NCVPP

National Centre for Violence Against Women & Girls and Public Protection

Executive Summary: **Domestic Homicides and Suspected Victim Suicides 2020-2025**

Year 5 Report

April 2026

College of Policing

NPCC National Police Chiefs' Council

Contents

Introduction

This executive summary presents the main findings and recommendations from the Domestic Homicide Project Year 5 Report. The full report is **available here.**

The National Domestic Homicide Project, funded by the Home Office and led by the National Police Chief's Council (NPCC), is delivered by the National Centre for Violence Against Women and Girls and Public Protection (NCVPP) within the College of Policing. The report tracks the scale and nature of domestic abuse-related deaths in quick-time, sharing learning from all police-recorded domestic homicides, child deaths, unexpected deaths and suspected suicides following domestic abuse. The project also gathers detailed case information, including suspect and victim demographics, prior police and partner agency contact, and risk factors.

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

Main Findings - Year 5

1,452 lives

This report marks five years of data collection and analysis. Across the full dataset (1st April 2020 – 31st March 2025) the project recorded 1452 domestic abuse-related deaths. These included:

- 641 (44%) domestic homicides (414 IPH and 227 AFH)
- 553 (38%) SVSDA
- 131 (9%) unexpected deaths
- 86 (6%) child deaths, and
- 41 (3%) deaths classified as 'other'

Since Year 3 (1st April 2022 – 31st March 2023) recorded cases of SVSDA have surpassed the number of recorded IPH, with SVSDA being the most recorded typology across the full five-year dataset (38%). The increased reporting of SVSDA cases is likely due to improved awareness and identification of the link between suicide and domestic abuse. The number of IPH deaths has remained relatively stable over the five years of data collection. This continues to highlight the enduring issue of abuse by an intimate partner, its consequences and the need to work towards prevention.

In Year 5 (1st April 2024 – 31st March 2025), there were a total of 347 deaths encompassing

- 150 (43%) SVSDA
- 125 (36%) domestic homicides (80 (23%) IPH and 45 (13%) AFH)
- 43 (12%) unexpected deaths
- 17 (5%) child deaths, and
- 12 (3%) deaths classified as 'other'

Across the five-year dataset, the most common method of death was by hanging (23%), almost exclusively recorded in SVSDA cases, being the most common method of death in these cases (59%). Sharp instrument was the second most common method of death overall (22%), and the most common in cases of IPH (40%) and AFH (49%), accounting for 43% of domestic homicides.

Deaths involving a fall from height

The coding and analysis of deaths involving a fall from height was introduced within the project's analysis in Year 4, following conversations with the Killed Women Network in relation to their campaign "Fallen Women".

In Year 5 alone (April 2024 – March 2025), 18 cases involving a fall from height were reported, increasing the total to 39 deaths by this method across the five years of data collection. This may be evidence of an increased understanding and awareness by forces of such cases involving a history of domestic abuse rather than an empirical rise in this type of death.

Victims and Suspects

Across the five-year dataset, most victims (73%) were female, and primarily aged between 25 to 54 years old (60%). Notably, the majority of AFH victims were older, with 40% of them being aged 65 years or older. In contrast, SVSDA victims were younger, most commonly aged 25 to 44 years old (59%). Suspects were predominantly male (79%), with 69% of them aged between 25 and 54 years.

In domestic homicide cases (AFH and IPH) and SVSDA cases (n = 1186), most incidents involved one victim and one suspect (92%), frequently with a female victim and male suspect (72%). This pattern was particularly pronounced in IPH cases, whereby the majority involved a female victim and male suspect (85%), compared to 46% in AFH cases.

Across the five years of data collection, 46% of suspects were the current partner of the victim and 23% the ex-partner/spouse. Additionally, the suspect was the child of the victim in 11% of cases across all five years, primarily in cases of AFH (53%).

victims
73%
female

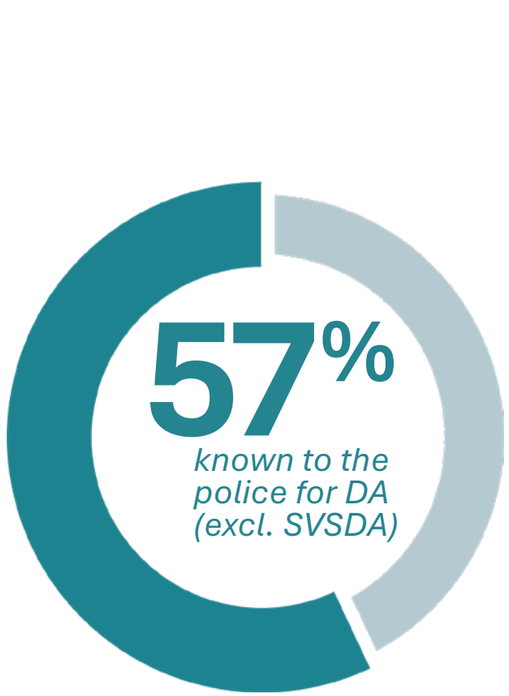
suspects
79%
male

Whilst this project's overall definition of DA-related deaths includes 'any age', Year 5 marks the first case of suspected suicide following teenage relationship abuse (TRA) in the dataset, whereby both the victim and suspect were under the age of 18. It should be noted that a potential barrier to case submission for cases involving individuals under 16 may be the statutory definition of domestic abuse, which applies only to individuals aged 16 and older. Consequently, incidents involving under-16s may not be recorded as domestic abuse or domestic homicide, making them less identifiable to the police and other agencies.

Data collected for this project shows a high rate of police-recorded data on ethnicity (96% of victims and 95% of suspects). Most victims (79%) and suspects (78%) were recorded as White, however, those from Black, Black British, Black Welsh, Caribbean or African ethnic groups remain slightly over-represented compared with their presence in the general population (7% vs 4%). Notably, 17% of victims of domestic homicide (IPH and AFH) were women from minoritised ethnic groups.

Additionally, whilst the figures may be influenced by barriers to data recording within the policing context, 3% of victims (n=48) and 3% of suspects (n=44) were recorded as being LGBTQ+. The majority of LGBTQ+ victims (65%, n=31/48) and suspects (61%, n=24/44) were recorded within SVSDA cases, suggesting the importance of considering suicide prevention opportunities for victims of DA within this population.

Overall, mental health was the most commonly recorded care need for victims (29%) and suspects (49%). In the case of victims, mental health needs were most common in cases of SVSDA (55%). For suspects, mental health care needs were highest in cases of AFH (62%).



Risks and Response: Risk Factors, Previous Police Contact and Review Referrals

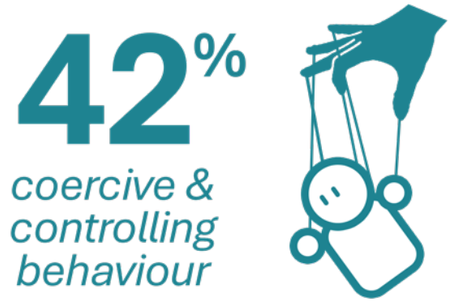
Across the five-year dataset, of 1,554 suspects, the most commonly identified antecedent risk factors were:

- Any mental ill health (44%, n=687)
- A history of coercive and controlling behaviour (CCB; 42%, n=646)
- Alcohol use (35%, n=540)
- Drug use (32%, n=503)

Notably, for 20% of suspects, alcohol and drug use were recorded as co-occurring risk factors. Furthermore, these risk factors varied by typology. For example, CCB was highly prevalent in cases of IPH (42%), SVSDA (56%) and unexpected deaths (45%).

Additional analyses indicated that CCB had a strong statistical correlation with harassment and Image-Based Sexual Abuse (IBSA), indicating that these forms of abuse were more likely to be identified in cases where CCB was present than would be expected by chance. Previously recorded non-fatal strangulation (NFS) was significantly associated with the presence of all other recorded risk factors, particularly 'threats to kill'. Furthermore, NFS was more prevalent in cases of SVSDA compared to DH (IPH and AFH).

Across the five-year dataset, excluding cases of SVSDA, 57% of suspects were known to the police for DA perpetration prior to the victim's death. Within cases of SVSDA, 88% involved a history of DA perpetration known to the police prior to the victim's death. This would be expected given the need for the police to know about the abuse to submit the case to this project, but it also suggests that some cases are being identified posthumously through information from family, friends or other agencies. This finding also indicates that SVSDA victims were often 'visible' to the police, which indicates opportunities for intervention or prevention.



In 70% of incidents across the five-year dataset the victim and/or suspect was known to a partner agency, most commonly in cases of SVSDA (80%). Mental health services were the single most recorded agency (25%), and when combining all cases known to social services, this accounted for 43% of victims and/or suspects. For those cases in which the suspect was not previously known to police for any reason (n=214), 27% involved a suspect and/or victim that were known to a partner agency, continuing to highlight the importance of multi-agency collaboration and information sharing.

Excluding child deaths, of those cases that were referred for a Domestic Homicide Review (DHR) or other type of review, 65% were accepted, which rises to 84% when considering only those cases that were referred, and the referral outcome was known.

70%

of victims and/or suspects **known to a partner agency**

known to mental health services

25%

known to combined social services

43%

Suspected Victim Suicide Following Domestic Abuse

The project conducted 'deep dive' work on the police response to unexpected deaths involving a history of domestic abuse. Highlighting the relevance of **updated APP guidance**, themes arising from this work include the continued importance of gathering information from family members and friends, use of professional curiosity in relation to the investigation of any unexpected death and consideration of posthumous prosecution based on a previously recorded or newly identified history domestic abuse.

Across the five-year dataset, 17 cases of SVSDA successfully achieved a posthumous charge (representing 3% of the overall SVSDA dataset), with three of these simultaneously pursuing further investigations for Unlawful Act Manslaughter (UAM). At the time of analysis there were at least seven ongoing investigations into additional cases, including six pursuing a charge for CCB, in one of these cases alongside a potential charge for UAM.

Fourth consultation with bereaved family members: Perspectives from lived experience

Over the past five years, with support from Advocacy After Fatal Domestic Abuse (AAFDA), our project has held consultations with families bereaved by fatal domestic abuse. We are sincerely grateful for their support and willingness to share their invaluable insights. Their perspectives and experiences helped inform the findings and recommendations in this report.

The consultation event allowed space for the family members to share their feedback for the police and their partner agencies. They described potential barriers to the response to unexpected deaths, including SVSDA. Family members mentioned challenges to information gathering and sharing when multiple force areas and/or agencies are involved, limitations to the use of body worn camera footage, narrow remit for coronial conclusions, the ripple effect on and responsibilities of families, victim blaming attitudes and unconscious bias. In contrast, themes for potential solutions included the collection of relevant data, adapting learning from this research to other sectors, consistency of investigations, and providing support for bereaved family members.

Progress Against Year 4 Report Recommendations

In the Year 4 report, we made recommendations to policing on several issues, such as identifying and addressing Teenage Relationship Abuse (TRA); multiagency work in relation to prevalent risk factors such as mental ill health, coercive and controlling behaviour, non-fatal strangulation and substance use; strengthening links between suicide prevention and DA teams; and, seeking early advice from the CPS for posthumous prosecution in SVSDA cases.

Some of the main updates reported by forces to our project are:

Teenage Relationship Abuse

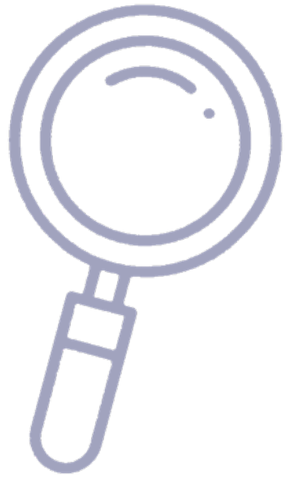
- Forces pointed out that the statutory definition of DA limits formal recording for under 16s. As such, DA in intimate relationships with individuals under 16 is often not labelled or dealt with as DA, which limits visibility.
- Many forces said that harm within under-16 relationships is often managed through child protection or safeguarding pathways, with PPNs, child concern forms, strategy discussions and MASH referrals as the core mechanisms.
- Forces indicated that they are working in collaboration with social care and health (e.g., via MASH) and education (e.g., via PolEd) to promote awareness of unhealthy relationships, coercive control, and online harms.

Multiagency work to address risk factors

- Forces continue to work on strengthening information sharing with social care, mental health and wider partners (e.g., via MARAC, MASH, adult safeguarding hubs, and shared data systems).
- They are also working on strengthening referral pathways by developing or adapting clear referral routes and escalation processes (e.g., mental health triage, substance misuse referrals and custody-based interventions)
- Several forces mentioned that they are ensuring that learning from DHRs, are embedded within DA processes, for example by triaging, secondary reviews and supervisory oversight.
- Where NFS is identified many forces consider this as increasing risk, linking NFS both to potential DH and suicide.
- NFS is being embedded into training and CPD packages to increase awareness.
- Improvements have been made to oversight and analysis of NFS cases, audits of risk gradings, and specific NFS scrutiny panels have been held to better identify gaps, improve consistency and share learning.

Strengthening links between suicide prevention and DA specialist teams

- Forces are continuing training to improve awareness of DA-related suicide risk and identification of suicidality in DA contexts, including coercive control and abuse post-separation.
- Some forces have specific liaison roles and models to bridge DA and suicide prevention teams, but not all forces have staffing for dedicated roles.



Identification of cases for posthumous prosecution

- Some forces are implementing processes to screen and routinely review all suspected suicides for DA history, implementing daily reviews of unexpected deaths and introducing mandatory checks and sign off processing in relation to DA.
- Forces are escalating cases early to specialist teams (e.g., Major Crime, CID, DA) and are involving senior officers and leads to provide appropriate oversight.
- Forces are using review processes (e.g., DHR) not only for learning, but also to identify missed investigative opportunities, and re-open or conduct parallel criminal investigations.
- Forces are proactively seeking early engagement with the CPS, particularly through Complex Case Unit (CCU) routes, and forums with representation from CPS (e.g., case conversations, clinics and Joint Operational Improvement Meetings (JOIMs)).

Year 5 Recommendations

Recommendation 1 - To the NCVPP and College of Policing [PREVENTION]:

For the NCVPP to work with the College of Policing to consider how the key findings and recommendations can be shared within domestic abuse training for all officers.

Recommendation 2 - To the Government, NCVPP, Department for Education, National Child Mortality Database, police and partners [PREVENTION]:

To work in partnership to ensure the identification, recording and submission of cases involving individuals under 16. To consolidate data from sources such as the National Child Mortality Database and police systems to ensure the scale and prevalence captures all domestic abuse-related child deaths, including unexpected deaths, suspected suicides and deaths related to teenage relationship abuse.

Recommendation 3 - To the College of Policing and NCVPP [PREVENTION]:

To work with partners and relevant stakeholders to update guidance for police practice, safeguarding and referrals for support in response to domestic abuse experienced by children and young people, including teenage relationship abuse.

Recommendation 4 - To NCVPP and Domestic Homicide Project [PREVENTION]:

Further to the government's VAWG Strategy commitment, the NCVPP and Domestic Homicide Project should consider scoping the expansion of this research to wider fatal VAWG, subject to agreement on definition and inclusion criteria as well as appropriate resourcing.

Recommendation 5 – To the police, NPCC, NCVPP and Domestic Homicide Project [PREVENTION]:

To continue collecting data and improve data quality in relation to protected characteristics, as well as areas of interest such as deaths involving a fall from height, to build an evidence base for targeted intervention and prevention activity.

Recommendation 6 – To the NCVPP and NPCC [PREVENTION/PERPETRATORS]:

The prevalence of coercive and controlling behaviour (CCB) alongside related risk factors (e.g., separation, non-fatal strangulation) is evident within the five-year dataset, particularly within cases of IPH, SVSDA and unexpected deaths. Therefore, the NCVPP should consider how the understanding of CCB, as a criminal offence and wider pattern of abusive behaviour, can facilitate a step change in the use of the legislation to support prevention and the pursuit of perpetrators.

Recommendation 7 – To the Government, Department for Health and Social Care and NPCC [PREVENTION]:

To work in partnership to improve cross-government working in relation to suicide prevention, ensuring learning regarding suicide following domestic abuse are captured within resources such as NHS England's Staying Safe from Suicide: Best practice guidance e-learning session described in the government's VAWG Strategy.

Recommendation 8 – To the NPCC, NCVPP and Domestic Homicide Project [PERPETRATORS]:

To scope the possibility of conducting in-depth case analysis to gather information regarding the history and trajectory of police and partner agency contact of domestic abuse perpetrators who go on to commit domestic homicide.

Recommendation 9 – To the Government [PREVENTION]:

The following recommendation is rolled over from the Year 4 report due to timelines for enacting legislative changes regarding Domestic Homicide Reviews (DHRs) - To monitor and evaluate changes influenced by the updated definition and forthcoming statutory guidance relating to DHRs (to be re-named **Domestic Abuse Related Death Reviews**), once these changes have been enacted.

Recommendation 10 – To the NPCC, NCVPP, College of Policing and Domestic Homicide Project [PREVENTION/PERPETRATORS]:

To build upon learning from the Domestic Homicide Project's work on the police response to unexpected deaths, including SVSDA, regarding the translation of policy into practice. The findings from this research should inform consideration of options for future work including the strengthening of relevant guidance and training.

Recommendation 11 – To the police, NPCC, NCVPP and CPS [PERPETRATORS]:

To engage in joint working across the police, CPS and relevant stakeholders to share learning and emerging practice in relation to the response to unexpected deaths and posthumous prosecution of Unlawful Act Manslaughter and domestic abuse related offending to inform future guidance and policy developments.

Recommendation 12 – To the NCVPP and Domestic Homicide Project [PREVENTION]:

For the Domestic Homicide Project to share relevant research findings regarding unexpected deaths and SVSDA with coroners, such as to inform the training programme for coroners described within the government's VAWG Strategy.

Recommendation 13 – To the police, NPCC and Coroners [SUPPORT FOR VICTIMS]:

To apply findings from this research to ensure consistency and standardisation of policy and practice surrounding coronial processes. To ensure police forces liaise with the coroner and identify and report any history of domestic abuse that may be relevant to the inquest.

Recommendation 14 – To the NCVPP and Domestic Homicide Project [SUPPORT FOR VICTIMS]:

To continue consultation with family members bereaved by fatal domestic abuse, Family Liaison and Coordination of Support Services (FLACSS) and the charities which represent bereaved families, to allow the voices of the victims to inform future work in this area.

NCVPP

National Centre for Violence Against Women & Girls and Public Protection

About the National Centre for Violence Against Women and Girls and Public Protection

We're a collaboration between the College of Policing and the National Police Chiefs' Council.

We work across law enforcement, the third sector and government to professionalise public protection and strive for a whole systems approach to prevent harm, give confidence to victims, survivors and witnesses to come forward and bring more offenders to justice.

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