect was previously suicidal (9%, n = 5/53 in Year 2; 27%, n = 8/30 in Year 3). As in previous reports (Bates et al. 2021, 2022), these changes may also reflect improved data quality and or coding and follow up processes rather than an empirical rise in the presence of these risk factors.

Figure 27 Number of AFHs with recorded risk factors relating to the prior domestic abuse perpetrator – Year 1, 2 and 3

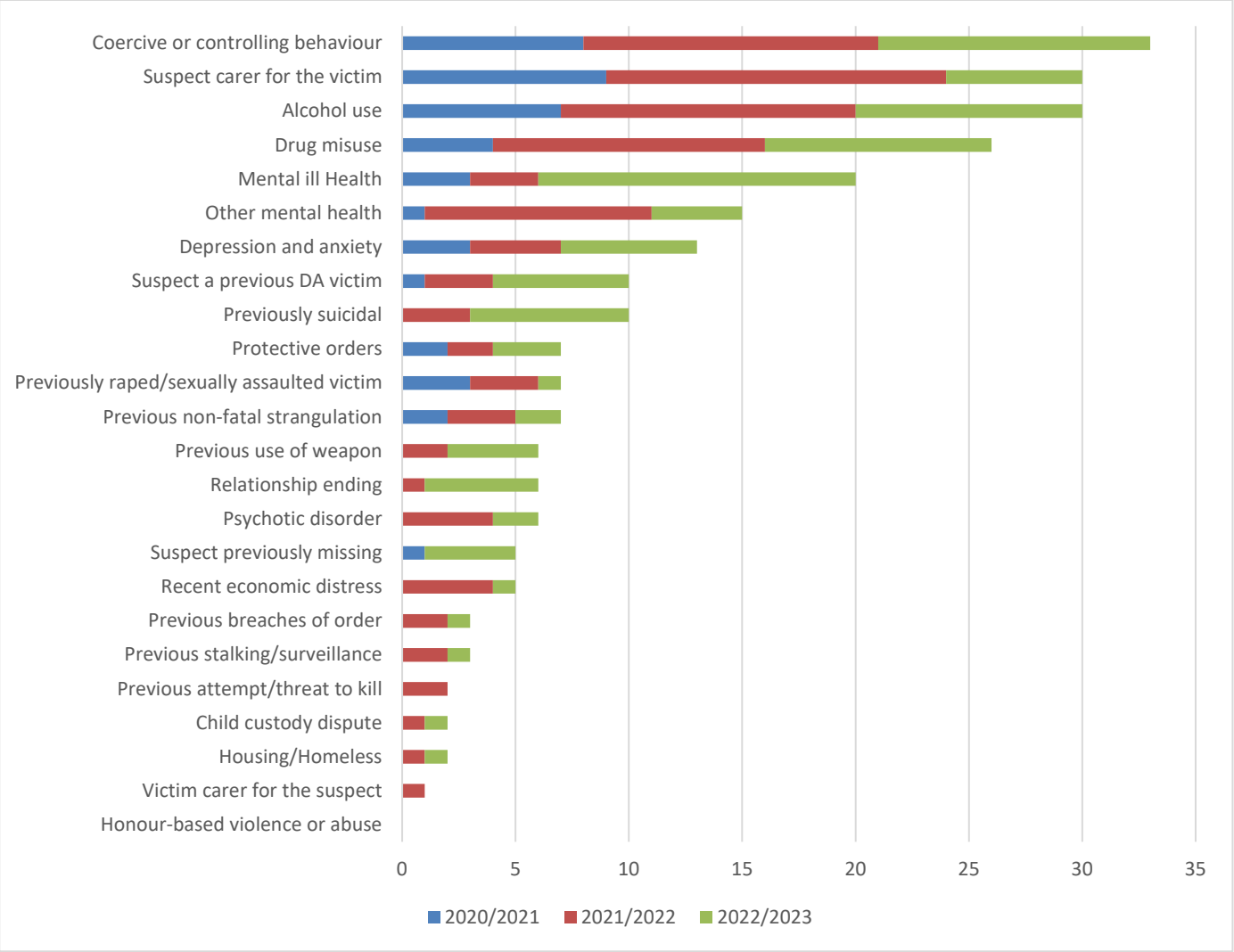


Source: Domestic Homicide Project

For unexpected deaths, any mental ill health and CCB were the most commonly identified risk factors in Year 3 (see Figure 28). During this year, any police-recorded mental ill health was identified in 58% (n = 14/24) of cases, compared to 9% (n = 3/34) in Year 2.

CCB was present in half (50%, n = 12/24) of unexpected death cases in Year 3, compared to 38% (n = 13/34) of cases in Year 2. There were also notable increases from Year 2 to Year 3 in cases where relationships between the suspect and victim had recently ended (3%, n = 1/34 to 21%, n = 5/24 respectively), where suspects had previously used a weapon (6%, n = 2/34 to 17%, n = 5 respectively) and where the suspect had previously been a victim of domestic abuse (9%, n = 3/34 to 25%, n = 6 respectively). Conversely, there was a notable decrease from Year 2 to Year 3 in cases where the suspect was the victim's carer (44%, n = 15/34 to 25%, n = 6/24 respectively).

Figure 28 *Number of unexpected deaths with recorded risk factors relating to the prior domestic abuse perpetrator – Year 1, 2 and 3*



Source: Domestic Homicide Project

Click here to return to the summary findings and recommendations for Chapter 4

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

This section describes analysis of how victims and suspects (or the perpetrator of the prior domestic abuse in cases of SVSDA) were known (if at all) to the police and other services.

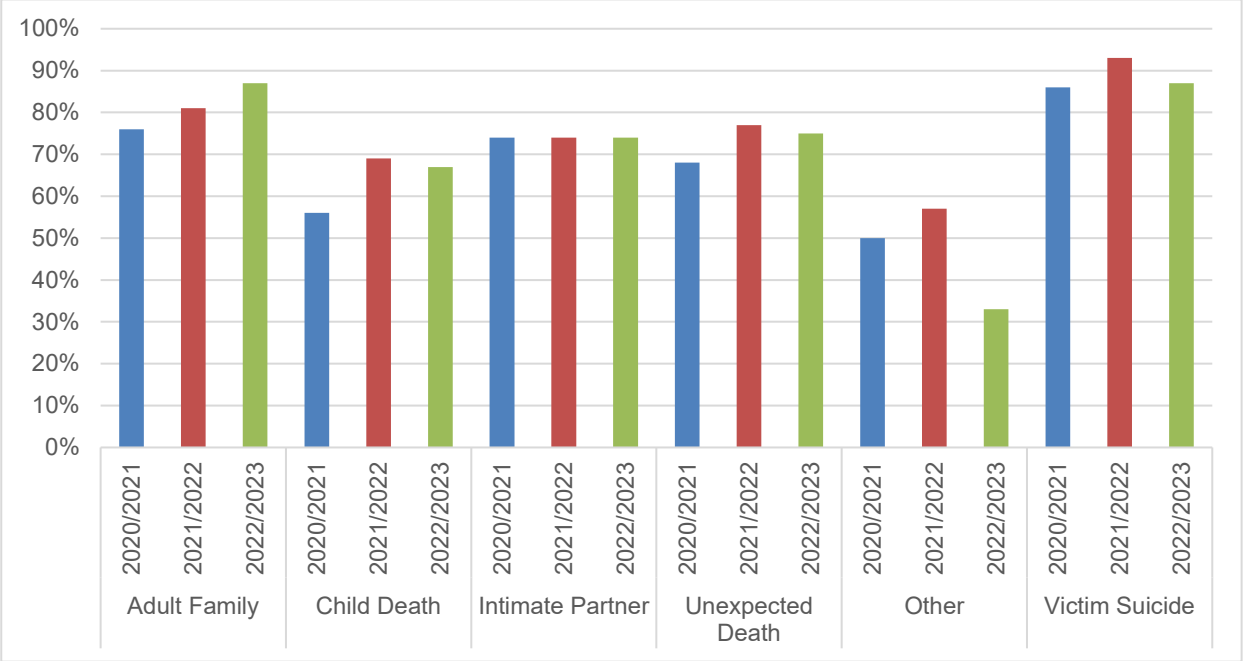
5.1 Suspect previously known to the police

Across the three-year dataset and including all typologies, 78% (n = 591/754) of suspects were previously known to the police for any reason (i.e., as a victim, suspect, vulnerable person, witness etc.). However, this varied by typology as illustrated by Figure 29.

As would be expected based on how the cases are identified, those most known to police were the prior domestic abuse perpetrators associated with SVSDA (89%, n = 204/229). Importantly, whilst the vast majority of cases of SVSDA will involve a victim and perpetrator who were known to the police prior to the death, there are cases in which the domestic abuse history is brought to the attention of the police only after the victim's death, potentially being known previously to other agencies, friends, or family members.

The suspects second most commonly known to the police were those associated with AFHs (81%, n = 101/125), followed by unexpected deaths (62%, n = 48/77) and child deaths (62%, n = 29/47). Finally, just over half (52%, n = 191/258) of suspects in IPHs were known to the police prior to the victim's death.

Figure 29 *Proportion of suspects known to police as a victim, suspect, vulnerable person or other circumstances – Year 1, 2 and 3*



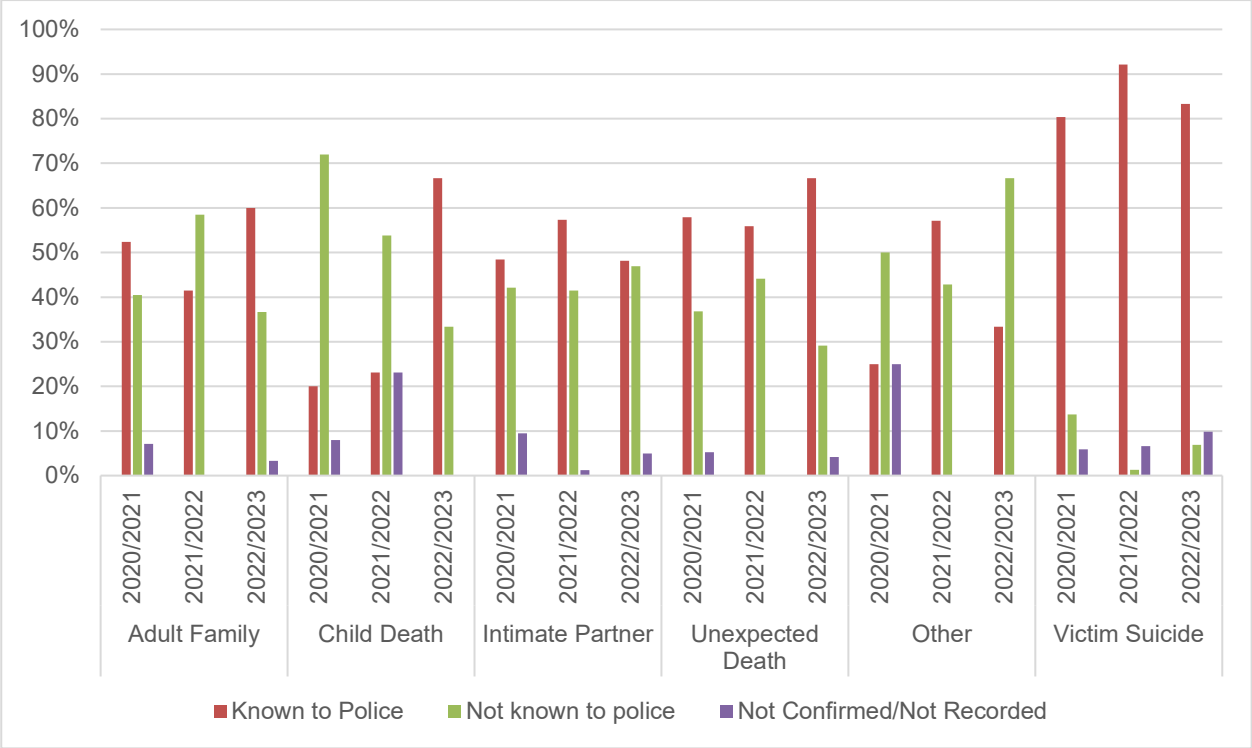
Source: Domestic Homicide Project

5.2 Suspect previously known to police for domestic abuse

The Project team coded a separate variable to record whether the suspect was previously known to police for domestic abuse offending (see Figure 30). Overall, 61% (n = 457/754) of suspects were known to the police for domestic abuse, as a suspect or perpetrator, prior to the victim's death. However, the inclusion of SVSDA (n = 229), which most often involve police knowledge of domestic abuse perpetration arising prior to the victim's death (86%, n = 196), does increase the proportion of suspects known within the overall dataset. Therefore, excluding cases of SVSDA, half (50%, n = 261/525) of suspects were known to the police for domestic abuse perpetration prior to the victim's death across the three-year dataset.

Within IPHs, the proportion of suspects previously known to the police for domestic abuse decreased by nine percentage points from Year 2 (57%, n = 47/82) to Year 3 (48%, n = 39/81). The proportion of prior domestic abuse perpetrators associated with SVSDA known to the police for domestic abuse also decreased by nine percentage points from Year 2 (92%, n = 70/76) to Year 3 (83%, n = 85/102). Conversely, the proportion of suspects known to the police for domestic abuse increased between Year 2 and Year 3 in unexpected deaths (56%, n = 19/34 to 67%, n = 16/24) and AFHs (42%, n = 22/53 to 60%, n = 18/30).

Figure 30 *Proportion of suspects known to the police for domestic abuse offending by typology – Year 1, 2 and 3*



Source: Domestic Homicide Project

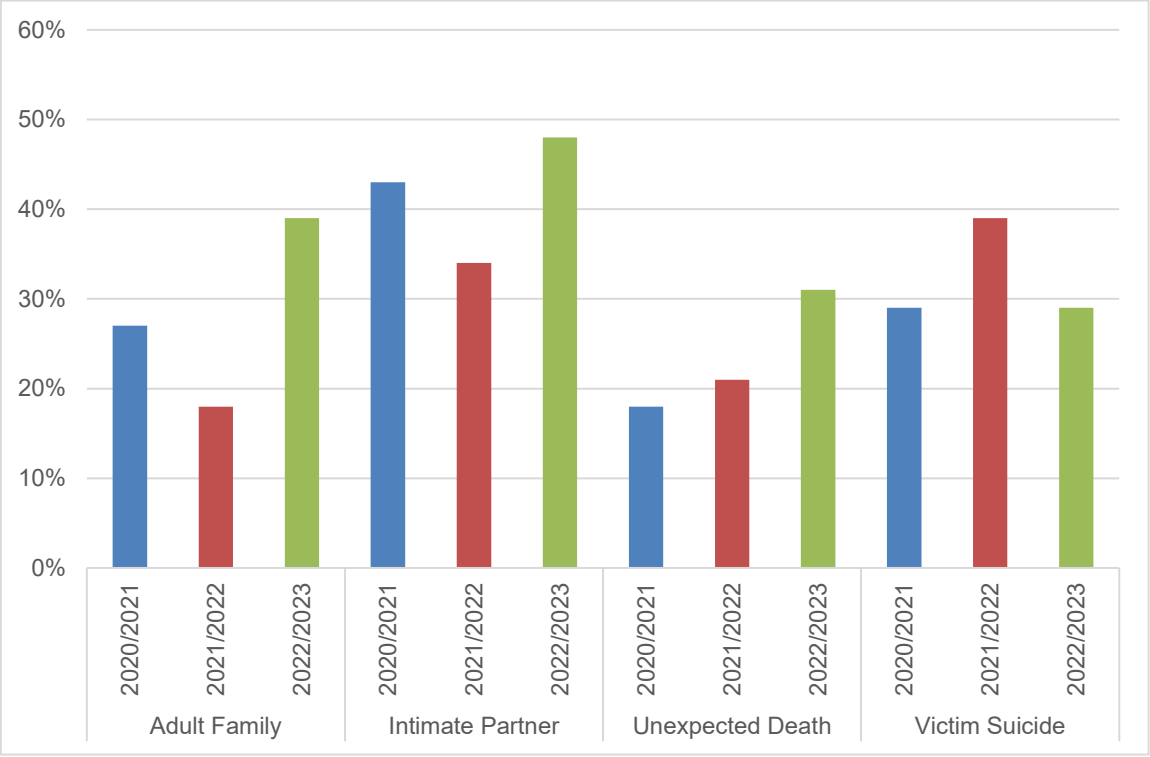
5.3 Suspect risk level and management

5.3.1 By case type

Data collection also captured whether the suspect was previously known to the police as a high-risk or serial perpetrator, previously referred to MARAC, and being managed by police or probation at the time of the death.

Of the suspects who were known to police for domestic abuse offending prior to the death, the proportion who were known as high-risk and/or serial perpetrators varied by typology (see Figure 31). Excluding child deaths and 'other' deaths due to the small sample size (both n = 1), the proportion of high-risk and/or serial domestic abuse perpetrators increased between Year 2 and Year 3 of data collection in IPHs (34%, n = 16/47 in Year 2 to 49%, n = 19/39 in Year 3), AFHs (21%, n = 4/22 to 39%, n = 7/18) and unexpected deaths (21%, n = 4/19 to 31%, n = 5/16). Conversely, there was a decrease of 10 percentage points in high-risk and/or serial domestic abuse perpetrators associated with cases of SVSDA (39%, n 27/70 to 29%, n = 25/85).

Figure 31 *Proportion of suspects known to police for domestic abuse offending and identified as high-risk or serial perpetrators by typology (excluding child and 'other' deaths) – Year 1, 2 and 3*

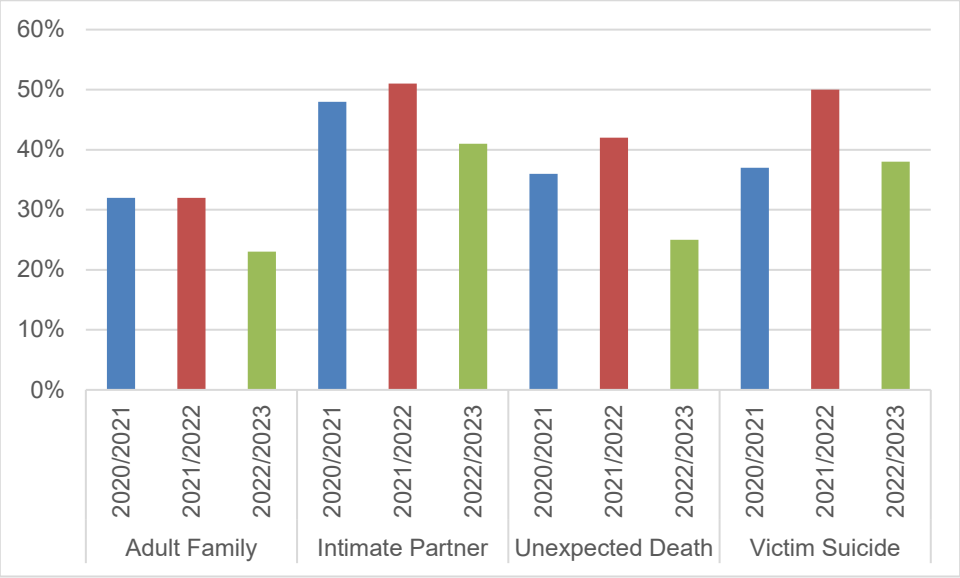


Source: Domestic Homicide Project

Second, considering suspects who were previously known to police for domestic abuse, some were also involved in cases which were referred to MARAC (see Figure 32). Excluding child and 'other' deaths, there were fewer suspects known to the police for domestic abuse that had been previously referred to MARAC in Year 3 as compared to Year 2 within AFHs (from 32%, n = 7/22 to 28%, n = 5/18), IPHs (from 51%, n = 24/47 to 41%, n = 16/39), unexpected deaths (from 42%, n = 8/19 to 25%, n = 4/16) and SVSDA

(from 50%, n = 35/70 to 38%, n = 32/85). Even with these decreases, consistent with the findings of the previous report (Bates et al. 2022), the data suggests that suspects of IPH and prior domestic abuse perpetrators in SVSDA are more likely to be referred to MARAC as compared to suspects within AFH cases.

Figure 32 *Proportion of suspects known to police for domestic abuse offending and referred to MARAC by typology (excluding child and 'other' deaths) – Year 1, 2 and 3*



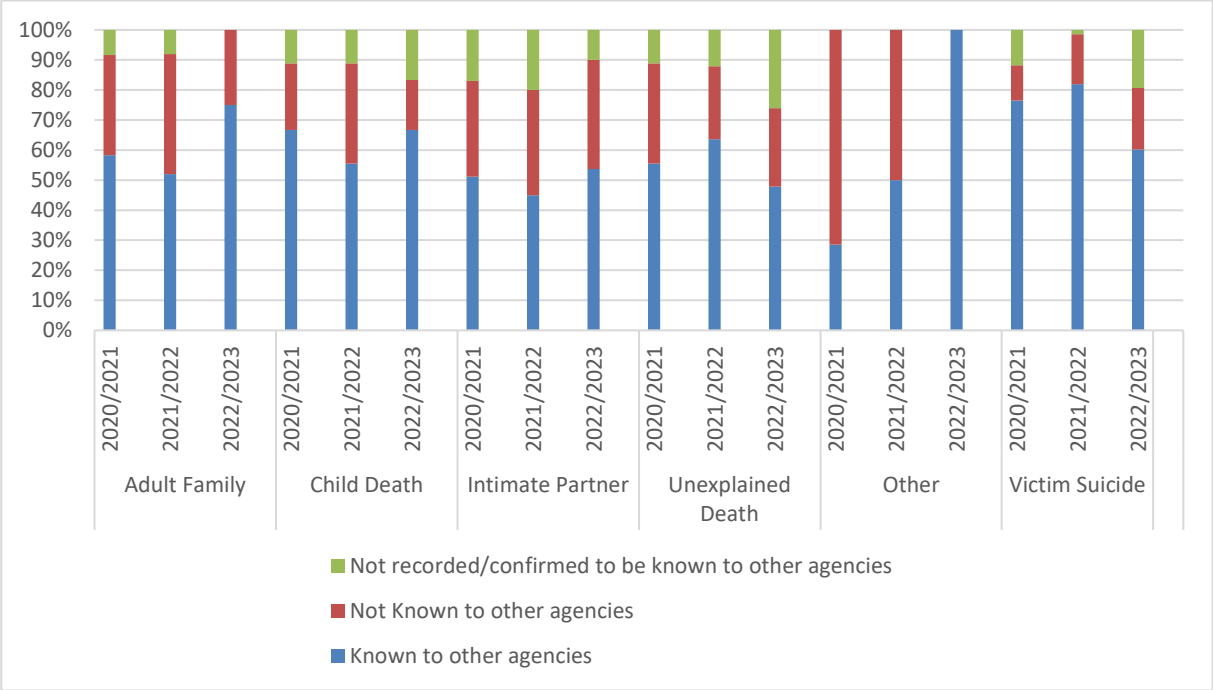
Source: Domestic Homicide Project

Third, across the three-year dataset (i.e., not only those known to police for domestic abuse) only a small proportion (10%, n = 75/754) of all suspects were recorded as having been previously managed by police or probation (e.g., under MAPPA, IOM, or DRIVE). When calculated as a proportion of just those suspects with previous police contact in any capacity, the proportion recorded as being previously managed by police or probation rose to 16% (n = 75/457). Notably, in Year 3, there were no suspects that were currently being managed by police or probation.

5.4 Suspect or victim previously known to other agencies

Across the three-year dataset (n = 701), in 60% of cases (n = 417) the victim and/or suspect was known to a partner agency. Conversely, 28% (n = 197) were not at all known and 12% (n = 87) were not recorded or confirmed to be known to a partner agency. Figure 33 shows the proportion of incidents known to partner agencies across all years, broken down by typology.

Figure 33 *Proportion of victims and/or suspects known to other agencies by typology (April 2020 – March 2023)*



Source: Domestic Homicide Project

In line with the broader dataset, in Year 3, in 59% (n = 138/233) of incidents the victim and/or suspect (or prior domestic abuse perpetrator in cases of SVSDA), was known to a partner agency. Conversely, in 41% (n = 95/233) of incidents the victim and/or suspect (or prior domestic abuse perpetrator in cases of SVSDA), were not at all known or not confirmed to be known to a partner agency.

Across the three-year dataset, in cases where the suspect was not previously known to police for any reason (n = 145), the suspect and or victim were known to a partner agency in 39% (n = 57) of cases. This highlights that safeguarding domestic abuse victims is a collective responsibility and requires a multi-agency approach. The victim and or suspect/prior domestic abuse perpetrator were most commonly known to partner agencies in SVSDA (71%, n = 154/216), followed by child deaths (64%, n = 21/33), AFHs (60%, n = 68/114) and IPHs (50%, n = 124/248). These findings highlight the importance of multi-agency work to prevent domestic homicides and suicides following domestic abuse (Home Office, 2022b).

For cases in Year 3 (n = 233) (excluding multi-agency forums that would involve police contact, e.g., MARAC, MATAC, MASH), the victim and/or suspect was most often known to mental health services (25%, n = 59), followed by children's social services (18%, n = 41), GP/health services (10%, n = 23) and adult social services (9%, n = 22).

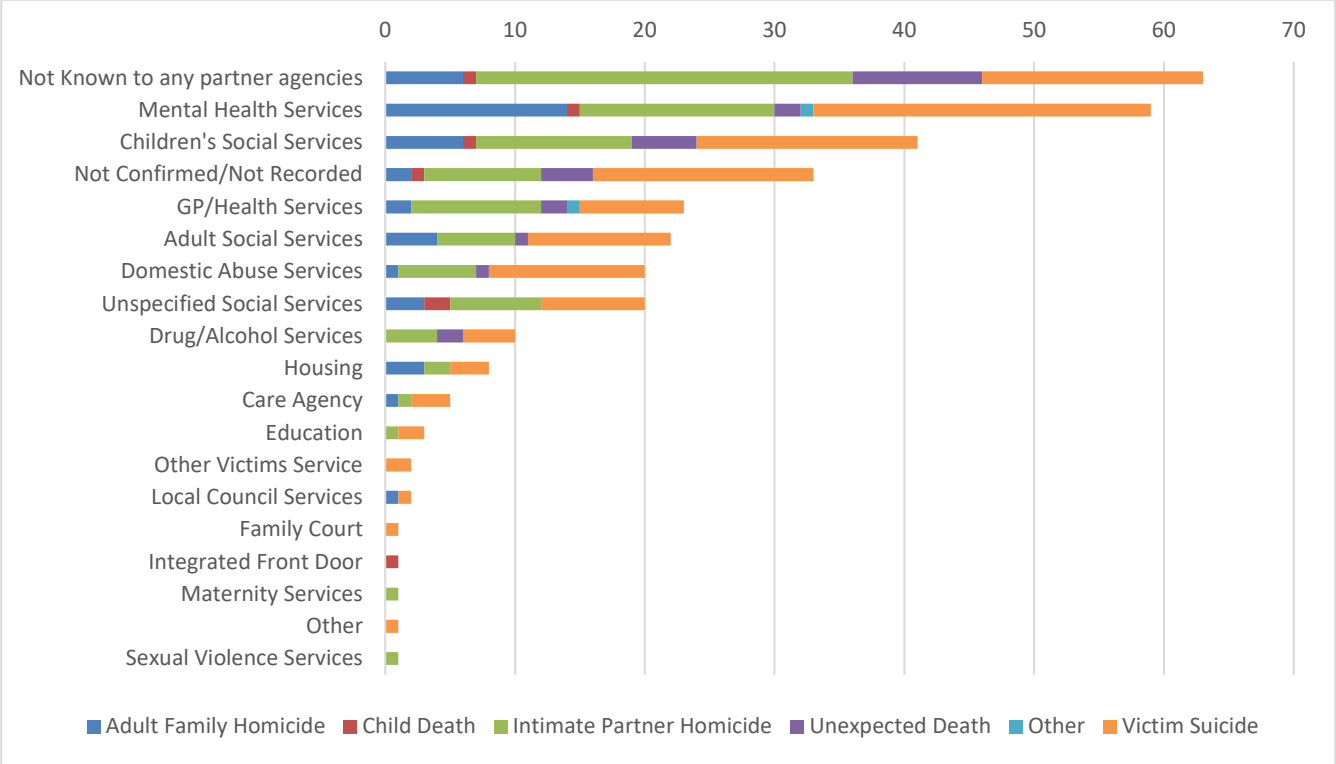
In line with the overall Year 3 dataset, within IPHs (n = 80), the agencies which victims and suspects were most often known to were mental health services (19%, n = 15), followed by children's social services (15%, n = 12), GP/health services (13%, n = 10) and adult social services (8%, n = 6).

Second, within SVSDA (n = 93), victims and prior domestic abuse perpetrators were most often known to mental health services (28%, n = 26), followed by children's social services (18%, n = 17), domestic abuse services (13%, n = 12) and adult social services (12%, n = 11). These figures show the relevance of offering multi-agency support to domestic abuse victims, which has been recognised as a risk factor for suicide in the Suicide Prevention in England: 5-year cross-sector strategy (Department of Health and Social Care, 2023).

Third, within AFHs (n = 28), suspects and victims were most commonly known to mental health services (50%, n = 14), followed by children's social services (21%, n = 6), adult social services (14%, n = 4) and housing (11%, n = 3).

Finally, within unexpected deaths (n = 23), the majority of cases were either not known or not confirmed to be known to any other agencies (61%, n = 14). For suspects and/or victims that were known, they were most commonly known to children's social services (22%, n = 5), followed by drug and alcohol services, health services and mental health services (9%, n = 2 for each agency). Figure 34 shows the proportion of victims and/or suspects known to a range of specific agencies by typology in Year 3.

Figure 34 *Number of victims and/or suspects known to other agencies by agency and typology (Year 3)*



Source: Domestic Homicide Project

Click here to return to the summary findings and recommendations for Chapter 5

Chapter 6 – Case review referral and acceptance rates

6.1 DHRs and other types of reviews

Every domestic homicide and suicide where there is a history of domestic abuse should be referred by the police or other agency to the local Community Safety Partnership, which makes a decision on whether the case meets the criteria to be accepted for a DHR or another type of review (e.g., Safeguarding Adult Review (SAR).[20] As in previous reports (Bates et al. 2021, 2022), the Project team also requested information from police on whether each case was being referred, by them or by another agency), to the Community Safety Partnership for a DHR (or another type of review), and then whether that referral was accepted.

Overall, excluding child death and unexpected death cases (n = 107), whether or not a case had been referred to the Community Safety Partnership for a DHR or other type of review was known in 86% of cases (n = 511/595), see Table 6 below: variable = '% of incidents known if referred'. Of those cases that were referred, 60% (n = 305/511) were accepted for a DHR or other type of review, decreasing from 76% (n = 148/195) in Year 2 to just 41% (n = 75/182) in Year 3. However, when cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 84% (n = 305/511) overall (85%, n = 82/97 in Year 1, 90%, n = 148/165 in Year 2, and 76%, n = 75/99 in Year 3). Therefore, where the referral outcome was known and recorded, only 16% (n = 56/361) of cases which were referred for DHR or other types of review were not accepted.

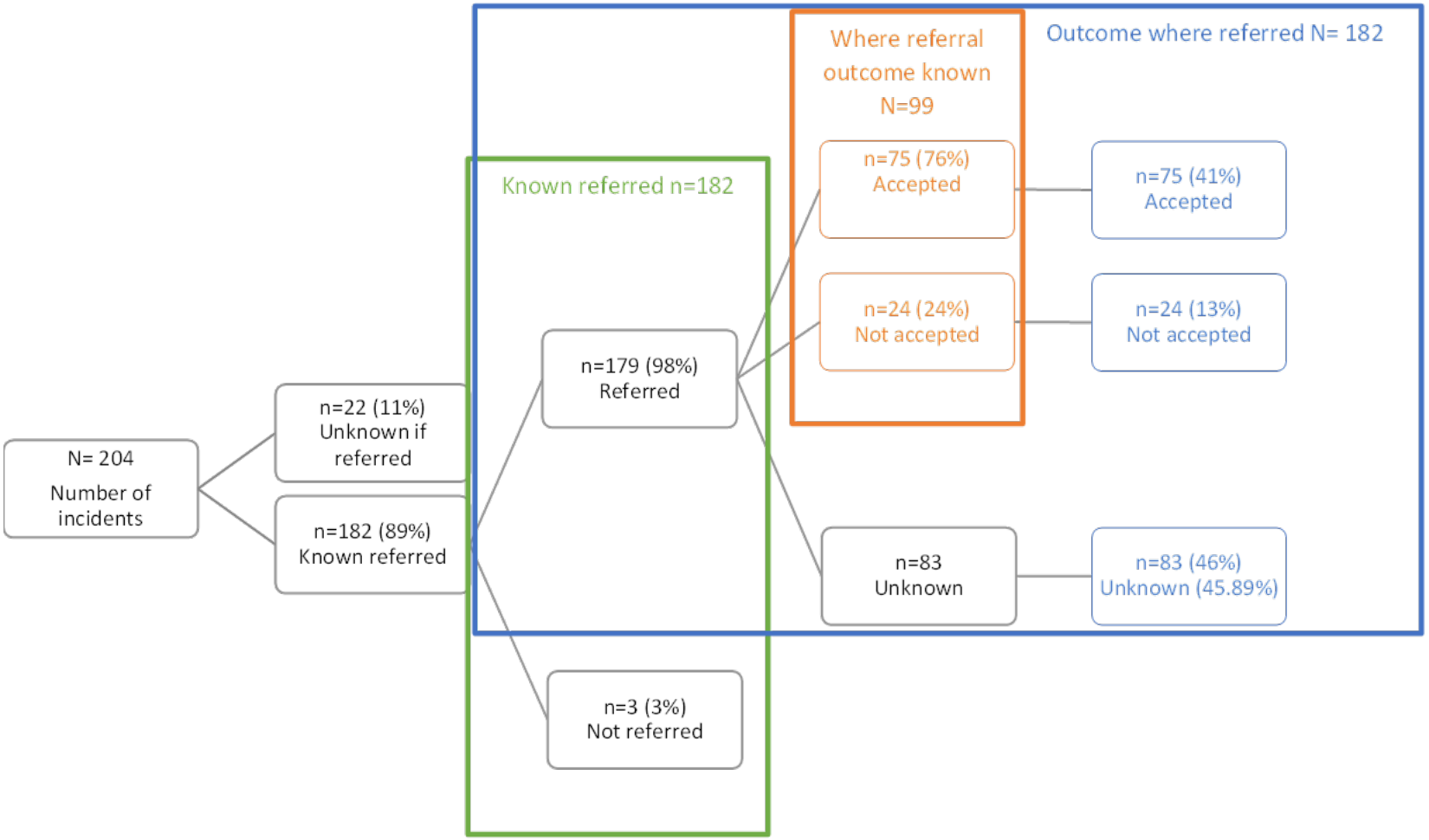
[20] Whilst most referrals (in all cases excluding child deaths) will be for a DHR, the Project team identified several cases which were instead referred/accepted for an SAR or other type of review process. Data cleaning will allow specific separation and analysis in future reports, but they are currently reported together.

Table 6 *DHR (or other type of review) referral and acceptance status – Year 1, 2 and 3*

	DHR or Other Type of Review Referral and Acceptance Status (excluding child deaths and unexpected deaths)							
	2020/2021		2021/2022		2022/2023		Total	
Referral/Acceptance Status	N	%	N	%	N	%	**N**	**%**
% of incidents known if referred	134	*73%*	195	*94%*	182	89%	**511**	***86%***
% of incidents referred (where known)	128	*96%*	191	*98%*	179	98%	**498**	***97%***
% of incidents accepted (where referred)	82	*61%*	148	*76%*	75	41%	**305**	***60%***
% of incidents accepted (where referred and referral outcome known)	82	*85%*	148	*90%*	75	76%	**305**	***84%***
% of incidents not accepted (where referred)	15	*11%*	17	*9%*	24	13%	**56**	***11%***
% of incidents not accepted (where referred and referral outcome known)	15	*15%*	17	*10%*	24	24%	**56**	***16%***

Source: Domestic Homicide Project

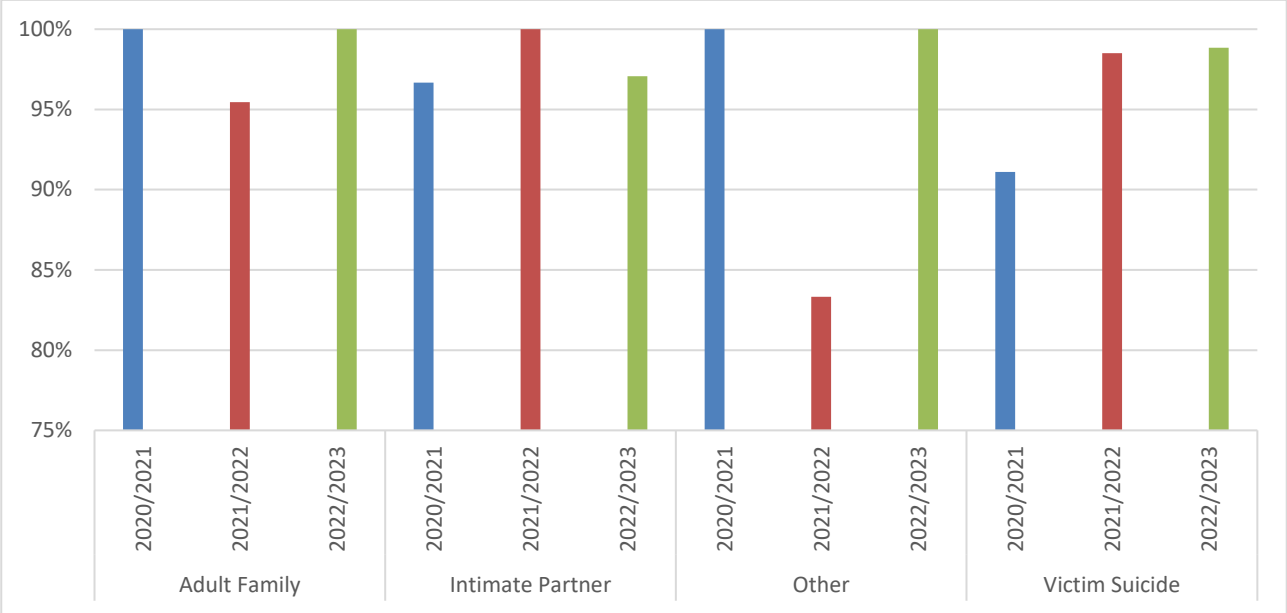
Figure 35 *Flow chart example from Year 3 cases to illustrate analysis process*



Source: Domestic Homicide Project

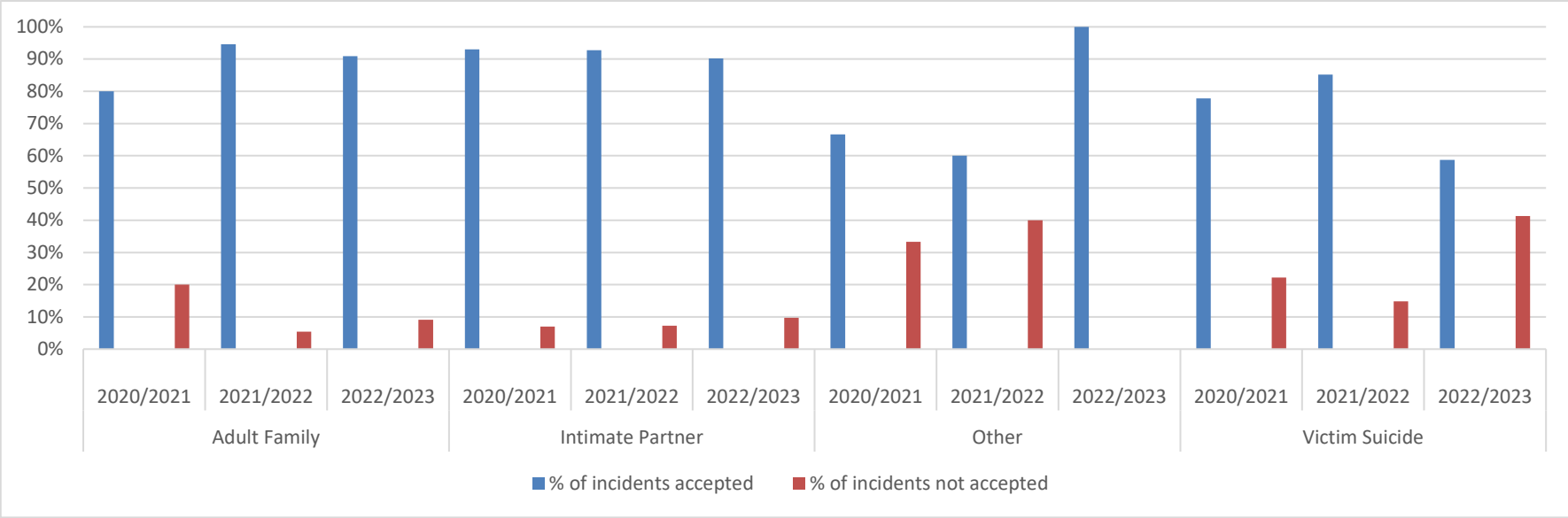
Figure 36 and 37 below present the figures for DHR (or other type of review) referral and acceptance rate by typology. Whilst much of this data is in line with the overall dataset, the referral/acceptance rate is an area of interest given ongoing work by the Home Office to update the name and definition used within DHRs, particularly in relation to cases of SVSDA. For SVSDA, 41% (n = 19/46) of cases were not accepted upon referral for a review in Year 3. This high proportion of non-acceptance rate is notable compared to Year 2 (15%, n = 8/54) and Year 1 (22%, n = 8/36) where samples were considerably smaller.

Figure 36 *DHR or other type of review referral rate by typology, where referral outcome was known (excluding child deaths and unexpected deaths) – Year 1, 2 and 3*



Source: Domestic Homicide Project

Figure 37 *DHR or other type of review acceptance rate by typology, where acceptance outcome was known (excluding child deaths and unexpected deaths) – Year 1, 2 and 3*



Source: Domestic Homicide Project

Click here to return to the summary findings and recommendations for Chapter 6

Chapter 7 – Suspected victim suicide following domestic abuse: Additional analysis and findings from consultation event with bereaved family members

7.1 Suspected victim suicide following domestic abuse additional analysis:

In last year's report (Bates et al. 2022, see Chapter 10), the Project team produced an in-depth analysis of SVSDA. As the Project's dataset is unique and provides a contribution to the growing literature in this field, this section provides updated findings focused on a review of the 93 cases identified within the Year 3 dataset (associated with n = 102 prior domestic abuse perpetrators/suspects). Previous sections described the monthly changes reported throughout the year, victim and suspect characteristics (such as age, sex, ethnicity), notable risk factors and previous police contact within the typology of SVSDA (see Chapter 2 to Chapter 5). The analysis described below delves deeper into emerging themes and key findings from last year, such as differences in cases involving male and female victims, younger victims, cases involving LGBTQ+ victims and suspects, prominence of CCB and overlapping risk factors, as well as any references to attempted posthumous prosecution.

7.1.1 Sub-typology and relationship between victim and suspect:

Of the 93 victims of SVSDA in Year 3, 91% (n = 85) had a history of domestic abuse perpetrated against them (exclusively) by a current or ex- intimate partner. As noted in previous years, this suggests that the characteristics of these cases would most closely mirror those found intimate partner homicides. However, 4% (n = 4/93) of victims had a history of abuse perpetrated by one or more family members, and in 3% (n = 3/93) of cases the victims had a recorded history of abuse by both intimate partner(s) and family member(s).[21] Additionally, six submissions included details of more than one prior domestic abuse perpetrator.

Looking at the specific relationship of the prior domestic abuse perpetrator to the victim, 49% (n = 50/102) were the victim's ex-intimate partner/spouse and 42% (n = 43/102) were the victim's current intimate partner/spouse. Additionally, four prior domestic abuse perpetrators were the victim's child, two were the victim's parent (both being mothers), one was the victim's grandparent (grandfather), and one was the victim's sibling (sister).[22] Notably, 47% (n = 38/102) of prior domestic abuse perpetrators were currently living with the victim at the time of the death (always, usually, or sometimes), including five cases in which the victim and prior domestic abuse perpetrator were ex-intimate partners.

[21] In one case the sub-typology of prior abuse was not known or not recorded.

[22] In one case the relationship between the victim and suspect was not recorded.

7.1.2 Sex of the victims – differences and similarities:

In Year 3, the vast majority of victims of SVSDA were female (74%, n = 69/93). However, a larger proportion of male victims of SVSDA were recorded in Year 3 (26%, n = 24/93) as compared to Years 1 and 2 (12%, n = 6/51 in Year 1 and 19%, n = 14/72 in Year 2; See Chapter 2). Whilst the dataset of SVSDA has grown year on year, it is not known why there would be an increase in the proportion of male victims. It will be important to consider this as data collection continues. Last year's report identified a dynamic within cases involving male victims who were known to the police as both a victim and suspect or perpetrator of domestic abuse (Bates et al. 2022, Chapter 10). This was specific to those cases involve a male victim of SVSDA and a female intimate partner as the prior perpetrator, with the female partner also known as a victim of domestic abuse. However, the Project team raised a question of whether similar findings would be seen in cases involving female victims of SVSDA.

When looking at the cases where the prior domestic abuse perpetrator was also known as a victim of domestic abuse (28%, n = 28/102), this showed that exactly half (n = 14) were recorded as cases involving a male victim and half (n = 14) involving a female victim.[23] Looking in more depth at the details of the previous domestic abuse perpetration, coding of the history of domestic abuse was undertaken to identify potential primary perpetrators of the prior domestic abuse. This coding decision was made not only looking at the number of police recorded incidents in which each party was listed as a victim or suspect of domestic abuse against one another, but also considering the records of abuse assessed as high risk, demonstrating CCB, and/or involving the pursuit of a criminal charge. The available options for coding were that the prior domestic abuse perpetrator was a) primarily a perpetrator of domestic abuse, b) primarily a victim of domestic abuse or, c) no primary victim or perpetrator (i.e., similarly known as a victim and suspect/perpetrator of domestic abuse as compared to the victim of SVSDA).

Of the 14 cases involving male victims, 13 involved female prior domestic abuse perpetrators. Within these, there were two cases in which the female was identified primarily as the perpetrator. On the other hand, coding identified seven cases in which the female suspect was primarily recorded as a victim, and four cases whereby there was no identifiable primary perpetrator or victim based on the available information. In the case involving a male victim and male prior domestic abuse perpetrator, there was not enough information to determine the primary perpetrator of the abuse. However, this male victim was also associated with two female prior domestic abuse perpetrators, one of which was primarily known as a perpetrator (victim's mother) and the other (ex-partner) was primarily known as a victim.

In contrast, of the 14 female victims, 12 involved male prior domestic abuse perpetrators. These include 10 cases in which the male was identified primarily as the perpetrator of the

[23] Please note that in one case the male victim was associated with two prior domestic abuse perpetrators who were also known as victims of domestic abuse, including the victim's mother and male ex-partner.

previous domestic abuse. There were no cases identified in which the male was primarily recorded as the victim, and two cases whereby there was no identifiable primary perpetrator or victim. The remaining two cases involved female victims and female prior domestic abuse perpetrators, both of which identified the female 'suspect' as the primary domestic abuse perpetrator.

This initial analysis would suggest that cases of male victims of SVSDA are more likely than those of female victims to involve a police-recorded history of domestic abuse in which the deceased was known as the primary perpetrator of domestic abuse. However, there are several limitations to the data that must be considered, and further research is necessary to draw any conclusions. First, this coding is based on the free text provided in the submission form that utilises details available on police systems and that were selected for inclusion by the submitter. This means there may be additional information available that was not included on the form. Second, in some cases where there is only a count of recorded crime and non-crime domestic abuse incidents it is not possible to identify which, if any, of those were assessed as high risk or involved a pattern of CCB.

Third, this analysis is based on information that has been reported to the police and could also involve counter and/or false allegations of abuse. Academic literature has considered how female victims/survivors of domestic abuse are perceived within the criminal justice system, including recent research from Barlow (2023) who found that the police use of body-worn camera footage may have unintended consequences for female victims/survivors of CCB since the abuse may not be 'visible' during the initial response. This includes where they do not appear to represent an 'ideal victim' on camera, or the footage appears to 'discredit' their later accounts delivered in court or victim statements when the extent of CCB may be better understood (ibid). Moreover, in some cases, the offending of women who have been subjected to domestic abuse and other forms of VAWG can result from their experience of abuse in ways that are not considered within the criminal justice system (The Centre for Women's Justice, 2022).

7.1.3 Younger victims:

Other findings from last year's report (Bates et al. 2022, Chapter 10) include an increase in the proportion of victim of SVSDA aged 16 to 24. Within the Year 3 dataset, just 10% (n = 9/93) of victims were aged 16 to 24. Within these cases, all victims were recorded as female and prior domestic abuse perpetrators as male. As found previously, the risk factors of a history of CCB (55%, n = 5/9) and mental ill health (44%, n = 4/9) were relatively common in relation to the prior domestic abuse perpetrator. However, the involvement of universities and university support services was not apparent within the recorded case details in Year 3.

7.1.4 LGBTQ+ victims and suspects:

Last year's annual report (Bates et al. 2022) also commented on an increase in victims recorded as LGBTQ+, particularly within cases of SVSDA following domestic abuse. In

Year 3, of the 93 victims of SVSDA, 6% (n = 6) were recorded as being LGBTQ+,[24] which was slightly less than the number and proportion recorded in Year 2 (11%, n = 8/76). Of the six LGBTQ+ victims of SVSDA, three were recorded as female and three were recorded as male. Two of these six cases involved prior domestic abuse perpetrators who were family members (a grandfather of a female victim, and a mother of a male victim). In the second case, the male victim was associated with four separate prior domestic abuse perpetrators including three ex-partners as well as his mother. The remaining cases involved a history of domestic abuse exclusively between intimate partners.

7.1.5 Prior contact and prominent risk factors:

Within the Year 3 dataset of SVSDA, 83% (n = 85/102) of prior domestic abuse perpetrators had a history of domestic abuse offending that was known to the police. Of the prior domestic abuse perpetrators who were known to the police for domestic abuse offending prior to the victim's death, 38% (n = 32/85) had previously been subject to a MARAC referral (as a perpetrator) and 29% (n = 25/85) were known as high risk or serial domestic abuse perpetrators (see also Chapter 5).

In Year 3, the most commonly reported risk factor in cases of SVSDA was a recorded history of CCB (47%, n = 48/102, see Chapter 4). Whilst this is lower than the corresponding proportion within Year 2 (61%, n = 46/76), it is higher than the proportion of Year 3 IPH cases with a recorded history of CCB (36%, n = 29/81). Additionally, of the 48 cases of SVSDA involving a history of CCB, 79% (n = 38) of victims were female.

Considering other risk factors potentially associated with CCB, 20% (n = 20/102) of cases identified a history of non-fatal strangulation. This is an increase from Year 2 (9%, n = 7/76) and may reflect greater awareness based on the criminalisation of non-fatal strangulation in the Domestic Abuse Act 2021. Moreover, all 20 victims in the Year 3 cases were recorded as female and associated prior perpetrators as male. To examine overlapping variables, within those cases with a history of CCB, 27% (n = 13/48) also identified the risk factor of non-fatal strangulation.

Moreover, looking at the risk factor of the relationship ending (or separation), which can lead to an escalation of CCB (Monckton Smith, 2020), this risk factor was identified in 56% (n = 27/48) of cases in which CCB was also an identified risk factor. Relatedly, last year's report (Bates et al. 2022, Chapter 8) identified an increase in the number of cases involving a recent child custody dispute (from 6%, n = 5/51 in Year 1 to 12%, n = 9/76 in Year 2). In Year 3, this overall proportion of cases remained level (11%, n = 11/102). Notably, 8 of the 11 (73% of) cases of SVSDA with the risk factor of a child custody dispute also had an identified history of CCB. Additionally, Chapter 5 findings showed that contact with children's social care was relatively common in cases of SVSDA (18%, n = 17/41).

[24] Similar to recorded victim characteristics, in Year 3, 6% (n = 6) of the 102 associated prior domestic abuse perpetrators were recorded as being LGBTQ+.

Similarly relating to partner agency contact, Chapter 5 listed mental health services as the most common agency (other than the police) to have contact with the victim and/or prior domestic abuse perpetrator in cases of SVSDA (28%, n = 26/60) in Year 3. Moreover, 24% (n = 24/102) of prior domestic abuse perpetrators had a recorded risk factor associated with mental ill health. Further highlighting the importance of mental health services in these cases, 40% (n = 37/93) of SVSDA were recorded as having mental health care needs.

7.1.6 Qualitative analysis of cases involving a history of coercive controlling behaviour

The Project team qualitatively analysed those cases where CCB was identified as a risk factor to identify any emerging themes. As in the previous report (Bates et al. 2022, Chapter 7), the history of CCB described within submissions was identified by the police in three different ways:

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

CCB can involve a pattern of abuse behaviour including threats, intimidation, degradation, isolation from family and friends, emotional and financial or economic abuse, jealousy, microregulation, monitoring and surveillance. This pattern of coercion and control can then be (re)enforced by physical and sexual violence (Barlow et al., 2020; Barlow and Walklate, 2022; Myhill, 2015; Stark, 2007).

Below are two examples which illustrate how CCB presented within cases of SVSDA, also describing their associated contact with the police. One case involves a female victim and other a male victim:

- The first case involved a female victim and male domestic abuse perpetrator, the victim's ex-partner. In this case the victim reported that he controlled what she wore and would assault her if she dressed 'too nicely' in front of other men, she could not wear makeup or go anywhere on her own, such as the gym, where he thought others would be looking at her. She did not have access to her own bank card and the police-recorded history described his threats to kill the victim, use of non-fatal strangulation and two referrals to MARAC as a high-risk case. The victim was said to be 'petrified' of her ex-partner and feared escalation when she ended the relationship prior to her death. The domestic abuse perpetrator was on bail for criminal damage and non-fatal strangulation at the time of the victim' death.

- The second case involved a male victim and female domestic abuse perpetrator who was the victim's current partner at the time of his death. The victim reported her as checking his bank account and raising questions as to his whereabouts, also trapping him by threatening to reveal the victim's sexuality if he attempted to leave the relationship. The victim had recently moved out prior to his death by suicide. It is unknown whether the allegations of CCB were pursued or are still under investigation, but the alleged perpetrator had not been charged at the time of submission.

Additionally, at least three cases specifically mentioned the use of rape and sexual assault. In one of these cases the victim reported rape whilst providing evidence of CCB, in line with findings from Operation Soteria Bluestone (Stanko, 2022). This case involved a female victim and male domestic abuse perpetrator who was her ex-husband, the victim described being financially manipulated into use of her life savings, her ex-husband monitoring her movements and preventing her from spending time with her friends and family, saying that she was physically and sexually assaulted if she ever 'stepped out of line'. The victim's suicide note described the abuse which was said to have gone unrecognised within the (Family) Court system.

7.1.7 Evidence of attempted posthumous prosecution:

Within the Year 3 cases of SVSDA, only one was listed as having achieved a charge following the death of the victim. In this case, the charges were for two recent assaults occasioning actual bodily harm (ABH), non-fatal strangulation, harassment and the breach of a restraining order.

In a further five cases, whilst no charges were confirmed, an investigation was said to be ongoing at the time of submission. These include one investigation of unlawful act manslaughter, and four for CCB, two of which included investigations of rape and non-fatal strangulation, and one which involved CCB identified by friends and family members. In a sixth case an ongoing investigation of rape was closed due to the death of the victim.

Also highlighting the use of professional curiosity and an investigative mindset, one officer who considered the scene of a suspected suicide as suspicious due to the history of domestic abuse including CCB ensured this was raised to a supervisor and included input from the Criminal Investigation Department (CID).

Though still a minority of cases, examples such as these provide evidence of the improvements in recognising and responding to SVSDA by working to hold the prior domestic abuse perpetrators to account.

7.2 Consultation event with bereaved family members

The previous year's report (Bates et al. 2022) described the Project's consultation and listening event with the charity Advocacy After Fatal Domestic Abuse (AAFDA) and the bereaved family members whom they support. AAFDA, led by Frank Mullane, ably supports bereaved families in navigating Coronial and Domestic Homicide Review processes after domestic homicides and unexpected deaths and SVSDA, providing specialist advocacy and peer support for families.

In February 2023, the Project team held a follow up consultation with the same group, as well as additional family members, the Domestic Abuse Commissioner Nicole Jacobs and representatives from the Home Office. The aim of this second consultation was to discuss the progress since our last event, and to listen to families' experiences and suggestions about how they felt police, government and other agencies might improve the response to victims/survivors experiencing domestic abuse and agencies' responses after a death occurred. We are tremendously grateful to all the families who gave their time and shared their perspectives and experiences with us. Their resilience, courage and determination to lift up the voices and honour the lives of their loved ones is remarkable.

To begin the event, the Project team presented the key findings on SVSDA, describing how previous comments influenced the Project's recommendations around the police identification and response to SVSDA and the associated review processes (See Chapters 6 and 10 in Bates et al. 2022). One key development were the requirements within National College of Policing guidance around the oversight of any unexpected death, including suspected suicides, by Senior Investigating Officers of specified levels of training. This followed from concerns voiced last year about who attends and oversees investigations of unexpected or sudden deaths, aiming to ensure that any evidence of a history or ongoing domestic abuse is considered at the earliest opportunity. Appendix A provides an update around how police forces and relevant organisations have responded to the Project's recommendations.

At the event in February 2023, the second half of the day focused on hearing from bereaved family members and listening to what they consider to be the biggest challenges for the police response to (fatal) domestic abuse, and what they would ask of the police and other government representatives in attendance to improve practice.

Several themes were evident within points relevant to the police, such as: standardising policy and practice across forces; recognition of support required for those victim/survivors

assessed as standard or medium risk since they may still be at high risk of suicide; the ability of victim-blaming language to undermine an investigation; and the importance of oversight, supervision, training, specialised teams and professional curiosity.

Families also raised points relevant to wider government and partnership working, including: ending the 'post-code lottery' of service provision and siloed working within and across organisations; raising the status of unexpected deaths, SVSDA and domestic homicide to ensure appropriate funding; for bereaved family members to be named as victims and have a voice in the Victims' Bill; ensuring appropriate DHR referrals for cases of SVSDA; recognition that domestic abuse perpetrators are not safe parents; facilitating co-location of agencies within a 'one-stop-shop' service; and, not to allow the cross-examination of family members of the victim by the perpetrator during inquest proceedings in Coroner's Court.

Moreover, the families provided a list of proposed reforms to the Multi-Agency Risk Assessment Conference (MARAC) process, like making it MARAC statutory responsibility and following a duty of disclosure; listening to third-party referrals from families; ensuring accountability for follow up of agreed actions and, improving systems and communications to facilitate collective working, such as through live access to organisational systems and sharing minutes with those unable to attend.

Whilst we must acknowledge that not all suggestions raised by the families are within the purview of this Project team, they have informed the findings and recommendations in this report with the belief that this work can help improve the experiences of future victims/survivors and their families. We plan to continue our consultation work with AAFDA to facilitate continued developments to guidance, policy and practice.

Click here to return to the summary findings and recommendations for Chapter 7

Report Conclusion

In summary, this report has presented new analysis of domestic homicides, unexpected deaths and SVSDA, drawing on three years' worth of data collected by the Domestic Homicide Project. The report shared the number of deaths by typology, victim and suspect characteristics (e.g., age, sex, ethnicity), case characteristics, risk factors, and police and other agency contact associated with deaths between the 1st April 2020 and 31st March 2023, highlighting any notable changes between years of data collection.

The findings, such as demographic differences by typology (e.g., intimate partner as compared to AFH), low proportion of suspects managed by the police or probation and prevalence of contact with partner agencies (e.g., mental health services and children's social services), inform the Project's recommendations for practice. These recommendations provide direction for future work by the police (local forces, National Police Chiefs' Council (NPCC), College of Policing), Crown Prosecution Service (CPS), Home Office, and associated multi-agency partners involved in safeguarding victims of abuse.

Notably, an in-depth focus on SVSDA continues to improve knowledge and understanding about the scale and nature of these deaths that is not available elsewhere. The findings from an analysis of Year 3 cases identified differences in dynamics of the abuse associated with male and female victims, prevalence of LGBTQ+ victims and suspects, as well as co-occurrence of risk factors such as CCB, separation and previous non-fatal strangulation, all of which have implications for prevention. The Project's research also appears to have facilitated increased attempts to pursue the posthumous prosecution of domestic abuse perpetrators.

This report demonstrates the importance of continuing to collect this unique, rich and detailed dataset to track progress on, and further develop, efforts to reduce and prevent future domestic homicides and SVSDA.

References

Aitken, R. & Munro, V. (2018). *Domestic abuse and suicide: exploring the links with Refuge's client base and work force*. London: Refuge. http://wrap.warwick.ac.uk/103609/

Asad, N., Karmaliani, R., Sullaiman, N., Bann, C., McClure, E., Pasha, O., Wright, L., & Goldenberg, R. (2010). Prevalence of suicidal thoughts and attempts among pregnant Pakistani women. *Acta Obstetricia et Gynecologica Scandinavica*, *89*(12), 1545–1551. https://doi.org/10.3109/00016349.2010.526185

Barlow, C., Johnson, K., Walklate, S., & Humphreys, L. (2020). Putting Coercive Control into Practice: Problems and Possibilities. *British Journal of Criminology, 60*(1), 160-179. https://doi.org/10.1093/bjc/azz041

Barlow, C., & Walklate, S. (2022) *Coercive Control*. London: Routledge.

Barlow, C. (2023) 'How Can You Capture What is Hidden?' Police Body-Worn Cameras and Coercive Control. *Journal of Gender Based Violence*, 7(1): 163-167. https://doi.org/10.1332/239868021X16436467287647

Bates, L., Hoeger, K., Stoneman, M.J., & Whitaker, A. (2021). *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*. Vulnerability Knowledge and Practice Programme (VKPP). https://www.vkpp.org.uk/assets/Files/Domestic-Homicides-and-Suspected-Victim-Suicides-2021-2022/VKPP-Domestic-Homicides-and-Suspected-Victim-Suicides-2020-2021.pdf

Bates, L., Hoeger, K., Nguyen Phan, T., Perry, P., & Whitaker, A. (2022). *Domestic Homicides and Suspected Victim Suicides 2021-2022.* Vulnerability Knowledge and Practice Programme (VKPP). https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

Butterby, K. & Donovan, C. (2023). The Impact of Police 'Process-Driven Responses' on Supporting Lesbian, Gay, Bisexual and/or Transgender + Victim-Survivors of

Domestic Abuse in England. *Journal of Family Violence.* https://doi.org/10.1007/s10896-023-00608-5

Card, D., & Dahl, G.B. (2011). Family Violence and Football: The Effect of Unexpected Emotional Cues on Violent Behavior,' *The Quarterly Journal of Economics*, *126*(1), 103–143. https://doi.org/10.1093/qje/qjr001

Cavanaugh, C., Messing, J., Del-Colle, M., O'Sullivan, C., & Campbell, J. (2011). Prevalence and Correlates of Suicidal Behavior among Adult Female Victims of Intimate Partner Violence. *Suicide & Life-threatening Behavior, 41*(4), 372-383. https://doi.org/10.1111/j.1943-278X.2011.00035.x

Centre for Women's Justice (CWJ) (2022) Double Standard: The Unjust Criminalisation of Victims of Violence Against Women and Girls. https://static1.squarespace.com/static/5aa98420f2e6b1ba0c874e42/t/6241a370051da468f5ba42d3/1648468856173/DS+FINAL+REPORT.pdf

Chang, E., Kahle, E., & Hirsch, J. (2015). Understanding how Domestic Abuse is Associated with greater Depressive Symptoms in a Community Sample of Female Primary Care Patients: Does Loss of Belongingness Matter? *Violence Against Women*, *21*(6), 700–711. https://doi.org/10.1177/1077801215576580

Christodoulou, C., Douzenis, A., Papadopoulos, F., Papadopoulou, A., Bouras, G., Gournellis, R., & Lykouras, L. (2012). Suicide and seasonality. *Acta Psychiatrica Scandinavica, 125*(2), 127-146. https://doi.org/10.1111/j.1600-0447.2011.01750.x

College of Policing (2023). *Categories for unexpected death investigations*. College of Policing. https://assets.college.police.uk/s3fs-public/2023-08/Categories-for-unexpected-death-investigations.pdf

Cooper, P. (2023, July 7). Kellie Sutton: New inquest finds abuse victim unlawfully killed. https://www.bbc.co.uk/news/uk-england-beds-bucks-herts-66132629

Department of Health and Social Care. (2023). *Suicide prevention in England: 5-year cross-sector strategy*. UK Government. https://www.gov.uk/government/publications/suicide-prevention-strategy-for-

england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy#addressing-risk-factors.

Devries, K. M., Mak, J.Y., Bacchus, L.J., Child, J.C., Falder, G., Petzold, M., Astbury, J., & Watts, C.H. (2013). Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Medicine, 10*(5). https://doi.org/10.1371/journal.pmed.1001439

Donovan, C. & Barnes, R. (2020). Help-seeking among lesbian, gay, bisexual and/or transgender victims/survivors of domestic violence and abuse: The impacts of cisgendered heteronormativity and invisibility. *Journal of Sociology, 56*(4), 554-570. 10.1177/1440783319882088

Donovan, C., & Hester, M. (2011). Seeking help from the enemy: Help-seeking strategies of those in same sex relationships who have experienced domestic abuse. *Child and Family Law Quarterly, 23*(1), 26–40.

Donovan, C., & Hester, M. (2014). *Domestic violence and sexuality: What's love got to do with it?* Bristol, England: Policy Press.

Femicide Census. (2020). *UK Femicides 2009-2018*. Femicide Census. https://www.femicidecensus.org/wp-content/uploads/2022/02/010998-2020-Femicide-Report_V2.pdf

Gangoli, G., Bates, L., & Hester, M. (2019). What does justice mean to Black and minority ethnic (BME) victims/survivors of gender-based violence? *Journal of Ethnic and Migration Studies, 46*(15), 3119-3135. https://doi.org/10.1080/1369183X.2019.1650010

Harris, L. (2022). *Regulation 28 Report to Prevent Future Deaths.* Coroner's Report. https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344_Published.pdf

Hassanian-Moghaddam, H., Zamani, N., & Sarjami, S. (2016). Violence and Abuse Against Women Who Have Attempted Suicide by Deliberate Self-Poisoning: A 2-Year Follow-Up Study in Iran. *Journal of Interpersonal Violence*, *31*(7), 1257–1273. https://doi.org/10.1177/0886260514564157

Hoeger, K., Bates, L., Perry., Nguyen Phan, T., & Whitaker, A. (2022). *Domestic Homicide Project - Spotlight Briefing #2: Older Victims*. Vulnerability Knowledge and Practice Programme (VKPP). https://www.vkpp.org.uk/assets/Files/VKPP-DHP-Ethnicity-Spotlight-Briefing-June-2022.pdf

Hofstra, E., Elfeddali, I., Bakker, M., de Jong, J., van Nieuwenhuizen, C., & van der Feltz-Cornelis, C. (2018). Springtime Peaks and Christmas Troughs: A National Longitudinal Population-Based Study into Suicide Incidence Time Trends in the Netherlands. *Frontiers in Psychiatry, 9*(45), 1-10. https://doi.org/10.3389/fpsyt.2018.00045

Home Office. (2016). *Domestic homicide reviews: statutory guidance*. Home Office. https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

Home Office. (2022a). *Key findings from analysis of domestic homicide reviews*. Home Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1048696/DHRs_Review_2019-2020_report_Final_Draft.pdf

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

Home Office. (2023). *Crime Recording Rules for Frontline Officers and Staff*. Home Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1187923/crime-recording-rules-for-frontline-officers-and-staff-july2023.pdf

Kafka, J., Moracco, K., Taheri, C., Young, B., Graham, L., Macy, R., & Proescholdbell, S. (2022). Intimate partner violence victimization and perpetration as precursors to suicide. *SSM - Population Health*, *18*. https://doi.org/10.1016/j.ssmph.2022.101079

Keynejad, R., Paphitis, S., Davidge, S., Jacob, S., & Howard, L. (2022). Domestic abuse is important risk factor for suicide. *BMJ (Online), 379*. https://doi.org/10.1136/bmj.o2890

MacIsaac, M., Bugeja, L., Weiland, T., Dwyer, J., Selvakumar, K., & Jelinek, G. (2018). Prevalence and Characteristics of Interpersonal Violence in People Dying From

Suicide in Victoria, Australia. *Asia-Pacific Journal of Public Health, 30*(1), 36-44. https://doi.org/10.1177/1010539517743615

MacIsaac, M. B., Bugeja, L. C., & Jelinek, G. A. (2017). The association between exposure to interpersonal violence and suicide among women: a systematic review. *Australian and New Zealand Journal of Public Health*, *41*(1), 61–69. https://doi.org/10.1111/1753-6405.12594

McGorrery, P., & McMahon, M. (2019). Causing someone else to commit suicide: Incitement or manslaughter? *Alternative Law Journal*, *44*(1), 23-28. https://doi.org/10.1177/1037969X18802455

McManus, S., Walby, S., Barbosa, E., Appleby, L., Brugha, T., Bebbington, P., Cook, E., & Knipe, D. (2022). Intimate partner violence, suicidality, and self-harm: A probability sample survey of the general population in England. *The Lancet. Psychiatry, 9*(7), 574-583. https://doi.org/10.1016/S2215-0366(22)00151-1

McLaughlin, J., O'Carroll, R. E. & O'Connor, R. C. (2012). Intimate partner abuse and suicidality: A systematic review. *Clinical Psychology Review*, *32*(8), 677–689. https://doi.org/10.1016/j.cpr.2012.08.002

Monckton Smith, J. (2020). Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide. *Violence against Women, 26*(11), 1267-1285. https://doi.org/10.1177/1077801219863876

Munro, V. E. & Aitken, R. (2020). From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse. *International Review of Victimology*, *26*(1), 29–49. https://doi.org/10.1177/0269758018824160

Myhill, A. (2015). Measuring Coercive Control: What Can We Learn From National Population Surveys?, *Violence Against Women*, *21*(3), 355–375. https://doi.org/10.1177/1077801214568032

Nguyen Phan, T. T., Bates, L., Hoeger, K., Perry, P., & Whitaker, A. (2022). *Domestic Homicide Project - Spotlight Briefing #1: Adult Family Homicides*. Vulnerability Knowledge and Practice Programme (VKPP). https://www.vkpp.org.uk/assets/Files/AFH-Spotlight-Briefing-Jan-2022-AC.pdf

Office for National Statistics. (2021a). *Population of the UK by country of birth and nationality: year ending June 2021*. UK Statistics Authority. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/ukpopulationbycountryofbirthandnationality/latest

Office for National Statistics. (2021b). *Domestic abuse in England and Wales overview*. UK Statistics Authority. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2021

Office for National Statistics. (2022). *Ethnic group, England and Wales: Census 2021*. UK Statistics Authority. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021

Office for National Statistics. (2023). *Homicides in England and Wales: year ending March 2022*. UK Statistics Authority. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/march2022#the-most-common-methods-of-killing

Oladunjoye, A., Oladunjoye, O., Ayeni, O., Olubiyi, O., Fuchs, A., Gurski, J., Yee, M.R., & Espiridion, E. (2020). Seasonal Trends in Hospitalization of Attempted Suicide and Self-Inflicted Injury in United States Adults. *Cureus 12*(10). https://doi.org/10.7759/cureus.10830

Perry, P., Bates, L., Hoeger., Nguyen Phan, T., & Whitaker, A. (2022). *Domestic Homicide Project - Spotlight Briefing #3: Ethnicity*. Vulnerability Knowledge and Practice Programme (VKPP). https://www.vkpp.org.uk/assets/Files/VKPP-DHP-Ethnicity-Spotlight-Briefing-June-2022.pdf

SafeLives (2023) Responding to Counter allegations: Guidance - A review of practice. https://safelives.org.uk/sites/default/files/resources/Responding_to_Counter_allegations_Guidence.pdf

Stanko, B. (2022). Operation Soteria Bluestone Year One Report. Home Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128688/E02836356_Operation_Soteria_Y1_report_Accessible.pdf

Stark, E. (2007). *Coercive Control: How Men Entrap Women in Personal Life* (Interpersonal violence (Oxford, England)). New York: Oxford University Press.

Verney, C. (2021). Why the Increase in Domestic Violence Over Christmas?, *DVACT-PAI.* https://www.dvact.org/post/why-does-domestic-violence-increase-over-christmas

Walby, S. (2004). *The Cost of Domestic Violence*. London: Women and Equality Unit (DTI).

West Midlands Police and Crime Commissioner. (2021). *Campaign to reduce domestic abuse at Christmas launched*. https://www.westmidlands-pcc.gov.uk/campaign-to-reduce-domestic-abuse-at-christmas-launched/

White, R., Azrael, D., Papadopoulos, F., Lambert, G., & Miller, M. (2015). Does suicide have a stronger association with seasonality than sunlight? *BMJ Open, 5*(6). https://doi.org/10.1136/bmjopen-2014-007403.

Woo, J., Gibbons, R., Rogers, C., Qin, P., Kim, J., Roberts, D., Noh, E., Mann, J., & Postolache, T. (2012). Pollen counts and suicide rates. Association not replicated. *Acta Psychiatrica Scandinavica, 125*(2), 168-175. https://doi.org/10.1111/j.1600-0447.2011.01813.x

Appendix A – List of recommendations from Year 2 report with progress updates

Our Year 2 report made a series of recommendations for the police, NPCC, College of Policing, government (Home Office) and the Project itself. The following text summarises the progress made against these recommendations:

Police force response to recommendations:

Recommendation 1

- ***Recommendation 1*** *[to the police and partners]: Whilst it is not possible to identify and confirm trends like seasonality within a small two-year dataset, the limited data available so far does indicate the possibility of an elevated risk of suicide amongst domestic abuse victims in the Christmas and New Year period. When carrying out domestic abuse communications campaigns in the Christmas and New Year period, forces and partners consider signposting to suicide prevention services as well as domestic abuse support.*
    - *Is this something that your force has / will consider this year?*

Forces have acknowledged an increase in suicide rates nationally in recent years. Resultantly, they are actively working with communication teams to create action campaigns to raise awareness and signpost victims to support networks and partner agencies. The theme has been included in a variety of campaigns around the Christmas and New Year period, however for some forces there is a lack of connection between mental health and domestic abuse communication strategies. Campaigns will include suicide prevention services and domestic abuse support. Domestic abuse reviews are underway regarding links between domestic abuse and suicide, and forces are actively linking with partners for increased awareness and communication. One force advised that officers are undertaking further training about investigative mindset, with a particular focus on suspect status and history within the home.

Some forces acknowledged there was more work to be done in this area and that there is a lack of signposting to partner agencies for suicide prevention. At times this is done through a domestic violence referral. Forces were keen to progress further in this area with support and advice. National Safeguarding week falls on November 13th, 2023, and this has been identified as a key period for collaboration with external partners to promote existing support charities. Data from one force showed a spike in suicides for November 2021 and 2022, so the National Safeguarding Week commences at a significant time for those struggling with mental health. Another force has utilised a significant and ongoing suicide surveillance programme, that has provided data that identifies isolation and past instances of domestic abuse as contributing factors for both victims and suspects.

Moving forward, strategies are in place across many forces to integrate communications for domestic abuse and suicide prevention campaigns in a more cohesive and combined approach, especially during identified high-risk times. One force has commissioned a Suicide Prevention and Partnership Manager to coordinate activity across the county, picking up on any emerging patterns and trends. The partnership has played an active part in the countywide partnership VAWG meetings, where there is a clear focus on domestic abuse. The communications surrounding domestic abuse and suicide prevention are highlighted throughout the year, not just at Christmas time. Forces have also utilised training opportunities in suicide awareness through external charities such as Mind. As well as communications campaigns and strategies, Forces are focusing resources operationally on staffing domestic abuse teams to ensure there is not a loss in service.

Recommendation 2

- ***Recommendation 2*** *[to the police]: We recommend that forces routinely review the 'problem profile' of their domestic abuse and domestic homicide cases, including identifying cases of adult family violence and intimate partner violence. Within the appropriate local structures for reviewing domestic abuse (e.g., Vulnerability Boards, local domestic abuse partnerships), forces should review what interventions best match their problem profiles, including prevention approaches. The problem profile and matching intervention plans could be included as part of Homicide Prevention Strategies, where those exist locally.*
    - *Has your force reviewed your 'problem profile', discussed this within relevant local structures, and/or included targeted actions within a Homicide Prevention Strategy? If not, is this something your force plans to consider?*

Many forces commented on how their problem profiles were refreshed and recirculated and refresher training was implemented for officers, following the recommendations made. Some homicide and near-miss homicide problem profiles did not have a specific focus on domestic abuse, though are now covering domestic abuse themes/trends and partnership working. Profiles have been further scrutinised to include a focus on mental health, domestic abuse, drugs and alcohol, serious and organised crime and knife crime.

Many Forces are looking to refresh their problem profile in relation to domestic abuse and domestic homicide. This has included a number of preventative approaches, including a dedicated Domestic Abuse Problem Solving Team in one force, and redesigning perpetrator cohorts to actively target the highest risk perpetrators of domestic abuse with a view of prevention. Forces advised that other strategies and reviews cover this theme with embedded review processes to explore patterns of domestic abuse, including adult family and intimate partner violence. Such strategies include domestic abuse scrutiny panels, domestic abuse steering groups, vulnerability and victim reference groups, MARAC, DHRs, MARAC steering groups along with Homicide Prevention Strategies and Multi-Agency Tasking and Coordination (MATAC). Through these avenues, interventions, preventative approaches and lessons learnt are reviewed and disseminated. The review of interventions ensures that any gaps in service provision are identified and addressed.

Forces commented on the use of the MORiLE based scoring system as part of the risk assessment methodology. An annually reviewed domestic abuse control strategy was implemented in one force to inform domestic abuse problem profiling, with a focus on intervention-based approaches. Many forces advised domestic homicide cases remain under regular review, with cases involving significant risk being referred onto focused teams to target and proactively respond to. One force advised that in their process, significant risk cases would be referred to a Domestic Abuse Perpetrator Panel for onward case management. Such cases require longer-term problem solving, which is often beyond the scope of MARAC meetings. By referring them into the panel, forces can provide a multi-agency stakeholder approach to manage the problem.

One force collaborated with a partner agency to specifically target out of court disposals, an option that is expected to be advantageous for adult partner violence cases, particularly when a parent is seeking support or help for their adult child. Recent problem profile mapping has also been undertaken for domestic homicides using the eight stages of domestic homicide timeline (Monckton Smith, 2020). This data will subsequently serve as a training product for officers. One force has commissioned a partnership analyst embedded in the community safety partnerships for each local authority. These analysts can provide police statistical data to support commissioning and focus limited resources to address specific problems.

Recommendation 3

- ***Recommendation 3*** *[to the Government and police]: Building on the recommendation in our Year 1 report, investigation is still needed into whether the overall number of domestic homicide suspects who were previously being managed by police or probation (e.g., under MAPPA, IOM or DRIVE) is actually as low as reported to this Project. If it is, further discussion may be needed between the police and government about what can be done to strengthen monitoring and disruption of these individuals.*

    - ***The recommendation from our Year 1 report*** *read: Further investigation is needed into why the proportion of domestic abuse suspects in this dataset being actively managed by MAPPA, probation or related agencies was so low (only 6%), and whether these numbers indicate that serial and dangerous perpetrators are not being referred into MAPPA in sufficient numbers.*

    - *Does your force know the number/proportion of domestic homicide suspects/perpetrators who were previously managed by police or probation? Or, more generally, the number of high risk / serial domestic abuse perpetrators currently being managed? (See also recommendation 4 below).*

With regards to this recommendation, several forces highlighted the need for additional work required to achieve this and that it is an ongoing development with links to the MARAC and IOM. Several forces had processes in place where a domestic homicide

perpetrator is managed or monitored by DAPPA or MAPPA. This will also be widened to include domestic abuse perpetrators linked to SVSDA and a review conducted by multiagency management so that safeguarding/DVDS can be explored. Forces also advised that high risk domestic abuse perpetrators are flagged by the domestic abuse team, which then triggers MATAC, IOM and/or MAPPA cases to be created. However, there are limited opportunities to disrupt perpetrator activity within MATAC due to limited resources across many forces.

Several forces advised their plan to pursue overall assessment of domestic homicide suspects, as the analysis could lead to a change in practice as to how domestic abuse perpetrators are managed. For this to be achieved, additional analytical resources would be required. Some forces advised the data requested was available. One Force reported having a newly embedded Domestic Abuse Threat Assessment Unit, which identifies high threat relationships where there are indicators of risk of domestic homicide. The unit has seen success in responses and reduction of crime, due to cases being flagged for Contact Management and frontline response officers to assist in decision making, with the support of specialist investigative units.

Overall, at present there appears to be a small number of domestic homicide suspects included in the MAPPA framework (many being in custody), despite a significant increase in domestic abuse perpetrators being managed under MAPPA via category 3 for designated dangerous offenders nationally. IOM officers collaborate closely with probation services to manage individuals identified as domestic abuse perpetrators. Moreover, domestic abuse perpetrators who fall outside the scope of MAPPA are regularly discussed at MARAC meetings, either identified through police crime records or via information shared by other agencies.

Some forces commented that they are unable to track the proportion of DHRs previously managed, but this is being tasked to analysts moving forwards to monitor. One force advised of their process which to date has been effective and proactive, whereby exceptional risk is identified through partnership engagement, analytical work or police risk management. An assessment is then made as to whether the case should sit locally within the Domestic Abuse Perpetrator Panel or where the risk is so exceptional that it is beyond the scope of the Panel, with MAPPA. Management of perpetrators has been subject to recent scrutiny in inspections for police and probation. New protocols have been implemented ensuring that potentially dangerous domestic abuse perpetrators who sit outside MAPPA arrangements will be regularly discussed at MARAC, identified by police crime occurrence or information sharing by other agencies.

<u>Recommendation 4</u>

- ***Recommendation 4*** *[to the police]: Forces should ensure that all potentially dangerous domestic abuse perpetrators who sit outside MAPPA arrangements are identified and managed in line with the College of Policing guidance, 'Identification, assessment and management of serial or potentially dangerous domestic abuse and stalking perpetrators'.*

- *Does this occur in your force?*

All forces who submitted responses have proactive engagement and response plans in relation to this recommendation. One force described the effective use of an 'MDAP' process for the top 10 perpetrators using an RFG matric, as well as benchmarking work into MATAC as an additional option. Another force described the launch of a Domestic Abuse Perpetrator Panel, a MATAC protocol held monthly to discuss specific cases of high-risk domestic abuse. The panel ensures that agencies work in partnership to engage high-risk/high-harm domestic abuse perpetrators in methods of support aimed at the causation factors behind their offending, with the aim of reducing re-offending and, where necessary, to take enforcement action to protect victims. The same principles will be applied to those responsible for VAWG. Offenders are identified through application of an algorithm which considers the recency, frequency and gravity of their offences, and the number of victims that have been affected by this.

The most harmful offenders are allocated to an offender manager who will use supervision, monitoring and control, interventions and treatments as well as victim safety to reduce risk of serious harm. Forces are utilising screening by probation, with regular communications and meetings to ensure all MAPPA Category 2 and 3 offenders and Potentially Dangerous Person (PDP) nominals are jointly managed. One force is undertaking a piece of work to review the definitions of High Harm/Serial/Repeat offenders under a VAWG task and finish group, with a view to use the crime harm index to consistently identify high harm perpetrators to be referred to MAPPA. One force identifies these perpetrators through a vulnerability PowerBi product. This information is an indicator discussed within the force's vulnerability boards, and Basic Command Units (BCUs) utilise the data to manage risk on a daily basis.

Revised crime allocation policy ensures the correct resources are aligned to the relevant crimes and a responsibility of the team to identify and manage the response for all domestic abuse perpetrators in their area. One force has introduced *Dauntless*, a data-led set of the most harmful domestic abuse perpetrators. This is provided to each BCU within the force area, setting key trigger plans for action and requiring proactive targeting as resourcing allows. For some forces, they advised a PDP pathway is being promoted within the region, however PDP numbers remained low. However, there is evidence of good use of parallel processes of multi-agency collaboration in the management of risk, such as the adapt programme, Drive and to an extent a growing focus on perpetrators within MARACs. It is acknowledged that PDP as an option needs to be promoted further, and domestic abuse offender managers with specific training need to be utilised to encourage applications.

There is also a consideration given by forces to adapt their models to cover training and prevention, identifying early indicators of stalking behaviour, CCB, non-fatal strangulation as well as high risk repeat domestic abuse. Reviews into this are likely to recommend an increase in resources. Forces are forward thinking in their approach to fast, real-time responses to domestic abuse and monitoring of perpetrators. The Nominal Harm Score app has been released for wider access, which requires a whole force standard operating

procedure to ensure the same criteria for identification is applied across the board and cohorts for assessment and management are identified accordingly. Inputs on MAPPA have been delivered recently to Safer Neighbourhood Team staff and disseminated to frontline staff to raise awareness and encourage the wider use of MAPPA.

Recommendation 7

- ***Recommendation 7*** *[to the police and their partners]: The police and partner agencies should be made aware of an elevated risk of both intimate partner homicide and of victim suicide where coercive or controlling behaviour (*CCB*) is present. Frontline and supervisory officers and safeguarding/vulnerable victim units should consider referrals to suicide prevention interventions in setting safeguarding actions when* CCB *is identified.*
    - *Are frontline officers in your force aware that CCB may be associated with a risk of suicide of a victim of domestic abuse and consider suicide prevention interventions during the safeguarding process? Or is this information something your force is considering taking forward?*

Forces recognised that further training could be carried out for frontline officers in CCB and the possible link to risk of suicide. Many forces have appointed a Suicide Force Champion, however acknowledged that training on suicide is often carried out independently of domestic abuse inputs and that this is something that needs further work on raising awareness and training. Forces stipulated that training is available and added to career professional development (CPD) days for mental health, CCB and suicide prevention. One force had enrolled a Mental Health Liaison Officer that highlighted hidden harm and associated risk of SVSDA. Their Domestic Abuse Safeguarding Team (DAST) will refer victims to support services and relevant support is signposted. One force approached training through utilising the Homicide Timeline research (Monckton Smith, 2020), which reinforces the requirement to take positive action in domestic abuse cases through highlighting the increased risk of domestic homicide associated with CCB, stalking and separation. Many other forces referenced effective training packages informed by this research that have been planned for 2024. Funding from the Homicide Prevention Fund is to be utilised to hold two further CPD events, targeting frontline supervisors and officers to assist in identification of risk. Further action and work are required to inform frontline officers and investigators of the need to consider referrals to suicide prevention interventions in settings where CCB is identified.

Many forces continue to carry out analytical work on suicides for any learning and requirements for ongoing referrals. Partnership meetings have included presentations on suicide and data on local trends. One force commented on how partner working and a joined-up approach of communication and coordination of shared information and resources with a neighbouring force has increased the capacity and data available for both forces. As such, their Intelligence Bureau has commenced a piece of work exploring the risk around perpetrators of CCB and stalking with plans to incorporate a product into the identification and management of perpetrators.

Referrals for mental health care needs are often disjointed with domestic abuse referrals and are considered adults at risk. Education is required around the link between CCB and homicide/suicide. Many forces said this recommendation is still in progress, with future training forecast and investment in officer development and awareness around CCB as a priority. One force shared that they have a dedicated safeguarding unit who provide support and safeguarding referrals for victims. There are also existing local pathways to relevant services for mental health crisis and suicide prevention. Every victim is assessed on a case-by-case basis and referred to relevant services depending on the needs identified.

Recommendation 8

- ***Recommendation 8*** *[to the police]: There should be a continued push within policing to identify, record and take positive action where coercive or controlling behaviour (CCB) is identified. This might involve forces reviewing their recording rates for CCB as part of their own crime auditing processes.*
    - *Has your force conducted this type of review? Or is it being considered for the future?*

Many forces advised this had been actioned or was currently in process for review/planned. Monthly performance statistics and data evaluation, accurate crime recording or missed opportunities and any learning is flagged and disseminated between departments. Many forces advised there is an enhanced focus at present on training/CPD and improvements to standards as a priority.

Many forces have a crime desk that reviews all crimes, which includes CCB, as well as checks investigations to ensure CCB is not missed. Continual review and feedback is provided to officers and supervisors, with several layers of risk assessment to ensure nothing is missed. Although not solely for CCB, specific audits are focused on recording of behavioural crime/stalking/harassment as part of a targeted action plan within the Crime Data Integrity improvement plans. Evidence suggests there has been a steady increase in recording rates of CCB over the last two years. Across forces, there is evidence of monthly reviews of domestic abuse data, with specific attention in some forces to CCB. For example, in one force there was an 7.5% increase in recorded CCB cases in the 12 months which followed DA matters training.

Many forces have a thematic audit plan, which includes stalking and harassment offences where CCB is present. In one force, this audit is conducted yearly by a Crime Incident Registrars Unit, whilst audits for domestic abuse are conducted separately as part of a weekly dip sample audit that picks up on CCB. Regular dip-sample audits focused on domestic abuse are conducted across several other forces and aim to identify any attrition, where crimes are missed and/or over-recorded. If any themes identified are associated with the recording of CCB then this will be highlighted.

There has been an increase in the recording of CCB across forces, which in part has been put down to greater awareness. The impact of the Home Office Counting Rules (2023) is yet to be fully understood and could affect figures, particularly in cases involving repeat offenders within a three-month span that may not qualify for recording under the new rules. The recent Principal Crime rule change under Home Office Counting Rules that was introduced in June 2023 will likely result in a decrease of recorded CCB.

Recommendation 11

- ***Recommendation 11*** *[to the police and their partners]: The police and partner agencies should consider ways to improve data sharing across compatible systems to facilitate communication and coordination that may help identify domestic abuse and risk within the context of adult family relationships.*
    - *Is your force considering ways to facilitate information sharing with partner agencies, such as health and social care, who may be more likely to have contact with those at risk of domestic abuse from (adult) family members?*

Many forces have implemented a Safeguarding Referral Unit within the MASH, as well as locality-based safeguarding hubs to ensure a collaborative approach to information sharing. Some forces are undertaking reviews into information sharing agreements, which will establish non-compliance and provide lawful basis information sharing. Panel meetings have been implemented to enable effective information sharing across children's and adult's services more effectively. Systems utilised by forces and departments to enable information sharing include referrals using Harbour, vulnerability hubs, tracker process, domestic abuse steering groups, IDVAs, MARAC, MATAC, MASH as well as engagement with schools settings.

A multi-agency risk assessment conference is held daily within one force, to share information between partners in health, social care, probation, and support agencies using a system called MODUS which can be accessed by partner agencies. Many forces commented on the need for a faster process of information sharing, as often forces and partner agencies do not hold compatible systems, and information sharing must be conducted through safeguarding referrals by centralised referral teams. There is a requirement further for a whole system approach, which one force is working on implementing, and seeking to engage with women in rural communities and divert women from crime where there is an opportunity to keep them out of the criminal justice system.

Many forces shared that achieving this recommendation was a challenging process; some reported that there is limited receptiveness from partners in relation to having compatible systems. One force has taken positive steps towards implementing a MASH arrangement across its area's local authorities, which marks a significant improvement in relation to information sharing. Another force investigated building a domestic abuse app which would focus on identifying domestic abuse and risk within the context of adult family relationships, however progress is currently stalled.

Recommendation 14

- ***Recommendation 14*** *[to the police]: We recommend that initial police enquiries in unexpected deaths or suspected victim suicides should: (1) record all persons present in the household at the time of the death; (2) record any known history of domestic abuse associated with the victim, address or persons present in the household at the time of the death; and (3) contact close associates and others who may have information material to a history of domestic abuse, including family, friends and neighbours. Any relevant information uncovered about domestic abuse could be included in the 'circumstances of death' section in the death report to Coroners.*
    - *Are these recommendations either already in place or being considered as part of your force area's response to unexpected deaths, including suspected suicides?*

In response to this recommendation, most forces have implemented changes and revisions in their sudden death policy. Others are undergoing draft stages or reviews to ensure that all the points raised above are captured in their enquiries and investigations into sudden deaths. Some forces stipulate alternative enquiries that are included within their policy, such as:

- Checking databases like Niche and PNC for warning markers on involved parties and possibly submitting a national intelligence check.
- Interviewing associates, friends, family and neighbours (as abuse may be unreported).
- Looking for evidence for CCB.
- Reviewing mental health reports or referrals for relevant disclosures.
- Examining existing complaints made by the deceased like assault or stalking; for victimless prosecutions and any cases with these elements they must then be reviewed by a Detective Inspector (DI) and reported to the coroner.

The holistic approach of covering all databases and enquiries ensures that officers are vigilant for signs that could indicate SVSDA or hidden domestic homicide.

Most forces had similar protocols around unexpected deaths in the home to be attended by a DI and/or a Police Coroners Officer. The use of death investigation packs/coroner reports has assisted with the full reporting on circumstances surrounding the death. Whilst many forces had been proactive in making amends to their policy in this area, they also acknowledged there was more to be done in respect of education to the investigator completing the report. Relevant information is recorded, and onward referrals are made if there is a history of domestic abuse, however often these are not recorded on Athena or the Coroner's report. There appears to be a lack of consistency across the board for forces

recording details of persons present in the household at the time of death, and upon police attendance. Some Forces record who permanently resides at the address, but there is a disparity in recording of all persons present in the household at the time of death. Forces newly instigating this process are ensuring compliance is audited. There appears to be a consistent drive to ensure that the circumstances surrounding the death are fully explored and that such circumstances are accurately recorded.

Recommendation 15

- ***Recommendation 15*** *[to the police]: When attending the scene of an unexpected death or suspected suicide, police must always apply professional curiosity and an investigative mindset to test the obvious explanation. Attending officers should be alert to any signs or disclosures of a history of domestic abuse, especially of coercive or controlling behaviour. Forces should develop mechanisms to check that learning is captured from key cases and that the College of Policing's guidelines for Recognising and Responding to Vulnerability-Related Risks (which focus on professional curiosity) are being implemented effectively.*

    - *Are you able to provide any updates on the use of professional curiosity and an investigative mindset within your force?*

    "Investigating death is one of the most important jobs that the police do. The way that we go about it leaves a lasting impression on families and communities. Officers need to be aware of potential conscious and unconscious bias and ensure they demonstrate professional curiosity by looking, listening, asking direct questions, and checking and reflecting on information received, if need be, with specialist units such as Forensic Services. Actions taken, or not taken, at the initial stages of the death investigation may have considerable ramifications during the investigation or future inquest."

Many forces advised they had carried out a variety of training and education surrounding vulnerability, with a priority focus on the frontline responder in training days and regular CPD. Training tends to centre around CCB, domestic abuse history, and child protection. All suspected suicide reports for most forces are attended by a DI to ensure an investigative mindset and professional curiosity considers a range of hypotheses. Forces are briefing and training their contact and control room staff as well as frontline officers to consider risk and hidden abuse at the first point of contact. Conferences that forces have held have included a requirement for Response Senior Leadership Teams to consider if there is a risk around SVSDA, and how an investigative mindset is paramount at the initial early stages of the call for service. Significant investment into training of the implementation of THRIVE and VAF across all investigative disciplines has been seen across forces. Masterclasses have been delivered to first responder cohorts and first line supervisors, with a focus on these areas, as well as evidence led prosecutions to bring about specific considerations in relation to the investigative mindset, scene assessment and interpretation.

Elements of this recommendation align with existing and wider force priorities of encouraging a suspect focus and improving investigative standards. Much of this work is governed via regular meetings chaired by force ACCs for oversight. Officers are provided with 'briefing sheets' in some forces, to remind the attending SIO to be professionally curious at all incidents and for them to consider all aspects of any previous domestic abuse which may have occurred in the past and the effect this may have had on any victim. Quality assurance reviews are conducted across many forces to ensure that opportunities are not overlooked, missed opportunities, and any appropriate learning is captured. Some forces used Quality Assurance Thematic Testing (QATT) for this. Many forces follow guidance provided nationally by the College of Policing and liaise with partners such as the Homicide Working Group, Getting It Right First Time (GIRFT), and the VAWG Working Group. The voice of the child has been a key element of the vulnerability strategy for one force, and instigated a drive around evidence led prosecution, which requires a higher degree of professional curiosity to ensure all evidential opportunities are explored.

Recommendation 16

- ***Recommendation 16*** *[to the police]: When there is an unexpected death or suspected suicide, reasonable and prompt system checks should be made for any known history of domestic abuse crimes and non-crime incidents by appropriate officers or staff. Where possible, this should be done prior to the attending officer leaving the scene and/or within initial enquiries. Slower-time searches for domestic abuse history should then be conducted to inform the investigation, for instance on call-handling, intelligence, and public protection systems. Considering that domestic abuse is often not reported to police, these slower-time searches should also consult local partners who may have knowledge of an undisclosed history of domestic abuse, including domestic abuse services.*
    - *Does this practice occur within your force?*

Many forces answered this with detail in recommendation 14 and 15. This remains an evolving practice for many forces, with compliance being described as *"sporadic"*. Forces are proactively encouraging this process to be embedded and senior ranking officers to claim ownership of the investigation. They report that this should involve liaising with response officers, control room and vulnerability hubs at all levels of the investigation process; from first response to slower time checks and historic research of the subjects involved. Forces confirmed that checks would be conducted at the scene to establish the history and circumstances of the deceased and family history, previous reports and calls to the address.

Attending officers are also required to start recording persons involved and residing at the address. Systems checks, house-to-house enquiries and other golden hour enquiries are required as well as obtaining antecedent information from relatives and friends, all of which are often completed prior to leaving the scene. Forces did advise that frontline officers are unlikely to speak with partner agencies to look for undisclosed history and this is

something that is often only undertaken in DHRs. The DI who coordinates the investigation will task officers to carry out further enquiries if concerns are raised about the death.

Where there is a criminal investigation in relation to SVSDA, many forces will record inciting suicide or assisting suicide, which will be subject to the direction and control of a SIO. Force Contact Management Departments routinely complete intelligence checks prior to officers' attendance which are captured on the STORM log and available for attending officers to view. Regarding the recommendation to include references of recent police incidents, this has been decided by one force not to be adopted as it is a speculative enquiry. Regarding slower time research/enquiries, this is often conducted by the force's domestic abuse team in relation to domestic abuse history, who will then link in with partners to ensure no wider knowledge is missed. Safeguarding managers for adults conduct weekly checks of unexpected deaths and suicides to ensure that no potential DHR referrals are missed. One force has a Protecting Vulnerable Persons Manager who reviews the circumstances leading up to the death in detail and through a lens to establish if domestic abuse is an impact factor. The force reported that the partnership context within this area could be explored more. Another force has created a multi-agency suicide review group, who examine the antecedents of parties involved and identify any themes, learning and opportunities to prevent harmful practice in future. There is also an agreement across the board that there is a need to improve faster paced research when officers attend a scene to assist in their enquiries.

Recommendation 17

- ***Recommendation 17*** *[to the police]: In line with forthcoming guidance from the College of Policing on unexpected deaths, a PIP 3 SIO (minimum detective inspector or police staff equivalent) should be appointed to provide oversight of all unexpected death investigations. This should include providing advice and direction to the officer in the case, reviewing investigations and conclusions. Oversight review should consider any evidence of domestic abuse history.*
    - *Is this recommendation already in place within your force? Or is it something you are aware of and considering implementing?*

This across many forces is already an embedded practice for all unexpected deaths and suicides. For many forces, DIs have oversight and control of a scene, and CSI attend all reports. DIs liaise with the SIO regarding the circumstances and history of the deceased person. The domestic abuse history is checked, and partners are sometimes consulted. For a lot of forces, there is a gap in the SIO portfolio due to resourcing and training allowances as not all officers are on the PIP 3 pathway.

One force reported this to be a challenge and advised that the Sudden Death Policy does not specify that a PIP 3 SIO must attend, as the amount of suitably trained officers would be unachievable. However, in terms of mitigation, the policy does direct that any unexpected death requiring further investigation will be overseen by the Local Investigations Manager. The current resource situation for many forces means that it is

currently not possible for a PIP 3 SIO to provide oversight to all unexpected death investigations. An alternative process has therefore been implemented whereby as aforementioned, the Detective Chief Inspector and two DIs review all deaths daily to ensure there is appropriate oversight and ownership of the investigation.

Another force advised that due to the number of PIP 3 accredited SIO's in the force, it would not be possible to provide oversight to every unexpected death. The force commented that if concerns of suspicions were raised or identified, then appropriate oversight is given. However, by virtue of the processes embedded in the PVP Governance structure, a PIP 3 or PIP 4 SIO would "technically speaking" have oversight of unexpected deaths.

Forces are looking to implement additional scrutiny and governance by capturing all sudden deaths at daily management meetings and requiring a DI to review each case within 24 hours. This change is seen as very achievable. Conversely, some forces held concerns around the achievability of this recommendation. The common theme for concern is the limited number of PIP 3 SIOs available. The majority sit within Major Crime Units, who also deal with serious crime incidents. The unexpected death policy for these forces requires a DI to attend the scene under certain circumstances (such as a history of domestic abuse) and there is always an on-call provision for an SIO if the attending DI determines it is believed the death is suspicious.

Recommendation 18

- ***Recommendation 18*** *[to the police]: We recommend that police officers should be made aware of the possibility of domestic abuse perpetrators attempting to manipulate the narrative and processes after a death, especially where they are next of kin.*
    - *Is the possibility of manipulation by a domestic abuse perpetrator, particularly if assumed as 'next of kin' something that officers are aware of? Relatedly, we have heard concerns from the organisation AAFDA (Advocacy After Fatal Domestic Abuse) that some officers believe 'next of kin' to have a legal status and believe that they are required to release the deceased (victim's) phone to their spouse/partner even if they are known to the police as a domestic abuse perpetrator.*

One force reported that Sudden Death Policy does refer to speaking to other members of the deceased's family when it is identified that there is a possibility of domestic abuse between the deceased and their partner and guidance has been sent out to officers regarding this. However, the wider understanding of possible manipulation by a domestic abuse perpetrator and an assessment of whether officers believe they need to release the victims' phone to their spouse, is something that will need further investigation to assess formally. The force has set out plans to formally discuss this at vulnerability boards and have agreed on approaches to assess the position more formally with officers. If it is felt that further communication to all Response and Neighbourhood officers and staff is

required to update this position, this will be undertaken via existing communication channels in the force.

Many forces advised that officers are taught to have an investigative mindset and exercise professional curiosity. One force reported that there is an expectation for officers to apply professional judgement and remain conscientious in all cases of domestic abuse that perpetrators can manipulate the narrative following an incident being reported to the police. Victim's phones are therefore a consideration to contain evidence. However, there is not a standard operating procedure or formal monitoring of this built into the sudden death policy or process, and no consistent auditing or monitoring of this. Real time suicide surveillance processes pick this up for some forces and provide advice to officers if something is flagged as a concern. Further work is required to ensure this is formalised in training plans and policies. Several forces have been proactive in training on perpetrator manipulation and a desire to control the narrative. Some advised that they would benefit greatly from training packages focusing on the possibility of manipulation by domestic abuse perpetrators in DA matters training and training student officers or newly promoted sergeants.

The procedure many forces are working with provides clear guidance around different types of deaths, however, there is no clear reference to perpetrators of domestic abuse or others at the scene manipulating the narrative. One force suggested that within sergeants training, there should be an overarching principle of looking for inconsistent accounts provided by those present, which applies equally to all unexpected deaths attended. However, within the policy for forces, there is clear direction around contacting a DI in specific circumstances and providing significant detail around suicides.

Many forces have undertaken training to all CID and Neighbourhood Policing Officers highlighting the increased risk associated with CCB, stalking and separation, utilising the Homicide Timeline research conducted by Professor Jane Monckton-Smith (2020), which as previously mentioned provides insight into the mindset of perpetrators of CCB. There is also an enhanced effort by some forces to ensure intelligence checks are carried out where there is a specialist or complex case and advised to contact the 24/7 Intelligence Bureau. One force has been an early adopter of the VAWG pillar work, including relentless perpetrator pursuit, and has incorporated this across investigations. They reported that DA Matters training will reinforce this narrative and professional curiosity, to ensure consideration is given to a vigorous understanding of both victim and perpetrator positions.

Recommendation 19

- ***Recommendation 19*** *[to the police]: We recommend that police forces not already using Real Time Suicide Surveillance (RTSS) systems to share information on suspected and attempted suicides and domestic abuse histories should consider implementing them. Forces already using an RTSS system should consider adding domestic abuse agencies' data to that system and should review how information from domestic abuse partners can best be used to inform suicide prevention activities.*

- *Does your force have an RTSS system? If not, is it something your force is aware of or considering? If your force has an RTSS system, does it capture information from partners including specialist domestic abuse services?*

Forces that did report having an RTSS system stated the benefits with partner agencies and information sharing, providing partners hold this system as well. However, most forces responded that they did not have an RTSS system or were not aware of it, though expressed a desire to receive more information about this. The importance and value of this system has nevertheless been acknowledged and several forces are currently engaging with partners to ensure that a RTSS system is implemented at the earliest opportunity. Some forces were currently in discussion with piloting and launching this system and intended to complete this recommendation by the end of next year. One force advised that the HM Coroner would not support this system, and information held on suicides was the property of the coroner's officer, though they were keen to revisit this barrier.

Conclusion

In summary, most forces have taken positive and proactive action with regards to enhancing their training, knowledge and understanding of the connections between suicide and domestic abuse. Forces have followed the recommendations set out in the year 2 report and are striving to incorporate additional training and skillsets to tackle any disparity, address failings or missed opportunities and draw from lessons learned. There is an enhanced effort to strengthen communications with partner agencies and utilise information sharing in real time responses, using the most effective platforms. Forces have responded positively to the recommendation of communication campaigns around peak seasons of elevated risk, to introduce suicide intervention strategies, and signposting to support agencies and charities.

There is an increased focus within the narrative of response policing of domestic abuse, CCB, stalking, and harassment to further disrupt perpetrators and engage with vulnerable victims. Following recommendations made, many forces refreshed and recirculated their 'problem profile' and included additional training from service providers within their vulnerability strategy. A targeted approach of using domestic abuse scrutiny panels, steering groups, MARAC, MASH, DHRs, MAPPA, MATAC and collaboration with partner agencies has further improved the service offered to victims and officers understanding of homicide prevention. Forces are being proactive within their capabilities and embedding Domestic Abuse Threat Assessment Units to identify high threat relationships, and high harm perpetrators. There is an indication that further work could still be done in this area, and the requirement for joint interoperability working between partner agencies is vital in effective information sharing, with faster and more compatible systems across agencies.

Forces recognised the need for more training in understanding how CCB can play a part in suicide risk. There are areas for further improvement for example with regards to recommendation 3, whereby many forces see limited opportunities to disrupt activity within MATAC due to limited resources. Additionally, many forces recognised that referrals for

mental health care needs are often disjointed with domestic abuse referrals, and education is required around the link between CCB and homicide/suicide. Whilst thorough investigative work is being undertaken at the report of a death in the home, there is a lack of consistency across forces between recordings of domestic abuse history and recording all persons present in a household at the time of death. Following this recommendation, many forces have implemented changes and revisions in their sudden death policy, with an enhanced focus on investigative mindset and professional curiosity of frontline officers. However, there is still a gap in reliable recording of encompassing information in the circumstances of death report to the coroner. One area that provided the largest contrast in responses from forces was the awareness of domestic abuse perpetrators attempting to manipulate the narrative and processes after a death. This is something that many forces acknowledged requires further training and intelligence checks to understand both victim and perpetrator positions. Another area that could be utilised for some forces is the use of RTSS system, which has been reported to enhance capabilities within information sharing and partner agency working.

Overall, the recommendations made in the Year 2 report, have furthered knowledge and understanding for frontline and specialist officers, enhanced training opportunities, increased communication fields between partners, and promoted positive action with regards to suicide prevention. There has been an increased focus on intervention strategies, domestic abuse awareness, identifying emerging trends, links to CCB, safeguarding and activity disruption of domestic abuse perpetrators. These developmental changes and reviews will have a positive impact with a clear focus on domestic abuse and will inform vulnerability strategies and homicide prevention strategies nationally.

NPCC response to recommendations:

Recommendation 13 [to the National Police Chiefs' Council]: We recommend that the National Police Chiefs' Council (NPCC) explore with Coroners whether there is scope for standardising police unexpected death investigations (previously 'sudden death investigations'). This might include exploring whether unexpected death reports (previously 'sudden death reports') could be standardised across force areas, something that forces from our deep dives welcomed.

- The possibility was explored by the NPCC, and whilst national standardisation was not feasible, CC Kate Meynell has pursued additional progress as the NPCC lead for Homicide Prevention. The Homicide Prevention Working Group has undertaken work to review all relevant sudden/unexpected death policies across England and Wales to identify good practice. Additionally, the NPCC has worked with the College of Policing to update policy and guidance in response to unexpected deaths to address concerns from the HMICFRS inspection following the murders by Stephen Port.

College of Policing response to recommendations:

Recommendation 9 [to the College of Policing]: We recommend that the College of Policing, in consultation with the Home Office and NPCC develop training to directly address the evidential issues experienced in domestic abuse cases where suicide and/or coercive or controlling behaviour is identified.

- There has been very significant development of training and guidance in relation to investigative practice. With the content we set out below we believe that responders to domestic abuse are trained to identify and deal with CCB. The revisions to investigations related training and guidance addresses the potential for domestic abuse to be a factor in apparent suicides.

- The investigative content of the curriculum for new recruits has been significantly increased. The standard of training for recruits is considerably higher than it has been. In addition, there has been very significant changes to guidance regarding 'unexpected deaths' following the inquests related to the murders committed by Stephen Port. DA Matters continues to rolled out with every force that wants to take the training, doing so by the end of this financial year. There is content in the course related to suicide. DA APP also refers to suicide risks. Revised APP on investigation was released in August 2023 emphasising the need for professional curiosity. The APP reflects many of the same points made in the College evidence based guidelines on risk assessment – investigators should use excellent Communication to inform their professional Curiosity to identify the Clues (the 3 Cs).

Recommendation 21 [to the College of Policing]: At present, guidance for police on responding to unexpected deaths and suspected victim suicides where there has been domestic abuse sits across several different documents. We therefore suggest that all the recommendations in this report on responding to unexpected deaths and suspected victim suicides should be considered for inclusion in the appropriate sections of these key policing guidance documents:

• The College of Policing Practical Advice on dealing with sudden and unexpected death

• The College of Policing APP on Initial Investigation

• The College of Policing APP on Mental Health which includes a section on Suicide and Bereavement Response

• The College of Policing APP on Domestic Abuse

• The Major Crime Investigation Manual 2021

• The (forthcoming) College of Policing guidance on Unexpected Deaths

- There is ample coverage of these issues in College documents. As mentioned in response to recommendation 9, there has been very significant developments in relation to investigative practice, particularly unexpected deaths. We consider it important to allow these changes to take effect and then consider if there are further changes that are required. DA APP is currently being updated and will take account of content of this report.

- The College tries to avoid repetition of guidance contained elsewhere or within other College documents.

Recommendation 22 [to the College of Policing]: We recommend that the College of Policing should propose to the Domestic Abuse Matters Board that any key learning in this report which is not already in the Domestic Abuse Matters police training programme should be included in the next programme refresh.

- This report was discussed at the DA Matters Editorial Board. DA Matters focuses very closely on CCB. The key messages from this report have been included. The identification of CCB by officers should result in a detailed risk assessment and measures to improve safety of the victim. The training product has not been subject to a major refresh since it was launched. The Editorial Board considers what changes are necessary and has concluded that some amendments to content are needed, but not a major refresh.

- The Editorial Board is satisfied that the relevant issues raised in the report are addressed by the training course.

CPS response to recommendations:

Recommendation 20 [to the CPS]: We recommend that the CPS include guidance on prosecuting the domestic abuse perpetrator posthumously for CCB in cases of suspected victim suicide in its forthcoming refresh of Legal Guidance on Controlling or Coercive Behaviour in an Intimate or Family Relationship. We further recommend that the CPS review its guidance on Unlawful Act Manslaughter in relation to suspected victim suicides following domestic abuse.

- The CPS included updated guidance in relation to charging murder or manslaughter in cases of suicide, with specific reference to cases involving prior domestic abuse and coercive control; this can be accessed in the guidance titled: Homicide: Murder, manslaughter, infanticide and causing or allowing the death or serious injury of a child or vulnerable adult.

Home Office response to recommendations:

Recommendation 3 [to the Government and police]: Building on the recommendation in our Year 1 report, investigation is still needed into whether the overall number of domestic

homicide suspects who were previously being managed by police or probation (e.g., under MAPPA, IOM or DRIVE) is actually as low as reported to this Project. If it is, further discussion may be needed between the police and government about what can be done to strengthen monitoring and disruption of these individuals.

- The government know continued investment in this area is so important to improving our understanding of how to prevent individuals reoffending. Between April 2020 and March 2023 we awarded over £41m to increase the availability of interventions for domestic abuse perpetrators, including behaviour change and stalking programmes, and to expand effective projects such as Drive.

- We have recently awarded up to £39,000,000.00 over the next two years (financial years 2023/24 and 2024/25) to improve the safety of victims by reducing the risk posed by perpetrators. Our ambition, through this competition, is to identify and fund best-in-class projects that both deliver on this aim whilst also better establishing what works to manage offenders and drive down recidivism.

- We intend to bring forward legislation at the earliest opportunity to ensure that offenders convicted of CCB are managed in the same way as physically violent offenders.

- We know that controlling and CCB can be a precursor to domestic homicide, and therefore these offenders will be more robustly managed by police, prison and probation under Multi-Agency Public Protection Arrangements (MAPPA). This means a range of agencies will have a legal duty to cooperate to manage the risks posed by that offender.

Recommendation 5 [to DHR Panels]: All professionals involved in DHRs must take personal responsibility to ensure the victim is treated with care, respect and dignity, with their voice and perspective centre stage. This means attention to details such as: checking that their name is spelled correctly (and avoiding replicating others' errors) and ensuring that only relevant details of the victim's life are focused on, and that their lifestyle or vulnerabilities are not used to victim-blame, or allowed to overshadow the abuse.

- The government has committed to procuring a supplier to implement a comprehensive training for DHR Chairs to ensure individuals can effectively conduct a DHR and identify recommendations to improve the safety of domestic abuse victims and ultimately prevent further deaths. The tender is expected to go live in October 2023, with a supplier being appointed in 2024.

Recommendation 6: [to DHR Chairs / DHR Panels / Government]: Bereaved families should be given the opportunity to contribute to the DHR from the outset, and to ensure that the victim's voice and perspective are central to the review. The Home Office Statutory Guidance on DHRs clearly sets this expectation, but it seems that this may not always be well implemented in practice. DHR Chairs and Panels should ensure that they are following the Guidance closely in involving families.

And,

Recommendation 24 [to the Home Office]: We recommend the Home Office proceed as quickly as possible to publish their forthcoming refresh of the DHR guidance. This re-issued guidance should reflect the learning on suspected victim suicides presented throughout this report.

- We continue to redraft the statutory guidance and are grateful to those that have generously provided feedback on their experiences of the DHR process and how we can strengthen the next version of the guidance. The guidance will be formally consulted on it later this year and we welcome feedback on it in due course.

Recommendation 12 [to the Government and health agencies]: We recommend that, in developing local and national suicide prevention activities, health agencies should consult domestic abuse specialists to ensure that appropriate measures relating to domestic abuse victims are included. At a local level, Local Health Partnerships should consider the risk of SVSDA in their suicide prevention strategies. At a national level, the Department for Health and Social Care should ensure that domestic abuse is reflected in national suicide prevention strategies.

- On September 11, the Department of Health and Social Care published a new, five-year cross-Government and cross-sector Suicide prevention strategy for England. The strategy identifies domestic abuse as a key risk factor for suicide to be addressed. We will update guidance for local areas by the end of 2024 to support alignment of local suicide prevention plans with the national strategy.

Project progress on recommendations:

Recommendation 10 [to this Project]: We recommend that this Project, in Year 3, conduct further work to understand the profile and implications of caring relationships in domestic homicides (both suspect to victim, and victim to suspect).

- The Project team delivered a Spotlight Briefing on caring relationships between the victim and suspect. Additionally, this briefing was utilised in the Safe Care at Home Review, who commented to our team that, 'The review benefitted greatly from the Vulnerability Knowledge and Practice Programme and specifically the Carers Spotlight, which was published in November 2022. This provided vital evidence into domestic homicide statistics where a care relationship is a factor in the homicide.'

Recommendation 23 [to this Project]: We recommend that this Project co-ordinate a learning event for police on SVSDA to share promising practice from forces, including on initial enquiries in unexpected deaths with a history of domestic abuse, on Real Time Suicide Surveillance, and on pursuing posthumous prosecutions.

- The Project team delivered numerous presentations to police forces including at a conference dedicated to SVSDA held by West Midlands Police, at the VKPP's

national conference and at a National Suicide Prevention Group meeting hosted by ACC Charlie Doyle. The Project team also coordinated a learning event at the National Domestic Abuse Stakeholder meeting hosted by AC Louisa Rolfe with attendance from force representatives from across England and Wales which included co-presentation with CPS representatives with experience prosecuting Unlawful Act Manslaughter in a case of SVSDA. As noted in this report, this work will be an ongoing feature of the Project.

Recommendation 25: [to this Project] We recommend that this Project continue to develop and report on SVSDA in Year 3. The Project should continue to consult with AAFDA and bereaved families to inform this work.

- The Project team held our second consultation event with AAFDA, presented at AAFDA's annual conference and will continue our partnership work into the future. Chapter 7 in this Year 3 report is dedicated to the analysis of SVSDA, and it is evident from the response from police forces that our work has had a significant impact on policy and practice in this area.