Vulnerability Knowledge and Practice Programme (VKPP)

Domestic Homicides and Suspected Victim Suicides 2021-2022

Year 2 Report

Lis Bates[1], Katharine Hoeger[2], Thien Trang Nguyen Phan[3], Phoebe Perry[4], and Angela Whitaker[5]

"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

December 2022

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

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

[3] Research Assistant (during this report preparation), Vulnerability Knowledge and Practice Programme (VKPP)

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

[5] 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

“See me”

A 999 call, there’s a body on the beach,

Please listen to my story, I have so much to teach.

Are there any identifiers, do we know who she was?

My name is Lyndsay and I have so many scars.

Policies and protocol, reports to complete,

You’re not listening or seeing me coz my life’s obsolete.

We’ll have to tell the family, is it your turn or mine?

I was abused and belittled, broken in spirit, body and mind.

Have we got all we need here, witness statements and things?

I’m sorry for my suicide and the trouble it brings.

Telling the family is not easy at all,

We have listened and if missed anything just give us a call.

You’ve not listened to anything, you don’t know my life.

You’ve got what you need though, next of kin and the like.

You’ve got someone to identify the body on the beach,

But you’ve missed the desperation in my family’s speech.

They are begging you to help me, to know who I am,

I’m a mother, daughter, sister and friend but I’m also the wife of a cruel, monstrous man.

I fought for my life, fought with all that I had,

But I was coerced and controlled and abused so bad.

I was left feeling worthless and scared and sad,

The abuse left me thinking that I was going mad.

Should we question capacity, could that give us a lead?

Please don’t insult me. Question abuse, that’s what I need.

You see, if you ask the right questions and understand who I was,

I’m no longer a body, crime number or report, I die as a victim and that’s who I was.

By Laura, for her twin sister Lyndsay

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 national work to develop a strategy for Violence Against Women and Girls has only driven this determination.

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 lockdown and this is the second annual report. The impact of COVID 19 cannot be underestimated and the true impact on victims and their families won't be fully understood for many years. However, academic research has assisted policing in many ways throughout this unprecedented period and we have listened and adapted. This research provides policing the opportunity to learn from the horrific cases of domestic homicide and have a deeper look at suicides following domestic abuse.

Throughout this project we have been greatly supported by the domestic abuse and homicide stakeholders, alongside a variety of academics who are experts in this field. We would like to thank former lead for Homicide, DAC Stuart Cundy, and the police forces of England and Wales for their unwavering support and contribution to this project.

The report also provides the opportunity to remember the victims and their families who have lost their loved ones in horrific circumstances. In particular we would like to thank the families who have emphasised the importance of the police response to suicide following domestic abuse.

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

DAC Stuart Cundy QPM
Deputy Assistant Commissioner
Former National Policing Lead for Homicide

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

Chief Constable Andy Marsh QPM
Chief Executive Officer
College of Policing

Foreword – Parliamentary Under Secretary of State (Minister for Safeguarding)

Domestic homicide is a horrific crime. It is also devastating that some victims of domestic abuse are taking their own lives. As Minister for 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.

Domestic abuse affects 2.3 million adults every year, while one in five homicides is a domestic homicide. There is also a wider, societal and economic cost associated with these awful crimes. There is a clear need for action and the Government is committed to this vitally important effort. Our landmark Domestic Abuse Act became law in April 2021. It is bolstering our response on every level and strengthening protections for victims, while also ensuring perpetrators feel the full force of the law.

In addition, we published the cross-Government Tackling Violence Against Women and Girls (VAWG) Strategy in July 2021, followed by our Tackling Domestic Abuse Plan in March 2022. The Plan includes commitments to update police guidance on suicide to explicitly include references to domestic abuse, and to strengthen the Domestic Homicide Review process. These documents are designed to have a transformational impact and we are making good progress implementing their commitments. This includes the launch of the “Enough” national communications campaign which tackles harmful attitudes and has reached millions across England and Wales. We have also announced we will be adding VAWG to the strategic policing requirement and ratified the Istanbul convention, showing international leadership on this issue.

However, we are not complacent. As this report shows, we must keep up the momentum in our efforts to confront the scourge of domestic abuse.

I am grateful to the National Police Chiefs’ Council, the Vulnerability Knowledge and Practice Programme and the College of Policing, as well as everyone else who has contributed to this project. It has offered a great deal of learning and allowed the police to improve their response to domestic abuse. The focus on improving our understanding of suicide following domestic abuse is also welcome.

Domestic abuse and VAWG cause enormous harm, and we must continue working together to tackle these horrific crimes wherever and whenever they occur.

MP Sarah Dines

Contents

Executive Summary of Findings and Recommendations

Chapter 2: Domestic Homicides and Suspected Victim Suicides 2020-2022

Findings

Finding 1: There was a rise in both domestic homicides and suspected victim suicides as counted by this Project in Year 2 (April 2021-March 2022) compared with Year 1 (April 2020-March 2021). The overall number of domestic homicides relating to an intimate partner, family member or 'other' increased by 16% (n = +23), including a 3% increase in intimate partner homicide (n = +3), a 55% increase in adult family homicide (n = +22), and a small decrease (n = -2) in 'other' deaths, as counted by this Project. Based on the pattern in Year 1 of this Project, we estimate this may increase a bit further due to late submissions. There was also a 28% increase (n = +14) in suspected victim suicides following domestic abuse. The increase in suspected victim suicides is likely to be reflective of better awareness and identification by police of these cases, as a result of this Project having become better established, greater general discussion of the issue, and close follow-up with forces by the Project team. It is good news that police are increasingly identifying such cases. The increase in adult family homicides is less reliant on police identification of incidents than suspected victim suicides, and thus more likely to reflect an empirical rise in cases. It is possible that the pandemic and its after-effects have had an impact on the increase in these adult family deaths. It is too soon to know whether this increase will be sustained following the Covid pandemic. It is not possible to identify whether this is a long-term trend based on two years of data. Further years of data collection and analysis will be required.

Finding 2: For suspected victim suicides slightly more deaths were recorded in January across both years (n = 7 in Year 1, n = 10 in Year 2) compared with other months. Whilst suicides more generally do not mirror this seasonal pattern, domestic abuse does, with the Christmas and New Year period particularly associated with higher rates of abuse. These numbers can only be interpreted as a possible indicator; they represent a small relative increase in overall small numbers; so, again, data over at least three more years is needed to identify trends. However, given the known seasonal pattern of domestic abuse, it seems plausible that Christmas and around the New Year may also be a time of increased risk of suicides following domestic abuse – a link that has not previously been identified.

Recommendations

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.

Chapter 3: Typologies and characteristics of victims and suspects

Findings

Finding 3: In Year 2, there was a drop in the proportion of older victims (aged 65 years and over) of intimate partner homicide (n = 18, 18% in Year 1; n = 11, 11% in Year 2). This follows our Year 1 finding of a rise in older intimate partner victims and suspects during the pandemic.

Finding 4: By contrast, in Year 2, as in Year 1, there remained a high proportion of older victims in the adult family homicide cases (n = 17, 43% in Year 1; n = 26, 42% in Year 2). As in Year 1, these were primarily killed by their adult children or grandchildren. In contrast to Year 1, where we saw more adult family homicide cases where the victim was caring for the suspect – usually due to the suspect's mental ill health and/or substance use – in Year 2 this caring relationship reversed, and we saw a larger proportion of suspects who were caring for the victim – often due to age or infirmity.

Finding 5: In Year 2, there were slightly more male victims (although still in the minority) compared with Year 1: an increase from 28% (n = 61) to 32% (n = 79). Overall, across both years, male victims were principally associated with the child death and 'other' categories.

Finding 6: Whilst the LGBTQ+ variable was often recorded as 'not known' (n = 67, 31% in Year 1; n = 85, 34% in Year 2), the Project dataset did record a slightly higher number of LGBTQ+ victims in the second year of data collection (n = 6, 3% in Year 1; n = 10, 4% in Year 2). It is possible that officers are improving their identification of LGBTQ+ victims, especially within suspected victim suicides (n = 2, 4% in Year 1; n = 8, 13% in Year 2).

Finding 7: Whilst numbers are small, the full two-year dataset appears to include a lower proportion of victims and suspects of white ethnicities and a higher proportion of victims and suspects of minority ethnic heritages compared to the general population as measured by the 2011 Census (22% of victims and 20% of suspects were of minority ethnic heritages, compared to 14% in the Census). This was particularly true of victims and suspects of black ethnicities (8% compared with 3% in the Census).

Finding 8: Victims of Polish nationality were the second most common after victims of British nationality across the full two-year dataset, at 5% (n = 17). This mirrors findings over ten years from the Femicide Census, which highlighted Polish victims as being most represented after British victims in femicide cases. Both these findings are likely to reflect the fact that, according to the 2021 Census, Polish has been the most common non-British nationality in the UK since 2007.

Recommendations

No recommendations.

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

Findings

Finding 9: As in Year 1, across the board, the most commonly identified antecedent risk factors for all suspects in domestic homicides and the perpetrators of prior domestic abuse in victim suicides were: prior perpetration of domestic abuse, coercive or controlling behaviour, mental health issues, alcohol and drug misuse. These risk factors did vary by type of death, with coercive or controlling behaviour and prior police record of domestic abuse being particularly prominent in intimate partner homicide and in suspected victim suicides; and mental illness, alcohol and/or drug misuse and carer relationships being more prominent in adult family homicides.

Finding 10: In Year 2, a greater number of risk factors across the board were positively identified by police as present in the suspect's history in each submission – an increase of around 10 percentage points in most risk factors. Whilst these are subject to the usual caveats about the relatively small dataset, the Project team believes these overall increases may be partially explained by the more detailed case follow-up with forces conducted in Year 2 by the Project team. It is also likely to reflect better identification by police of antecedent risk factors, which is a positive development. However, it is also possible that the Year 2 dataset involves higher risk cases, each with a greater number of risk factors present in the history. It will be important to continue data collection into future years to allow consideration of broader patterns within the data. Risk factors which stood out as having changed by more than the 10-percentage point average in Year 2 were: for intimate partner homicide, a decrease in the proportion of victims and suspects in caring relationships; for suspected victim suicide, an increase in the recorded proportion of cases involving the domestic abuse perpetrator's known prior breach of a protective order and a decrease in the proportion of prior non-fatal strangulation; and for adult family homicide, an increase in the suspect being a carer for the victim and of suspect alcohol use.

Finding 11: This report demonstrates that risk factors present in, and therefore interventions appropriate to, intimate partner abuse and family member abuse, differ. To intervene effectively, police need to understand the 'problem profiles' of different domestic abuse related deaths in their force.

Recommendations

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.

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

Findings

Finding 12: In Year 2 the proportion of all suspects / perpetrators known to police for domestic abuse rose to two thirds (66%, n = 167) from just over half (55%, n = 131) in Year 1. In Year 2, fewer suspects in adult family homicide cases were previously known to police for domestic abuse (47%, n = 29/62), compared with suspects in intimate partner homicide cases (63%, n = 65/104). Suspects in intimate partner homicides and perpetrators of the previous domestic abuse in suspected victim suicide cases were much more likely to be previously known to the police as high-risk domestic abuse offenders and/or to be known to MARAC than suspects in adult family homicides.

Finding 13: We were able to show a statistical association between high-risk perpetrators and various antecedent suspect risk factors including: prior threats to kill, coercive or controlling behaviour, breach of orders, non-fatal strangulation, and stalking. These associations seem reassuring in the sense that they indicate that police are using presence of these risk factors appropriately in assessing and assigning risk in domestic abuse cases, and further confirm that these risk factors are key to understanding the most dangerous domestic abuse perpetrators.

Finding 14: Across the two-year dataset, only 10% (n = 49/492) of suspects (or perpetrators of prior abuse in suspected victim suicides) were recorded as 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 police for anything, this rose to 16% (n = 49/297). Our Year 1 report highlighted that further investigation was needed to test whether this figure is accurately capturing all offenders who are being managed – or whether there is under-reporting to this Project. Year 2's data shows that additional investigation is still needed.

Finding 15: The police alone cannot prevent domestic abuse or homicide. Of the cases in this dataset in which the individuals were not previously known to police, almost half were known to one or more non-police agency. This shows that multi-agency partnerships such as MARAC and MASH are absolutely vital to identify those most at risk and put in place appropriate interventions, especially in adult family violence cases.

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.

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'*.

Chapter 6: Domestic Homicide Reviews

Findings

Finding 16: Where known, in Year 2 the overall number of domestic homicides and suspected victim suicides referred for Domestic Homicide Reviews (DHRs) rose from 84% in Year 1 to 97% in Year 2. The known acceptance rate also rose, from 91% to 96%. This is an encouraging development.

Finding 17: Domestic Homicide Reviews (DHRs) are the right vehicle to respond to requests we heard from bereaved families for lessons to be better learnt about agency responses in individual cases, including about whether adequate safeguarding and protection actions took place in relation to the preceding domestic abuse. Home Office Statutory Guidance on DHRs makes explicit that families and friends should be clearly involved right from the start of a DHR process. The Guidance specifies that they should be a key stakeholder, that they may have information that is not known to agencies, and that "their contributions must be afforded the same status as other contributors" (Home Office, 2016, p. 17). It advises that families should be given the opportunity to meet the review panel and the Chair, to influence the scope, content and impact of the DHR, and be given completed reports in advance of submission to the Home Office, with time to absorb the report, identify any incorrect information in it, and register any areas of disagreement (Home Office, 2016, pp. 18–19). Yet we heard from some families that they had felt side-lined in this process and that their loved ones' voices were not necessarily afforded the respect or centrality that the Guidance recommends. Whilst the Guidance is explicit and detailed on the role family and friends should be given in DHRs, it seems that this may not always be well implemented in practice by Chairs and Review Panels.

Recommendations

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.

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.

Chapter 7: Coercive or Controlling Behaviour

Findings

Finding 18: This report presents new evidence to show that coercive or controlling behaviour was strongly present in both intimate partner homicide and suspected victim suicide cases. The findings show that the nature and extent of prior coercive control are severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.

Finding 19: When asked to identify indicators of coercive control in the victim's history, a remarkable level of detail was provided in submissions, demonstrating a sophisticated understanding by police of coercive or controlling behaviour and its various manifestations. Yet there were only a small number of cases in this two-year dataset where the specific offence of controlling or coercive behaviour was recorded or charged.

Recommendations

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.

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.

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.

Chapter 8: Adult Family Homicides

Findings

Finding 20: In Year 1, some adult family homicides were characterised by victims caring for suspects (often with mental ill health and complex substance use), whereas in Year 2, they were more characterised by suspects caring for older victims (often with ailing health and care needs).

Finding 21: A qualitative examination of risk factors in the Year 2 dataset shows that adult family homicide suspects are most commonly characterised by mental ill health, caring responsibilities, and a lack of previous police and agency contact.

Finding 22: The low number of adult family homicide suspects with mental ill health who were known to mental health services, coupled with the sizeable number acting as carers for victims at the time of the homicide, suggests a potential failure of victims and suspects to access care services and mental health services. It is unclear whether this is a short-term consequence of the pandemic and subsequent disruption of service provision, or whether it reflects more enduring structural issues, including already high thresholds for mental health services and adult social care.

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).

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.

Chapter 9: Impact of the Covid-19 pandemic and restrictions

Findings

Finding 23: As mentioned earlier, the pandemic and its after-effects may have had an impact on the deaths reported to this Project. As would be expected following the lifting of lockdown, there were fewer victims and suspects identified by police as having potentially been impacted by the Covid-19 pandemic and related restrictions in Year 2 (n = 15 victims, 13 suspects from 1st April 2021 to 31st March 2022) as compared with Year 1 (n = 28 victims, 31 suspects from 1st April 2020 to 31st March 2021). However, of those that did identify a potential Covid impact, thematic analysis showed that five of the seven themes arising from Year 1 analysis were similarly present in the Year 2 dataset.

Recommendations

No recommendations.

Chapter 10: Suspected Victim Suicides following Domestic Abuse

Findings

Finding 24: There was a rise of 28% (n = +14) in the number of submissions for suspected victim suicide in Year 2. This was a greater rise than intimate partner homicides, but less than adult family homicides. At least part of the increase in suspected victim suicides we think can be attributed to improved police awareness of the issue overall and greater awareness of this Project, meaning that more cases are being identified. Overwhelmingly, the domestic abuse which preceded the suspected suicide in these cases was from an intimate partner (92%, n = 46/50 in Year 1; 95%, n = 61/64 in Year 2).

Finding 25: Comparing the two years, there was a rise in male victims of suspected victim suicide, from 10% (n = 5) in Year 1 to 19% (n = 12) in Year 2, although the great majority of victims were still female (n = 45 (90%) in Year 1, n = 52 (81%) in Year 2). Within these 12 cases in Year 2, the majority (n = 10) had experienced prior abuse from an intimate partner. In two cases this abuse was from a male partner and in eight cases from a female partner. There is perhaps an interesting dynamic in these eight cases involving prior female-to-male abuse: in all eight, the male victim was previously known to police as both a victim and as a perpetrator of abuse. A more detailed exploration of primary perpetration in these suspected suicide cases is an important area for future research.

Finding 26: In Year 2, the proportion of suspected victim suicides amongst younger people (aged 16-24 years) increased, whilst the proportion of suspected victim suicides of older people (aged 65+) decreased. This may support the conclusions in our Year 1 report, that the pandemic put additional pressure on older victims and corresponded with a drop in care support. With the younger victims, coercive or controlling behaviour was present in almost all cases; in almost half, the victim was known to mental health services; and in a third, the victim was at university, several of which had had contact with university support services.

Finding 27: There was a rise in the number of LGBTQ+ victims of suspected victim suicide identified in Year 2 (13%, n = 8, compared with 4%, n = 2 in Year 1). Just under half these victims were male (n = 3), of whom two had experienced domestic abuse from a same-sex male partner. Just over half (n = 5) were female, of whom four had experienced abuse from a same-sex female partner.

Finding 28: In relation to prior risk factors in suspected victim suicides, as mentioned above, the most common factor was a history of coercive or controlling behaviour, which was even higher than in intimate partner homicides. In Year 2, whilst acknowledging the small overall numbers of cases for analysis for each risk factor, there was a higher-than-

average increase in breach of protective orders (6% (n = 3) in Year 1, up to 21% (n = 14) in Year 2), and a notable drop in recorded prior non-fatal strangulation (32% (n = 16) in Year 1, down to 6% (n = 4) in Year 2). This is a surprising finding, especially considering that there was an increased awareness of non-fatal strangulation during this period, arising from its inclusion as a new criminal offence in the Domestic Abuse Act 2021.

Finding 29: Across both years, one-third (n = 36) of the perpetrators of the prior domestic abuse in suspected victim suicides were known to police as high-risk or serial perpetrators. This rose from a quarter (n = 10) in Year 1 to over two-thirds (n = 26) in Year 2. Across both years, over two-thirds (n = 47) of perpetrators in these cases were known to MARAC; this rose from one-third (n = 15) in Year 1 to one-half (n = 32) in Year 2.

Finding 30: In terms of other agencies, victims and/or domestic abuse perpetrators in suspected victim suicides were most commonly known to domestic abuse services, GP/health services, mental health services, and children's social care. In Year 2 there was a noticeable rise in cases known to children's social care (14%, n = 7 in Year 1 and 34%, n = 22 in Year 2); alongside this there was an increase in cases identified as involving a recent child custody dispute (6%, n = 3 in Year 1 and 12%, n = 8 in Year 2).

Arising from our 'deep dives' with forces, the following conclusions were reached about police practice in understanding, identifying and responding to unexplained deaths and suspected victim suicides:

Finding 31: Whilst there is ongoing work to develop a consistent approach, we found that individual forces differed considerably in their policies and treatment of suspected suicides as unexpected deaths, including in the use of terminology.

Finding 32: Individual force policies varied in their guidance on how to account for domestic abuse as part of the evidence-gathering process in an unexpected death or suspected suicide. Some had specific guidelines; others did not.

Finding 33: How and when system checks for any prior knowledge of domestic abuse were conducted on the individuals and the address differed among forces. Some forces said that response officers completed checks before attending or when at the initial scene, whilst others said system checks might be conducted after leaving the scene and during the write up of the initial report.

Finding 34: Most forces had a policy for a supervisory officer to review the attending officer's actions, although this policy could not always be located. Several suggested that practice might differ from the policy. Others were unclear as to whether this policy resulted in supervision in-person on the scene, or if it was a desk-based review of the initial case file, with the approach taken seemingly dependent on the circumstances of the death and resource availability.

Finding 35: In practice, forces described that if the circumstances at the scene were not perceived to be suspicious, the initial investigation would be paused at that point when all initial investigative avenues were exhausted. Therefore, if a history of abuse was not

identified within the early stages of the investigative response, future opportunities to hold the perpetrator to account could be limited. Importantly, in some cases new information did come to light after the initial response, including when officers completed an investigation on behalf of the Coroner, and this did inform the police re-looking at the case. The 'deep dive' interview participants identified the need for a shift in investigative mindset, to really underpin professional curiosity amongst all officers attending and reviewing such deaths.

Finding 36: Following the initial response to a sudden or unexpected death, officers notify the local Coroner by completing a form as specified by the Coroner (often called a Sudden Death form). The format and contents of these forms are not standardised and, whilst they ask for information of the circumstances of the death, there is no routine prompt about domestic abuse history. There is an opportunity here to consider standardising this form, or at least to urge all forces to consider and record domestic abuse history on it.

Finding 37: One force raised a concern that attending officers might not be routinely recording all individuals present in the household at the time of the death. This interviewee suggested that not doing so might prevent the identification of domestic abuse, of appropriate enquiry relating to that individual, and of evidence-gathering in relation to later coronial inquest investigations.

Finding 38: Following an unexpected death or suspected suicide, in the vast majority of cases where there is a co-habiting couple, the spouse or partner would be considered next of kin. Some interviewees suggested that in cases where a suspect of domestic abuse had isolated a victim from their family and friends, as next of kin, this suspect could be in a position to manipulate the narrative and any future criminal justice and/or coronial process. This demonstrates the importance of police always consulting wider family and friends in initial enquiries, as they may have information about abuse which had not been disclosed previously to the police or other agencies. Several police forces raised this as an important issue.

Finding 39: We found several examples of promising police practice, including: use of Real Time Suicide Surveillance (RTSS) systems; attempted posthumous prosecutions in suspected victim suicide cases, including for coercive or controlling behaviour and for manslaughter; dedicated suicide prevention partnerships; and good early information-sharing with local Coroners.

Finding 40: Home Office clarifications to Community Safety Partnerships on when to commission Domestic Homicide Reviews (DHRs) in suspected suicide cases seems to have given police and local partners the confidence to push for more suicide DHRs.

Recommendations

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 suicide following domestic abuse 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.

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.

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.

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.

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.

Recommendation 17 [to the police]: In line with forthcoming guidance from the College of Policing on unexpected deaths, a PIP 3 Senior Investigating Officer (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.

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.

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.

Recommendation 20 [to the CPS]: We recommend that the CPS include guidance on prosecuting the domestic abuse perpetrator posthumously for controlling or coercive behaviour 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.

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**

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.

Recommendation 23 [to this Project]: We recommend that this Project co-ordinate a learning event for police on suicide following domestic abuse 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.

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.

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

MAIN REPORT

Chapter 1: Introduction

1.1 The Domestic Homicide Project

In 2020 the Domestic Homicide Project was established by police and government in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides and also from suspected suicides of individuals with a history of domestic abuse victimisation in the wake of the Covid-19 pandemic and restrictions. Responding to concerns about rising domestic homicide rates from the domestic abuse sector, the Project aimed to establish the impact of the Covid-19 pandemic on domestic homicides and learn lessons from every tragic death to seek to prevent future deaths.

This Domestic Homicide Project is separate to the existing statutory process for Domestic Homicide Reviews, which examine every domestic homicide in-depth to draw out learning from all agencies.

1.2 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. As well as domestic homicide by a (current or ex) partner or family member, the Project also counted child deaths in a domestic setting, unexplained or suspicious deaths,[6] 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.

It should be noted that 17 deaths in Year 1 and 36 deaths in Year 2, which are included within the data on domestic homicides (intimate partner or adult family member) and child deaths presented in this report, were recorded by police as ‘unexplained deaths’ (in the new terminology, unexpected deaths).[7] These deaths were coded by the Project team into

[6] In the definition of relevant deaths on our Project submission forms and during our deep dives into suspected victim suicide, we use the term ‘unexplained deaths’ as this was the terminology in use at the time. The NPCC and College of Policing have subsequently moved to using the term ‘unexpected deaths’ rather than ‘unexplained deaths’, a shift in terminology which will be reflected in forthcoming guidance from the College of Policing. In the recommendations in this report, we use the new terminology, namely ‘unexpected deaths’; elsewhere in this report we may use ‘unexplained’.

[7] The College of Policing is preparing updated guidance on the categorisation and investigation of deaths, reflecting a change from previous language around unexplained or sudden deaths to refer instead to expected and unexpected deaths. 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.

the typology of adult family homicide, intimate partner homicide, or child death depending on the relationship between the victim and suspect. These 'unexplained' deaths will then be investigated by the police, may undergo a 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. This same approach to coding and analysis of 'unexplained' deaths has been taken across both years of the Project, and so observations in this report about changes in numbers of deaths between Year 1 and Year 2 are comparing like with like.

This Project's wide definition has been crucial in identifying relevant deaths in quick-time and for allowing the analysis of sub-groups of cases with different characteristics. Throughout our analysis we divide cases into five types, primarily based on victim-perpetrator relationship:

- Adult Family Homicide (AFH) – homicide (including currently unexplained death) of an individual aged 18 or over by an adult family member who is not an intimate partner
- Child Death – homicide or unexplained or suspicious death of a child aged under 18 by a family member
- Intimate Partner Homicide (IPH) – homicide (including currently unexplained death) 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 – suspected suicide of a person aged 16 or over following known domestic abuse against them

Where we use the umbrella term 'domestic homicides' in this report, we are referring to the combined categories of Adult Family Homicide, Intimate Partner Homicide and Other, with each category including relevant cases of currently unexplained deaths (as outlined above).

Counting of domestic homicides in this report will therefore differ from Home Office Homicide Index (HOHI) numbers on domestic homicides, on three main grounds:

1. We count victims aged 18 and over in AFH and IPH deaths; the HOHI counts victims aged 16 and over.

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 in our AFH and IPH categories deaths that are, at the time of initial report to us, unexplained, unexpected and/or suspicious - but have not yet been formally deemed a homicide or suicide. If, following further investigation, police deem these cases to be non-suspicious they are removed from our dataset before analysis.

Where we present analysis of the whole dataset in this report and 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'.

1.3 Our Year 1 report

In 2021, the Project published its first report examining each and every death identified by police as meeting the Project definition between 23rd March 2020 and 31st March 2021. This report made a number of recommendations: to policing, to the College of Policing, to the NPCC and to this Project in its second year. Appendix A contains a list of these recommendations with an update of progress against each one.

1.4 Our second year

Since the publication of our Year 1 report, the Project has:

- Continued to develop a pioneering near live-time national repository of all domestic homicides, suspected victim suicides, child deaths and unexplained deaths following domestic abuse.

- Continued to develop and streamline the process whereby police forces routinely identify and report all deaths following domestic abuse to a central unit (the Domestic Homicide Project team), achieving a high quality of data return and completion.

- Continued to consult with and develop governance and expert advisory panels consisting of police leaders, government, an extensive network of third sector stakeholders, commissioners, and academics in the field of domestic abuse, homicide, and child deaths.

- Provided quick time reporting on number, type and profile of domestic homicides, child deaths and suspected victim suicides to the policing strategic and operational front-line, the College of Policing and the Home Office.

- Provided bespoke briefings, for example looking at adult family homicides, ethnicity, older victims and suspected victim suicides following domestic abuse.
- Delivered talks to a number of forums, including the National Homicide Prevention Summit, the Connect Centre for International Research on New Approaches to Prevent Violence, and the Domestic Homicide Review network.
- Disseminated interim findings through academic, police, and third sector networks, events, and conferences.
- Been referenced in numerous guidance documents, including new Controlling or Coercive Behaviour Statutory Guidance and the Tackling Domestic Abuse Plan

1.5 About this report

This Year 2 report provides a similar examination and analysis of data spanning from 1st April 2020 to 31st March 2022. It describes domestic homicides, child deaths and suspected victim suicides from across a full two years' worth of data, and also compares Year 2 with Year 1, highlighting any differences. Additionally, it contains a substantial Spotlight section on suspected victim suicides following domestic abuse. This section (Chapter 10) highlights key learning from analysis of these suspected suicides and presents findings from an in-depth look at policing responses carried out by the Project team in Year 2. This included a series of 'deep dives' with police forces as well as consultation with bereaved families.

1.5.1 Data quality and completeness

As in Year 1, the Project team coded the data quality and completeness of each submission, using a three-point grading system of completeness across the sections of the submission form, and a three-point grading system of the quality of the information provided. In the Year 2 dataset, 99% of submissions were judged to be fully complete or mostly complete, with an increase from 50% in Year 1 to 79% in Year 2 of fully completed submissions. This shows that data completion improved from the Year 1 dataset. Additionally, data quality was judged to be good or excellent in 84% of cases (see Table 1), an 8-percentage point increase from the previous year.

Table 1. Data quality and completeness of submissions (April 2021 – March 2022)

	Quality					
Completeness	**Excellent**	**Good**	**Fair**	**Not Recorded**	**Total**	**%**
Complete	43	134	14	-	**191**	***79%***
Largely incomplete	-	-	1	-	**1**	***1%***
Mostly complete	-	25	24	-	**49**	***20%***
Not Recorded	-	-	-	-	**-**	***0%***
Total	**43**	**159**	**39**	**-**	**241**	***100%***
% Total	**18%**	**66%**	**16%**	**0%**		

Source: Domestic Homicide Project

1.5.2 Nil returns

In Year 2, seven 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 follow-ups with all forces that produced a nil return and confirmed that this information was correct. Thus, the Project received submissions from 36 of 43 (84%) police forces in England and Wales in Year 2. Comparatively, in Year 1, three forces sent a nil return, leaving just one force with a nil return in both years. Overall, across Year 1 and Year 2, 23% (n = 103) of submissions came from one force area, with 55% of submissions coming from nine force areas. The remaining forces (n = 33) submitted an average of six cases during the timeline of the Project.

1.5.3 Exclusions

Additionally, across the full dataset (Year 1 and Year 2), 18 initial submissions were later excluded from the analysis. In almost all of these 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.

1.5.4 Data reconciliation

The Project team also completed data reconciliation exercises with the cases collected by Counting Dead Women, ManKind Initiative, and Galop. Data reconciliation with the Counting Dead Women website identified a further 11 submissions. It also led to the identification of one force which had not sent any submissions in Year 2, which resulted in a number of last-minute submissions to the Project from that force. Data reconciliation with ManKind and Galop did not identify any new cases not already submitted to our Project. We are grateful to all three organisations for their generosity and co-operation in helping triangulate the cases.

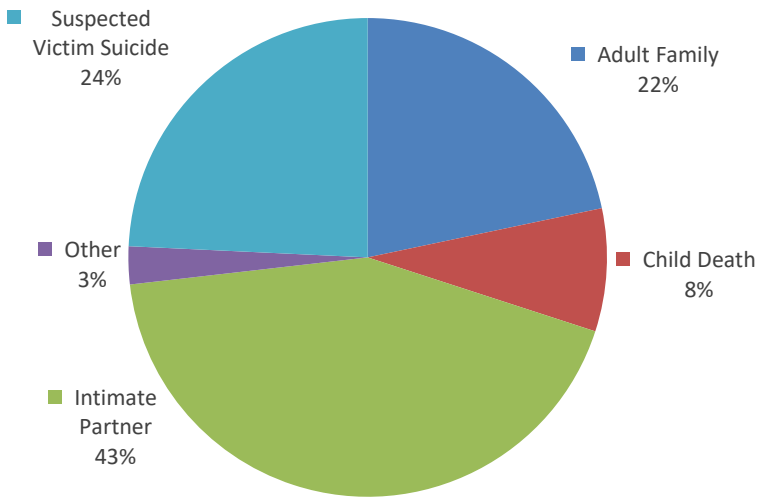
PART A: YEAR TWO DATA

Chapter 2: Domestic Homicides, Child Deaths and Suspected Victim Suicides April 2020 - March 2022

2.1 Overall deaths April 2020 - March 2022

Overall, across both Year 1 and Year 2 (1st April 2020 to 31st March 2022), this Project has now counted 470 total deaths in 457 incidents. These 470 deaths are spread across the following typologies: 43% intimate partner homicide, 24% suspected victim suicide, 22% adult family homicide, 8% child death, and 3% 'other' (see Figure 1 below).[8]

Figure 1. Proportion of deaths by typology (April 2020 – March 2022)



Source: Domestic Homicide Project

2.2 Year 2 (April 2021 – March 2022) compared with Year 1 (April 2020 – March 2021)

2.2.1 Overall domestic abuse related deaths – changes in Year 2

Between 1st April 2021 and 31st March 2022 (Year 2), the Project counted a total of 250 domestic abuse related deaths across all case types (see Table 2). In Year 1 (1st April 2020 to 31st March 2021), the Project initially counted 201 deaths. Due to some late submissions which came in after Year 1 but related to deaths which occurred during Year

[8] Please note that the Project also counted 14 deaths between 23rd March and 31st March 2020, which are not included in the analysis for the purpose of comparison across equivalent timeframes. These 14 deaths included 9 intimate partner homicides, 1 suspected victim suicides, 2 adult family homicides, and 2 child deaths.

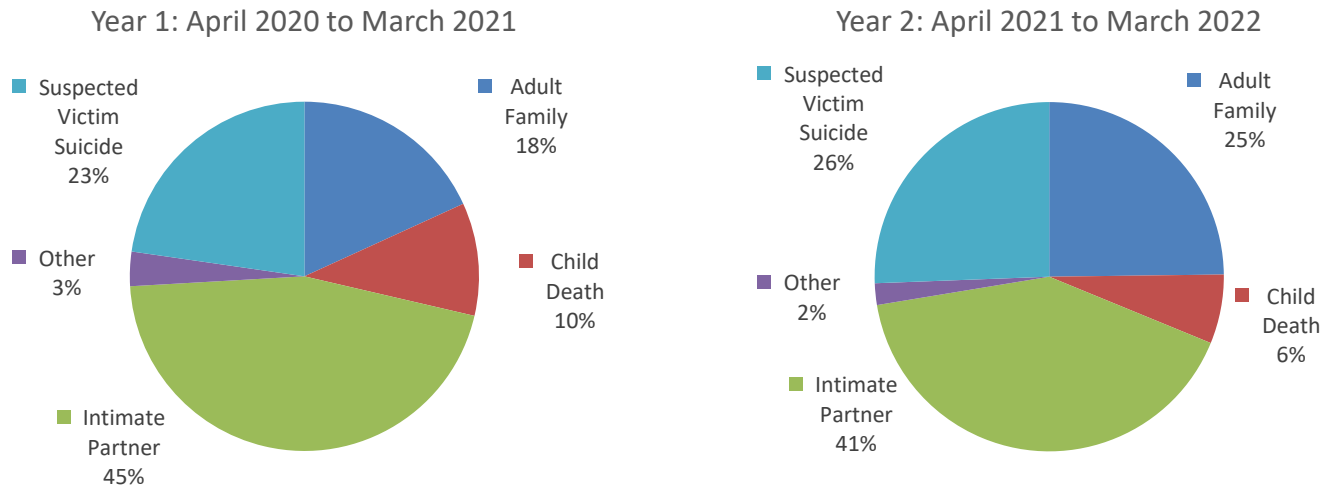
1, updated figures for the Year 1 dataset now show 220 deaths.[9] This means that Year 2 currently represents an increase of 30 domestic abuse related deaths overall (+14% change) compared with the updated Year 1 dataset.

Considering that the revised Year 1 figures increased by 9.5% (19 deaths) on the original Year 1 figures, we may yet expect some late submissions relating to Year 2 which would revise the Year 2 figures upwards too. Comparing the original Year 1 figures with the current Year 2 figures, the increase in total deaths between the years was 24%. We cannot know if a final revised figure for Year 2 will be of the same order of magnitude as in Year 1: it may be that the Project is now better embedded and has received submissions already for all or most of the relevant deaths.

2.2.2 Deaths by type – changes in Year 2

Regarding the typology of the 250 deaths in Year 2, this was again most commonly the homicide of a(n) (current or ex) intimate partner (hereafter intimate partner homicide, 41%), followed by the suspected suicide of a victim following known domestic abuse (hereafter, suspected victim suicide, 26%), the homicide of an adult family member by an adult (hereafter, adult family homicide, 25%), child death (6%), and 'other' (2%). Again, with comparison to the previous year, the typology of the 220 deaths in Year 1 was as follows: 45% intimate partner homicide, 23% suspected victim suicide, 18% adult family homicide, 10% child death, and 3% 'other' (see Figure 2).[10]

Figure 2. Proportion of deaths by typology – Year 1 and Year 2



Source: Domestic Homicide Project

Therefore, in Year 2, whilst the number of child deaths (n = -7) and 'other' deaths (n = -2) reported to the Project appears to have decreased, there was an increase in the total

[9] These revised figures for Year 1 are used throughout the rest of this report.

[10] As explained in Section 1.2, for both Year 1 and Year 2 these categories do include some deaths classified by police as 'unexplained' or suspicious at the point of analysis, but not yet formally deemed to be homicide.

number of suspected victim suicide (n = +14) and adult family homicide (n = +22) deaths, as well as a slight increase in intimate partner homicide deaths (n = +3). This means that in Year 2, total domestic homicides (intimate partner, family member and other) increased by 16% from Year 1 (from 147 to 170); within this, intimate partner homicides rose by 3% (from 100 to 103), adult family homicides rose by 55% (from 40 to 62) and 'other' deaths fell by 29% (from 7 to 5). As well, child deaths fell by 30% (from 23 to 16), and suspected victim suicides rose by 28% (from 50 to 64) (see Table 2).[11]

Table 2. Number and proportion of deaths by typology – changes between Year 1 and Year 2

Total Deaths						
	2020/2021		2021/2022		Overall	
	N	%	N	%	N	%
Adult Family	40	18%	62	25%	102	22%
Child Death	23	10%	16	6%	39	8%
Intimate Partner	100	45%	103	41%	203	43%
Other	7	3%	5	2%	12	3%
Suspected Victim Suicide	50	23%	64	26%	114	24%
Total	**220**	-	**250**	-	**470**	-

Source: Domestic Homicide Project

However, neither the rise in adult family homicide nor in suspected victim suicide deaths in Year 2 compared with Year 1 proved to be statistically significant at $p<0.05$. Cases of adult family homicide and suspected victim suicide are reviewed in additional detail later in this report (see Chapter 8 and Chapter 10). The rise in suspected victim suicides in Year 2 is likely to reflect better identification and submission of these cases to this Project, rather than necessarily an empirical increase in cases.

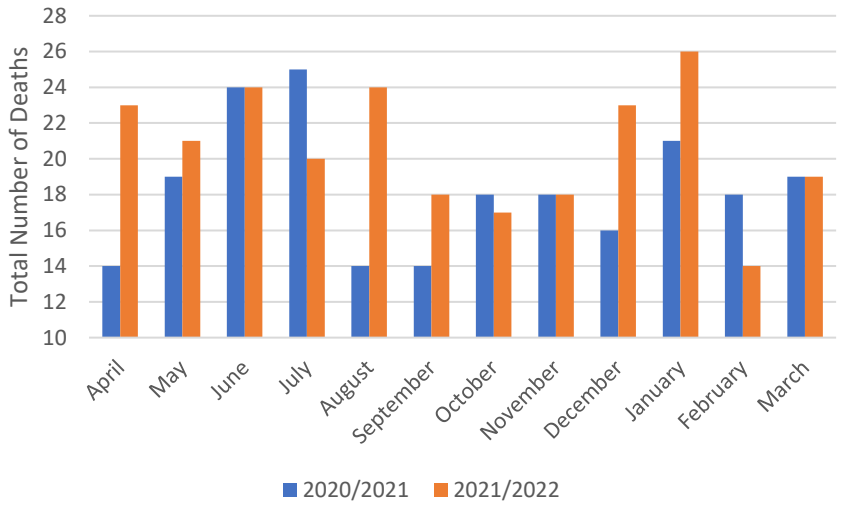
The Project's Year 1 report (Bates *et al.*, 2021, p. 28) identified that domestic homicides did not appear to increase significantly in Year 1 as compared to a re-analysis of Home Office Homicide Index data for the previous year (April 2019 – March 2020, n = 152) and were lower than the 15-year annual average of re-analysed Homicide Index data from April 2005 – March 2006 to April 2019 – March 2020 (n = 207). Importantly, because domestic homicide figures do fluctuate from year to year, this report's comparison of two years' worth of data may reflect this general fluctuation.

[11] Note that the inclusion of currently 'unexplained deaths' in these categories does not change the overall picture of a larger rise in AFH compared with other case types in Year 2. At the time of analysis, in Year 1, the number of currently unexplained deaths (at the point of analysis) within the typology of intimate partner homicide was 11 in Year 1 – this rose to 23 in Year 2. Moreover, in Year 1, the number of unexplained deaths within the typology of adult family homicide was 3 – this rose to 11 in Year 2. Therefore, when comparing just those cases formally confirmed as homicides, there was a (non-statistically significant) rise in adult family homicide cases in Year 2.

2.3 Monthly variance

Our Year 1 report showed that, after an initial spike in the first week of data collection (week commencing 23rd March 2020), the number of domestic homicides and suspected victim suicides remained relatively steady across the year. The Year 1 report summarised that data from other sources (e.g. the Home Office Homicide Index) relating to previous years did not show any clear seasonal or monthly patterns, and that whilst HO Homicide Index data may point to slight increases over Easter, Summer and Christmas, monthly figures vary considerably (Bates *et al.*, 2021, p. 28/29). As above, monthly fluctuation is to be expected with small numbers of cases. In Year 2, the monthly figures across all typologies (including suspected victim suicide) remained relatively steady. However, there were increases seen in the months of April, August, and December 2021 compared with the Year 1 data from this Project (see Figure 3):

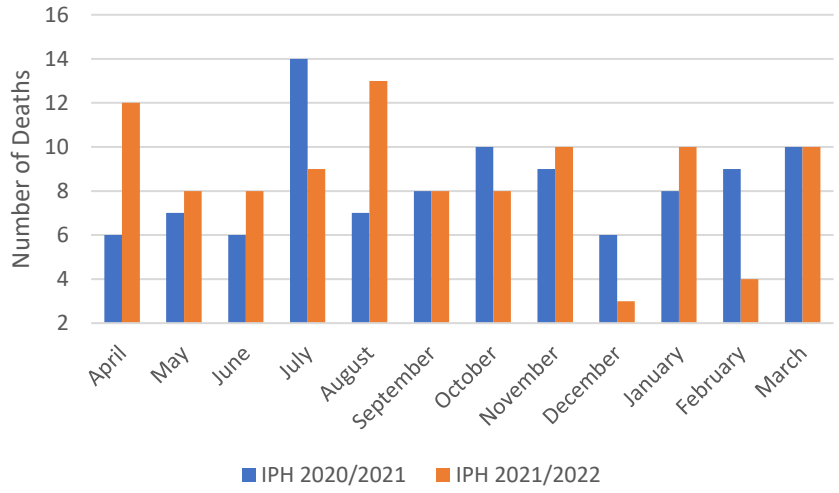
Figure 3. Number of all deaths by month – Year 1 and Year 2



Source: Domestic Homicide Project

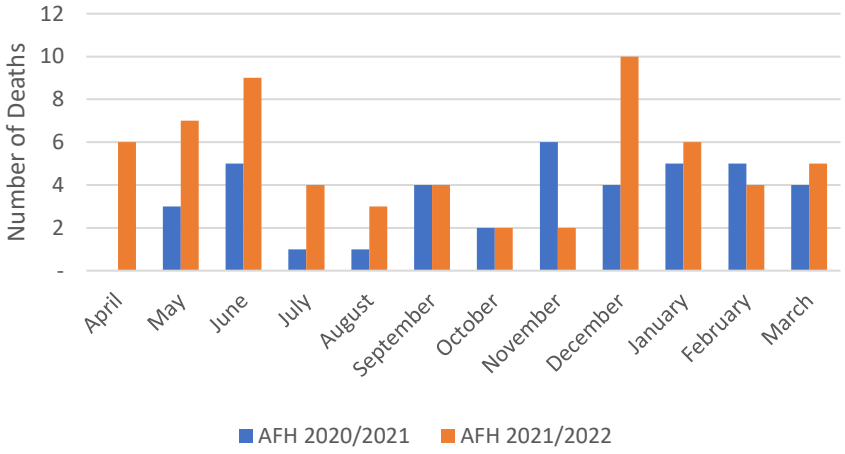
These increases were mainly accounted for by a relative rise in adult family homicides and intimate partner homicides in April 2021, intimate partner homicides and suspected victim suicides in August 2021, adult family homicides and child deaths in December 2021 (see Figures 4, 5, 6, and 7). As mentioned, Chapter 8 provides additional discussion about themes emerging from the adult family homicide cases. The Project's First Spotlight briefing on adult family homicide (Nguyen Phan *et al.*, 2022) also shares learning from previously published data from the Year 1 dataset.

Figure 4. Number of intimate partner homicides by month – Year 1 and Year 2



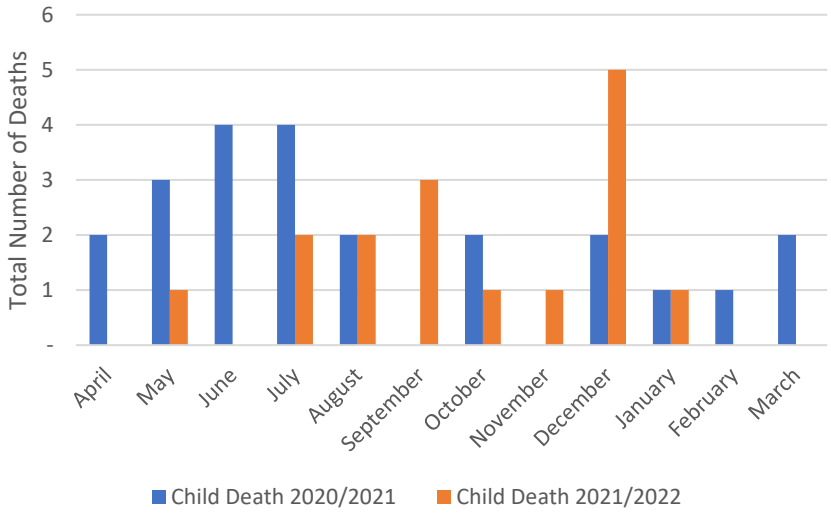
Source: Domestic Homicide Project

Figure 5. Number of adult family homicides by month – Year 1 and Year 2



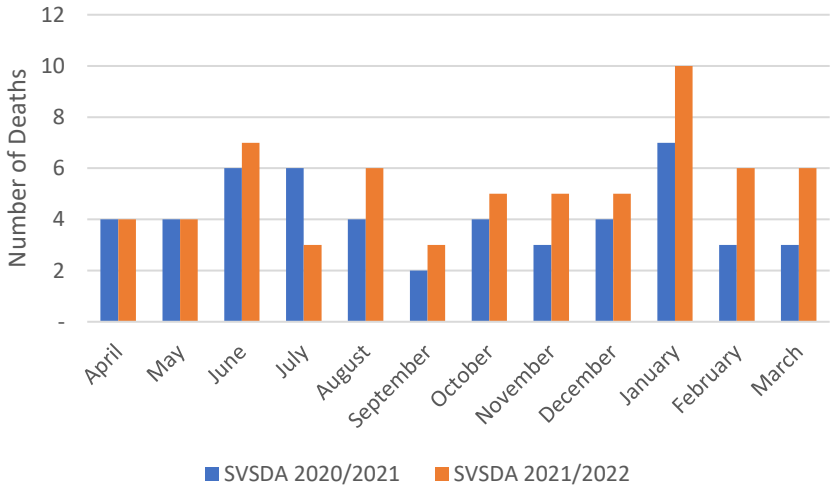
Source: Domestic Homicide Project

Figure 6. Number of child deaths by month – Year 1 and Year 2



Source: Domestic Homicide Project

Figure 7. Number of suspected victim suicides by month – Year 1 and Year 2



Source: Domestic Homicide Project

Perhaps of note is that suspected victim suicides, albeit involving small numbers, followed a more discernible monthly pattern each year, with a rise in January. It is established that domestic abuse has seasonal patterns, with a particular rise in police-recorded incidents around Christmas and New Year (Office for National Statistics ONS), 2021a, fig. 2; Verney, 2021; West Midlands Police and Crime Commissioner, 2021; Card and Dahl, 2011). Suicide more broadly (not only following domestic abuse) does not see the same seasonal patterns, however. Multiple suicide studies have shown 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; Woo *et al.*, 2012; White *et al.*, 2015). This picture holds true for England and Wales as shown by the NPCC National Collection Plan on all Suspected Suicides (a British Transport Police-led project collecting suicide data across England and Wales since 2021), which recorded higher

overall suicide rates in June and September, and lower in January (drawing on Home Office data). Suicide studies looking specifically at female suicide (which account for almost all DA-related victim suicides, but only a small proportion of overall suicides) variously identify spring, summer and autumn as having higher rates of female suicide, but less in winter (Woo *et al.*, 2012). There is a developing literature on the association between domestic abuse victimisation (particularly intimate partner abuse) and (attempted) suicide or suicidal ideation (Walby, 2004; Cavanaugh *et al.*, 2011; McLaughlin, O'Carroll and O'Connor, 2012; Devries *et al.*, 2013; MacIsaac *et al.*, 2017; MacIsaac, Bugeja and Jelinek, 2017; Aitken and Munro, 2018; Munro and Aitken, 2020; Kafka *et al.*, 2022; McManus *et al.,* 2022). However, there is little, if any, existing work specifically on the seasonality of suspected suicides following domestic abuse victimisation. So, it seems that this Project may have identified a previously unknown emerging pattern to suspected suicides following domestic abuse, namely an elevated risk around and after Christmas and New Year. This pattern is more aligned with seasonal patterns of domestic abuse than seasonal patterns of overall suicide.

Whilst the initial lifting of Covid-19 lockdown restrictions in England and Wales in 2021-22 occurred (in stages) from 12th April to 19th July 2021, the monthly variations in recorded deaths did not appear to relate to any remaining Covid-19-related restrictions in place in England and Wales during the period of data collection. See Chapter 9 for a brief qualitative discussion of these Covid impacts.

2.4 Findings and recommendations on case numbers and monthly patterns

Findings

Finding 1: There was a rise in both domestic homicides and suspected victim suicides as counted by this Project in Year 2 (April 2021-March 2022) compared with Year 1 (April 2020-March 2021). The overall number of domestic homicides relating to an intimate partner, family member or 'other' increased by 16% (n = +23), including a 3% increase in intimate partner homicide (n = +3), a 55% increase in adult family homicide (n = +22), and a small decrease (n = -2) in 'other' deaths, as counted by this Project. Based on the pattern in Year 1 of this Project, we estimate this may increase a bit further due to late submissions. There was also a 28% increase (n = +14) in suspected victim suicides following domestic abuse. The increase in suspected victim suicides is likely to be reflective of better awareness and identification by police of these cases, as a result of this Project having become better established, greater general discussion of the issue, and close follow-up with forces by the Project team. It is good news that police are increasingly identifying such cases. The increase in adult family homicides is less reliant on police identification of incidents than suspected victim suicides, and thus more likely to reflect an empirical rise in cases. It is possible that the pandemic and its after-effects have had an impact on the increase in these adult family deaths. It is too soon to know whether this increase will be sustained following the Covid pandemic. It is not possible to identify

whether this is a long-term trend based on two years of data. Further years of data collection and analysis will be required.

Finding 2: For suspected victim suicides slightly more deaths were recorded in January across both years (n = 7 in Year 1, n = 10 in Year 2) compared with other months. Whilst suicides more generally do not mirror this seasonal pattern, domestic abuse does, with the Christmas and New Year period particularly associated with higher rates of abuse. These numbers can only be interpreted as a possible indicator; they represent a small relative increase in overall small numbers; so, again, data over at least three more years is needed to identify trends. However, given the known seasonal pattern of domestic abuse, it seems plausible that Christmas and around the New Year may also be a time of increased risk of suicides following domestic abuse – a link that has not previously been identified.

Recommendations

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.

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 C.

3.1.1 Method

Overall, the most common method of death across the two-year dataset remained by 'sharp instrument,' such as a knife, accounting for 28% of the 457 incidents (see Table 3 below). This reflects 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; Office for National Statistics (ONS), 2022). This reflects in large part the fact that knives are readily available especially in domestic settings. The use of a 'sharp instrument' was most commonly recorded in adult family homicide (around 45% in Years 1 and 2) and intimate partner homicide (35% in Year 1, 40% in Year 2) deaths.

Returning to the overall dataset, the next most common method of death was by strangulation (including hanging) at 21%, involving mainly suspected victim suicide deaths. This was followed by the use of poison or drugs (10%), 'other' method of death (10%), kicking or hitting (6%), and blunt instrument (6%). Also note that in seven cases (2%) the method of death was recorded as shooting. In 11% of cases the method of death was 'not known'.

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

	April 2020/ March 2021		April 2021/ March2022		**April 2020-March 2022**	
	N	%	**N**	%	**N**	%
Blunt Instrument	12	6%	14	6%	**26**	**6%**
Burning or scalding (Incl. Arson)	7	3%	3	1%	**10**	**2%**
Drowning	4	2%	7	3%	**11**	**2%**
Kicking or hitting	21	10%	8	3%	**29**	**6%**
Other	16	7%	28	12%	**44**	**10%**
Poison or Drugs	23	11%	21	9%	**44**	**10%**
Sharp instrument	59	27%	70	29%	**129**	**28%**
Shooting	3	1%	4	2%	**7**	**2%**
Strangulation (Incl. Hanging)	38	18%	57	24%	**95**	**21%**
Suffocation	4	2%	7	3%	**11**	**2%**
Not Known	29	13%	22	9%	**51**	**11%**
Total	**216**	**-**	**241**	**-**	**457**	**-**

Source: Domestic Homicide Project

3.1.2 Setting of the death

Overall, across the combined two-year dataset, 90% of deaths were recorded by police as having occurred in urban locations, with 10% having occurred in rural locations. Most deaths occurred in the victim or suspect's[12] home (66%). This was followed by deaths which occurred outdoors (9%), and in hospital (9%).[13] There was no death recorded as happening at or outside the victim's place of work. Also, note that in 6% of cases it was not recorded where the death occurred. Comparing the two years, there was a slight rise in deaths occurring in other residential buildings (from 3% to 7%). This may reflect the easing of lockdown restrictions.

In total, 64% (n = 291) incidents involved victims and suspects who were living together at the time of the death, whilst 31% (n = 143) of incidents involved victims and suspects who lived separately, and in 5% of cases this was 'not known' or not recorded. As might have been expected, it was most common for victims and suspects to live together in intimate partner homicide (71% in Year 1, 66% in Year 2) and child death (81% in Year 1, 100% in Year 2) cases.

3.1.3 Suspect's relationship to the victim

Across both years, in 67% (n = 308) of the 457 incidents the suspect (or prior perpetrator of domestic abuse in the case of suspected victim suicides) was the current (52%) or ex- (15%) partner or spouse of the victim. These incidents related to intimate partner homicide and suspected victim suicide deaths, and it was most common for suspects of intimate partner homicides to be recorded as the victim's current partner or spouse (85% in Year 1, 81% in Year 2). The suspect was the (adult) child of the victim in 14% (n = 66) of incidents, including the majority of adult family homicide cases (62% in Year 1, 70% in Year 2). The remaining suspects associated with the 457 incidents were the parent (7%), sibling (4%), or other family member (4%). The relationship between the suspect and victim was recorded as 'other' in 1% of cases, and 'not known' or not recorded in 2% of cases. Comparing the two years across all typologies, there was a slight rise in (adult) children killing parents (from 12% in Year 1 to 17% in Year 2). These cases are discussed further in Chapter 8.

3.2 Victim demographics

3.2.1 Sex

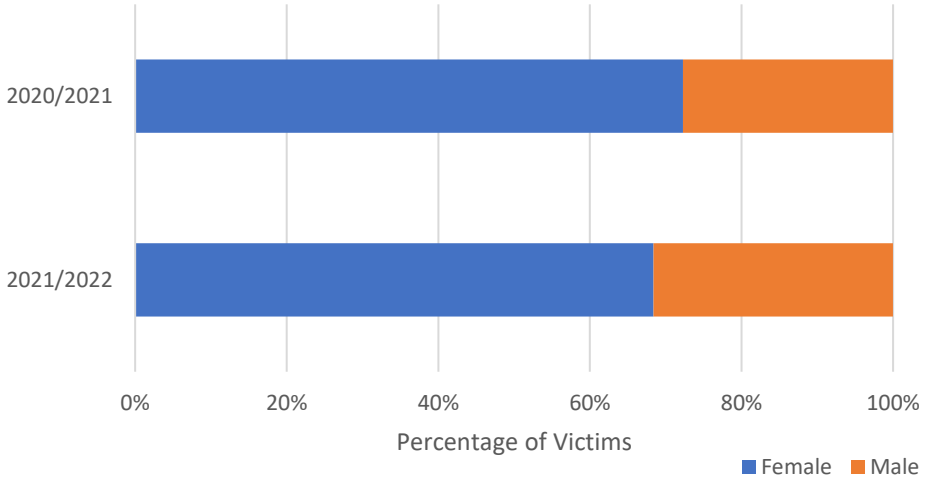
In Year 2, 68% of the 250 victims were recorded as female, whilst 32% were recorded as male. This is a slight rise in the proportion of male victims compared with Year 1 (where

[12] A reminder on terminology: where, like here, we present analysis of the whole aggregated dataset and 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'.

[13] Where a death occurred in hospital, this was as a result of incidents which took place in the home or outdoors, but the victim was taken to hospital where they died.

72% of the 220 victims were female, 28% male), with the overall breakdown in sex of the victim across both years being 70% female and 30% male victims (n = 470; see Figure 8 below).

Figure 8. Proportion of victims by sex – Year 1 and Year 2



Source: Domestic Homicide Project

However, this varied by typology, with the majority of the increase in male victims in Year 2 related to the child death category, and in both years male victims being associated with the 'other' category (e.g., lodger, housemate). Firstly, intimate partner homicides involved a majority of female victims. The proportion of female and male victims in this group remained relatively stable across both years, with a rounded figure of 83% of victims recorded as female whilst 17% were male (n = 100 in Year 1, n = 103 in Year 2; see Figure 9 below).

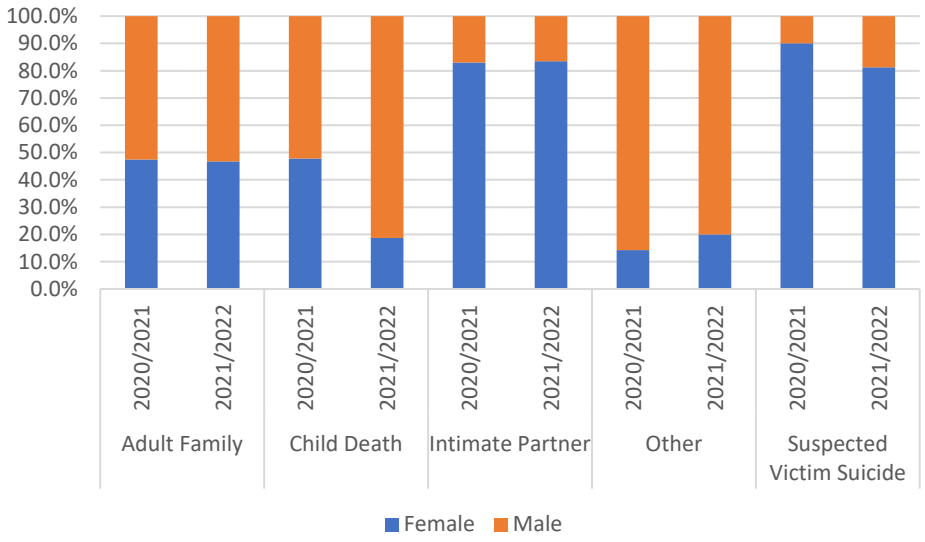
Next, suspected victim suicide similarly varied by victim sex, with 81% of the 64 victims recorded as female in Year 2, whilst 19% were recorded as male. In Year 1, the proportion of female victims was slightly higher and male victims slightly lower (see Figure 9 below). Male victims of suspected suicide are discussed further in Chapter 10.

Additionally, with regards to adult family homicides, there was a more even split between the sex of the victim. In Year 2, 47% of the 62 victims were recorded as female, whilst 53% were male. This was similar to Year 1, in which 48% of the 40 victims were recorded as female, and the remaining 52% as male (see Figure 9 below).

It is the child deaths which account for the overall rise in male victims in the Year 2 dataset. Child deaths in Year 2 involved a higher proportion of victims recorded as male (81%), than that which was recorded for Year 1 (52%). The proportion of female victims also varied accordingly, with 19% of child death victims recorded as female in Year 2, and 48% in Year 1 (see Figure 9 below). However, it is important to note these proportions are drawn from a very small number of cases (n = 16 in Year 2, n = 25 in Year 1). It is not

known whether the decrease in victims between Year 1 to Year 2 reflects a change in the number of child deaths, or a change in force reporting and submission to the Project.

Figure 9. Proportion of victims by typology and sex – Year 1 and Year 2

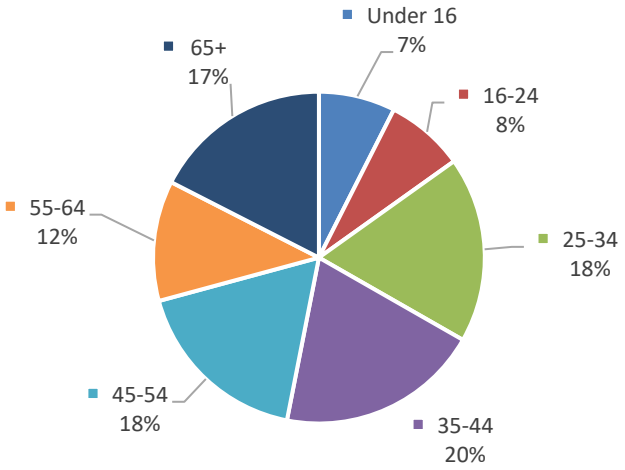


Source: Domestic Homicide Project

3.2.2 Age

Across the full dataset (Year 1 and Year 2), 56% of 470 victims were aged 25 to 54 years old, with 17% being 65 years or older, as per Figure 10 below:

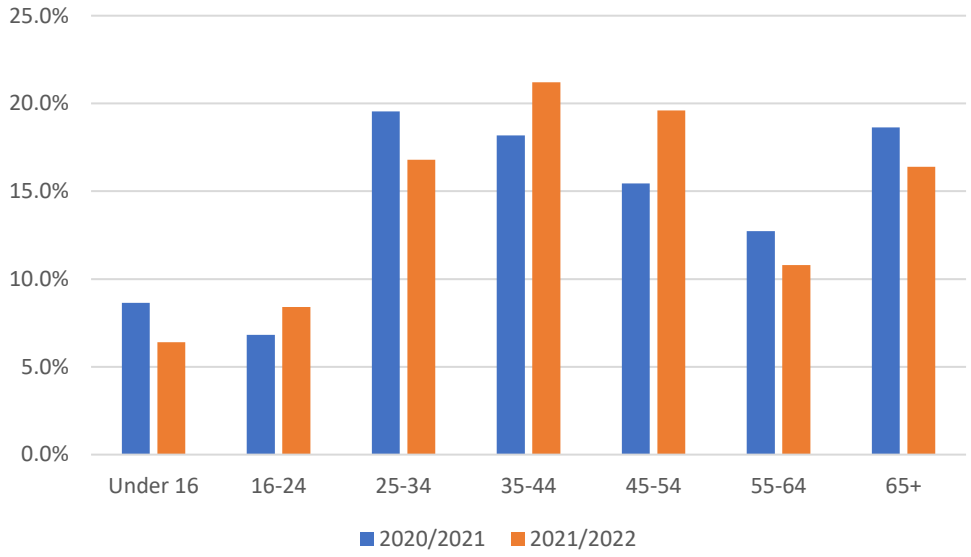
Figure 10. Proportion of victims by age group (April 2020 – March 2022)



Source: Domestic Homicide Project

Comparing the two years, there was a small drop in the number of older victims (aged 65 years +) in Year 2 (16% in Year 2 compared with 19% in Year 1), representing a fall from the higher number of older victims in Year 1 (see Figure 11). This reduction in older victims in Year 2 compared with Year 1 was not statistically significant. Even at the lower rate of 16% in Year 2, the proportion of older victims (aged 65+) was still higher than the proportion of older victims recorded in Home Office Homicide Index data averaged across 15 years 2005/06 to 2019/20 (see Bates *et al.*, 2021, p. 39). Of interest, amongst this older age group (65+) in our data, there were notably more male victims in Year 2 (44% of victims in this age category) compared with Year 1 (24% of victims in this age category). See Chapter 10 on suspected victim suicide for discussion of a greater rise in younger victims of suspected suicide in Year 2.

Figure 11. Proportion of victims by age group – Year 1 and Year 2

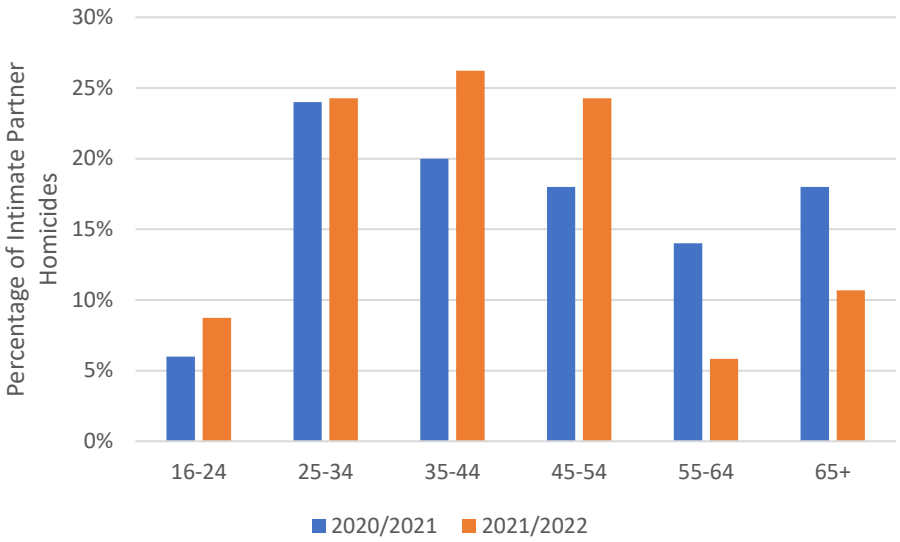


Source: Domestic Homicide Project

First, within the typology of intimate partner homicide, the overall age distribution appears to match that of the broader dataset, with the majority of victims aged 25 to 54 years old across both Year 1 and Year 2 (62% and 75%, respectively). However, it is important to note that in Year 1, 18% (n = 18) of intimate partner homicide victims were aged 65 years or older, whereas this fell to 11% (n = 11) in Year 2. There was also a decrease from Year 1 to Year 2 in the proportion of intimate partner homicide victims aged 55 to 64 (14%, n = 14 to 6%, n = 6; see Figure 12). 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). It noted that during the pandemic older people might have been at increased risk of being victims of domestic homicide due to lack of access to support, while there might have been a suppression of abuse among younger couples due to pandemic restrictions on movement and socialising. In this context, the decrease in older victims (aged 65 years +) and slight increase in younger

victims (aged 16-24) observed in Year 2, when most restrictions were lifted, appears to lend support to this finding.

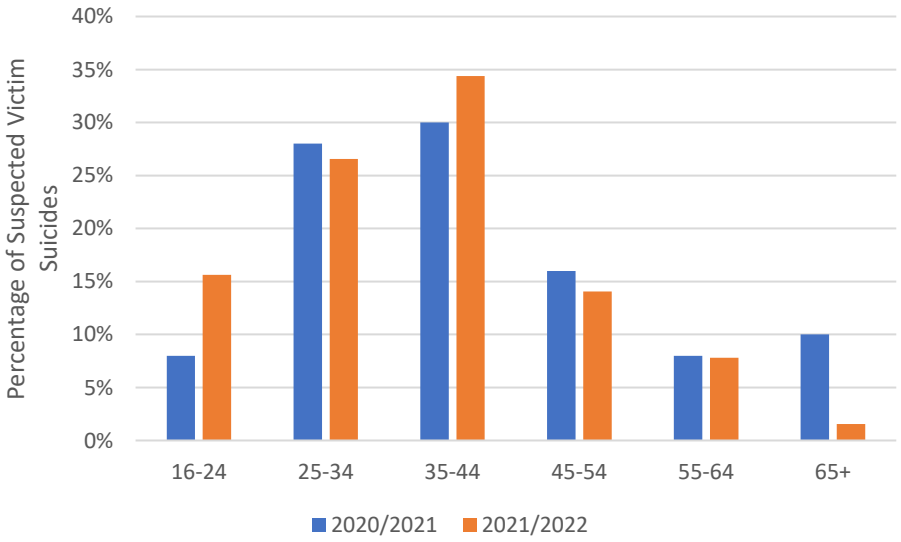
Figure 12. Proportion of intimate partner homicide victims by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Second, within suspected victim suicide deaths, overall victims were slightly younger, with the majority (58% in Year 1 and 61% in Year 2) aged between 25 to 44 years old (see Figure 13). When comparing the years, whilst numbers were small, there was a greater proportion of victims aged 16 to 24 (16%, n = 10 vs 8%, n = 4) and fewer aged 65 years or older (2%, n = 1 vs 10%, n = 5) in Year 2 as compared to Year 1. See Chapter 10 for further discussion on this.

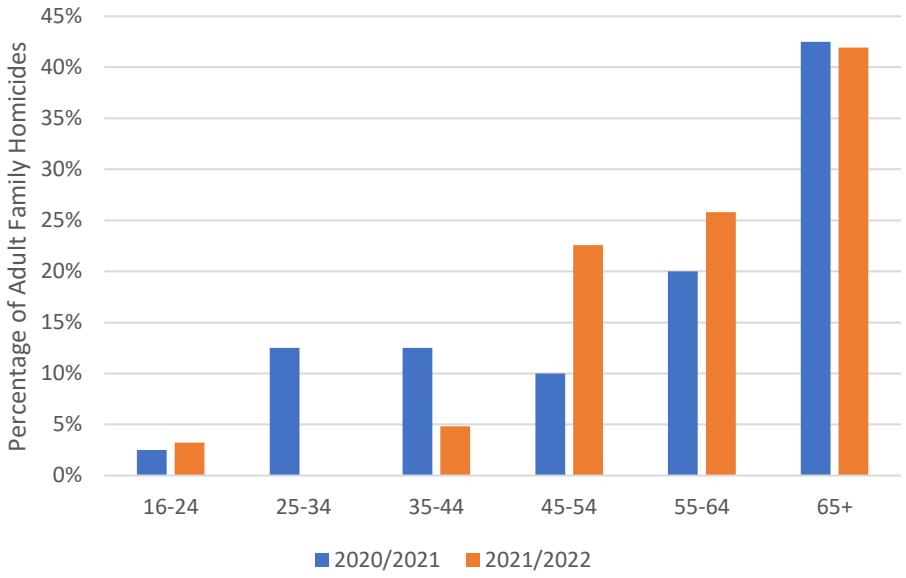
Figure 13. Proportion of suspected victim suicide victims by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Third, within adult family homicide deaths, overall, the proportion of victims increased with age. In fact, in both Years 1 and 2, the highest proportion of victims within this typology were aged 65 years or older (43% and 42%, respectively; see Figure 14), with the second highest being aged 55 to 64 (20% and 26%, respectively). In addition to the 6% increase in victims aged 55 to 64 between Year 1 and Year 2, the proportion of adult family homicide victims aged 45 to 54 also increased from 10% in Year 1 to 23% Year 2, with an associated decrease in victims aged 25 to 34 (13% in Year 1, 0% in Year 2). As found in the Year 1 report (Bates *et al.*, 2021) and considered in combination with the relationship data presented earlier, this data is commensurate with the victims being the parent or grandparent of the suspect. Perhaps of interest, within the older age group (65+) there was an increase in male victims in Year 2 compared with Year 1 (24% of victims of adult family homicide aged 65+ in Year 1 were male; 50% in Year 2). Chapter 8 presents additional information on adult family homicide deaths.

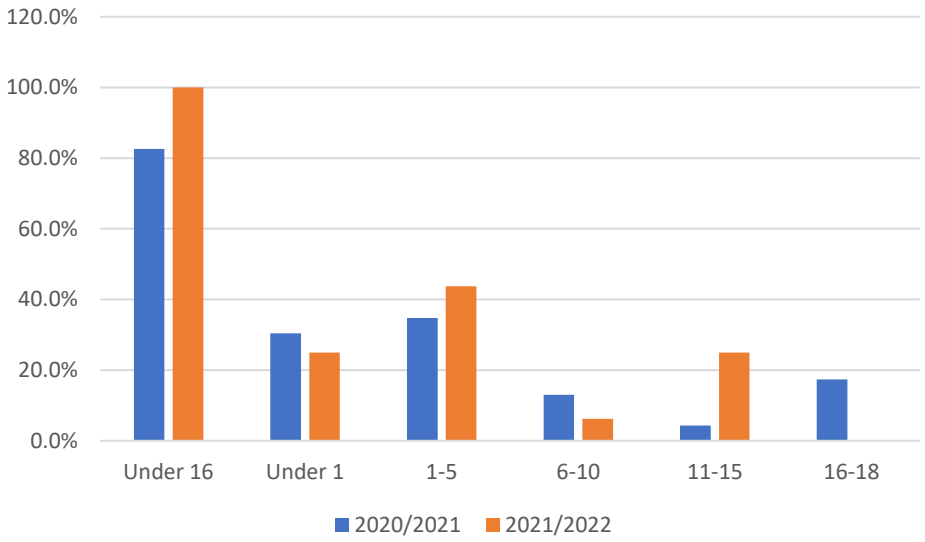
Figure 14. Proportion of adult family homicide victims by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Fourth, of the 16 victims of child death reported to the Project in Year 2, seven (44%) were aged 1 to 5, with four victims under 1 year of age, one victim aged 6 to 10, and four victims aged 11 to 15 years old. Whilst Year 1 data demonstrated similar proportions, that dataset included 23 victims, including four victims aged 16 to 18 years old, whereas there were no victims in that age group in Year 2 (see Figure 15).

Figure 15. Proportion of child death victims by age group – Year 1 and Year 2

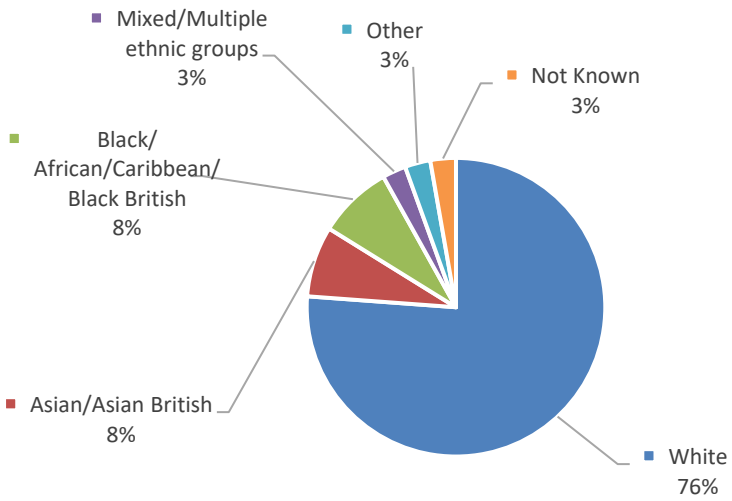


Source: Domestic Homicide Project

3.2.3 Ethnicity and Nationality

Submissions 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 combined Year 1 and Year 2 dataset, a total of 76% of the 470 victims were recorded by officers as of white ethnicities. In total, 8% were recorded as being of black ethnicities, 8% of Asian ethnicities, 3% of mixed ethnicities, and 3% of 'other' ethnicities. In 3% of cases the victim's ethnicity was not recorded (see Figure 16). Taken together, those of minority ethnic heritages (other than white ethnicities) therefore comprised 22% of our combined two-year Project dataset, with a further 3% where ethnicity was unknown.

Figure 16. Proportion of victims by ethnicity (April 2020 – March 2022)



Source: Domestic Homicide Project

The 2021 Census figures have not yet been published for ethnicity. However, the 2011 Census lists the following: 86% of the population was of white ethnicities, 3% of black ethnicities, 8% were of Asian ethnicities, 2% of mixed or multiple ethnicities, and 1% of other ethnicities (Office for National Statistics (ONS), 2018). Taken together, those of minority ethnic heritages (other than white ethnicities) comprise 14% of the general population as measured by the 2011 Census. Our 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 2011 Census (22% compared with 14%), and in particular, slightly higher proportions of victims of black ethnicities (8% compared with 3%).

Across both 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, Bates and Hester, 2019). 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. The Project's Third Spotlight Briefing on ethnicity provides additional analysis of ethnicity data collected during the first 18 months of data collection (Perry *et al.*, 2022).

Police forces were also asked to provide the nationality of the victim and suspect. Of the 470 victims across both years, 27% (n = 127) did not have a recorded nationality. Of the 343 cases in which the nationality of the victim was known, the most commonly recorded nationality was British, at 82% (n = 282). The next most commonly recorded nationality was Polish, including 17 victims (5%), followed by six victims (2%) recorded as Welsh. 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, 2021b).

All other recorded nationalities related to 1 to 4 deaths each. It is important to note that data completion for nationality of the victim increased by 5% between Year 1 and Year 2, which suggests some potential improvement in the collection of this data within police systems.

3.2.4 Other protected characteristics and additional factors

In the combined Year 1 and Year 2 dataset, 16 of the 470 victims (3%) were recorded as being LGBTQ+. For 32% of victims this characteristic was listed as 'not known' or was not recorded, whilst it was recorded as 'no' for 64% of victims. Comparing the two years, there was a slight rise in victims identified as LGBTQ+ in Year 2 (3% (n = 6) in Year 1, 4% (n = 10) in Year 2). Notably, 8 of the 10 LGBTQ+ victims in the Year 2 dataset were recorded within suspected victim suicide deaths. This is discussed further in Chapter 10. As in the Year 1 report (Bates *et al.*, 2021), none of the victims were recorded as having undergone gender reassignment, although this characteristic was 'not known' or not recorded for 27% of victims.

The overall dataset also identified 17% (n = 78) of the 470 victims as having a special need (physical, mental, learning or developmental, dementia, or more than one). However, this characteristic was 'not known' or not recorded for 49% of victims. In the Year 2 dataset, additional coding found that most of the victims with a recorded special need had a mental (n = 33) and/or physical (n = 27) health need. There were also seven victims with a learning or developmental need, and six victims recorded as having dementia. As this analysis was not conducted on Year 1 data, it is not possible to compare the figures between datasets, and some victims had more than one recorded special need.

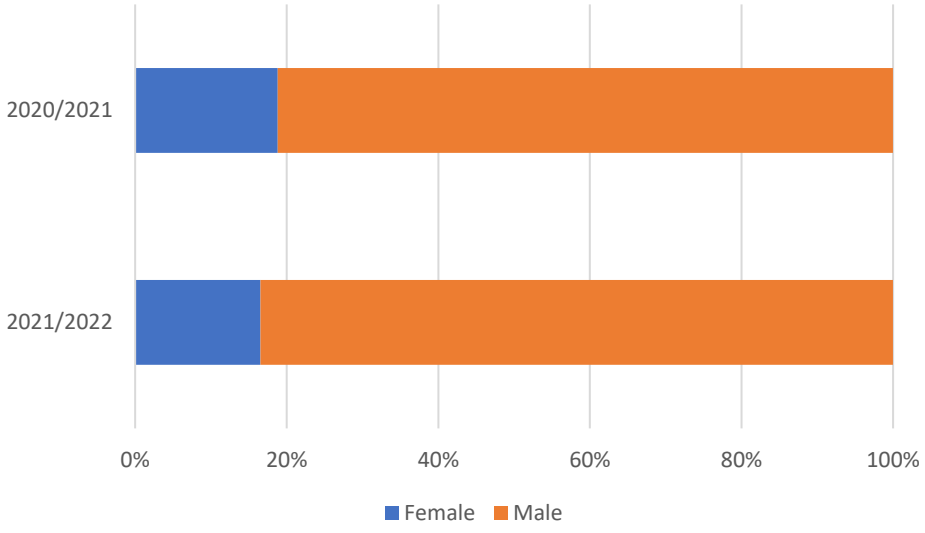
Furthermore, only 11 victims were recorded as having a known religion, with the remaining 98% being 'not known' or not recorded. Finally, four victims (1%) were recorded as being pregnant or having given birth within the previous six months.

3.3 Suspect demographics

3.3.1 Sex

In contrast to victims, in Year 2, 83% of the 254 suspects (or prior domestic abuse perpetrators in the case of suspected victim suicide)[14] were recorded as male, whilst 17% were female. This was similar to the proportion of male and female suspects in Year 1 (80% of the 238 suspects were male, 18% female, and 2% not recorded). Therefore, the overall breakdown in sex of the suspect across both years was 82% male, 17% female, with the sex of the suspect not recorded in 1% of cases (n = 492; see Figure 17).

Figure 17. Proportion of suspects by sex – Year 1 and Year 2



Source: Domestic Homicide Project

[14] Again, a reminder on terminology: where, like here, we present analysis of the whole aggregated dataset and 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'.

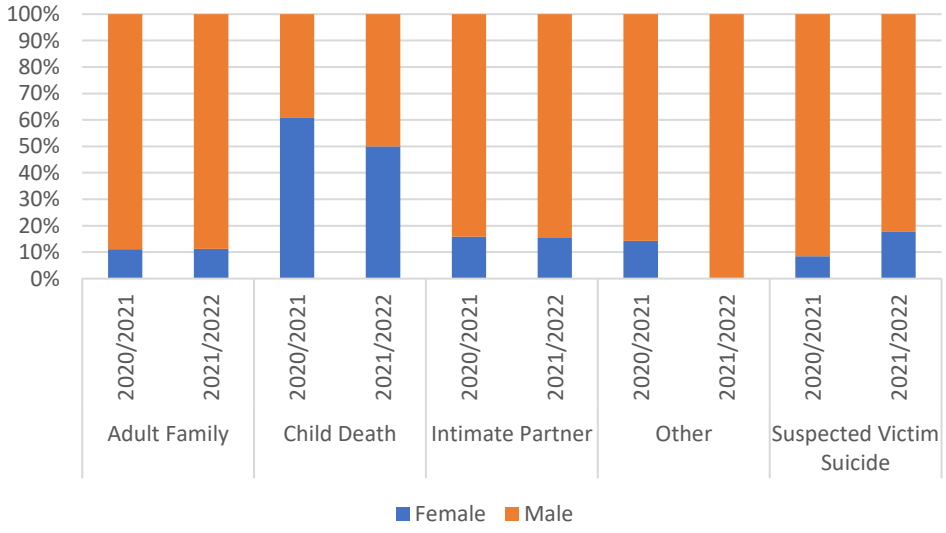
As noted within victim characteristics, this breakdown varied slightly by typology, but with the main difference between child deaths and all other types. Within intimate partner homicide, the proportion of male and female suspects remained relatively stable across both years, with around 84% of suspects recorded as male whilst 16% were female (n = 107 in Year 1, n = 104 in Year 2; see Figure 18).

Within cases of suspected victim suicide, the 'suspects' (hereafter referred to as prior domestic abuse perpetrators) are individuals known or suspected to be perpetrators of domestic abuse against the victim prior to their death. As in the intimate partner homicides, suspected victim suicide cases were also unequally represented by sex. Of the 68 prior perpetrators of domestic abuse associated with the suspected victim suicide deaths recorded in Year 2, 82% were male, whilst 18% were female. The Year 1 data showed a relatively similar proportion of male and female prior perpetrators of domestic abuse (86% of the 50 domestic abuse perpetrators were male, 8% female, and 6% were not recorded; see Figure 18).

Whilst victims of adult family homicide were more evenly split in terms of sex, the vast majority of suspects in these cases were male. In Year 1 and Year 2, 89% of suspects were recorded as male, whilst 11% were female (n = 40/46 in Year 1, n = 55/62 in Year 2; see Figure 18).

By contrast, of the 14 suspects associated with child deaths in Year 2, 50% were recorded as male, whilst 50% were female. In Year 1, 38% (n = 11) of the 29 suspects were male, 59% (n =17) were female, and in 1 case (3%) the sex of the suspect was not recorded. As noted in the previous section, these proportions are drawn from a very small number of cases, and it is not known whether the decrease in submissions from Year 1 to Year 2 reflects a change in the number of child deaths, or a change in force reporting and submission to the Project.

Figure 18. Proportion of suspects by typology and sex – Year 1 and Year 2

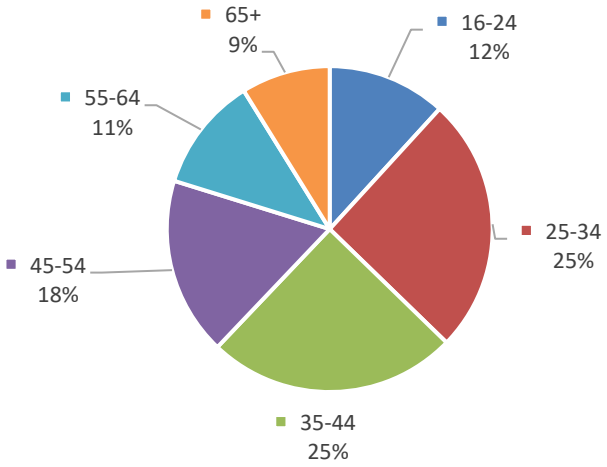


Source: Domestic Homicide Project

3.3.2 Age

Across the full dataset (Year 1 and Year 2), 68% of 492 suspects (or prior domestic abuse perpetrators in cases of suspected victim suicide) were aged 25 to 54 years old, with an additional 20% being 55 years or older (see Figure 19 below):

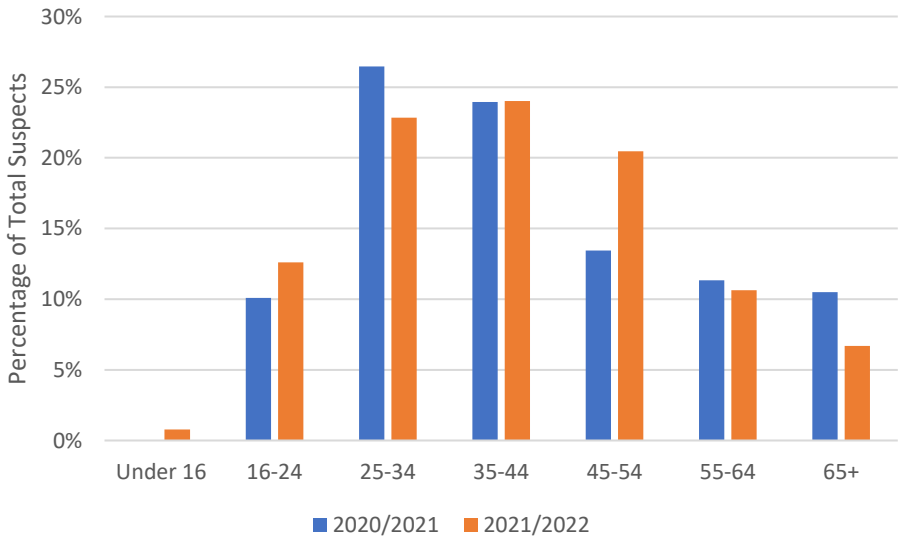
Figure 19. Proportion of suspects by age group (April 2020 – March 2022)



Source: Domestic Homicide Project

When comparing the two years, there was an increase in the proportion of suspects aged 45 to 54 (13%, n = 32 in Year 1; 21%, n = 52 in Year 2), and a decrease in the number of suspects whose age was 'not known' or not recorded (4% vs. 2%) between Year 1 and Year 2 (see Figure 20).

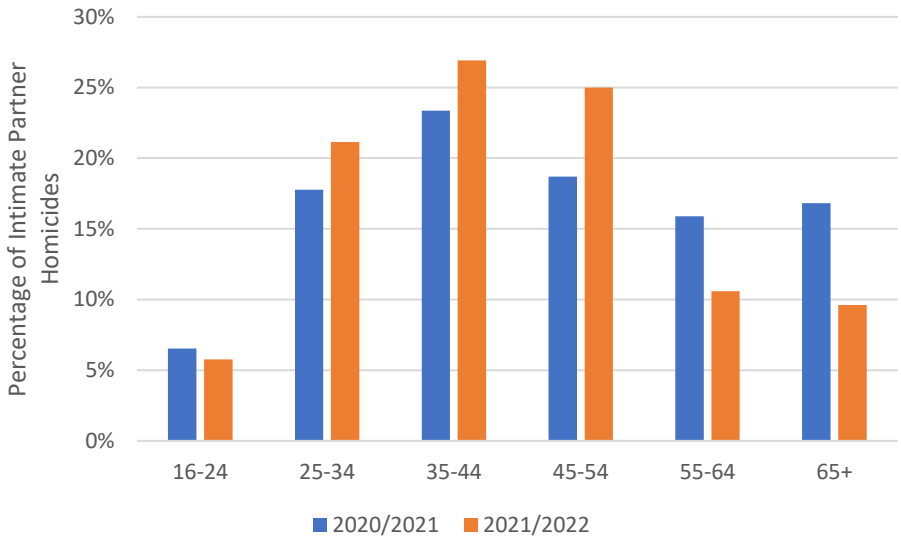
Figure 20. Proportion of suspects by age group – Year 1 and Year 2



Source: Domestic Homicide Project

First, within intimate partner homicide deaths, the age distribution of suspects appears to match that of the broader dataset and associated victims, with the majority of suspects aged 25 to 54 years old across both Year 1 and Year 2 (60% and 73% respectively). However, similar to the distribution of victims, in Year 1, 17% (n = 18) of intimate partner homicide suspects were aged 65 years or older, whereas this fell to 10% (n = 10) in Year 2. Similarly, the proportion of intimate partner homicide suspects aged 55 to 64 also decreased from 16% (n = 17) in Year 1 to 11% (n = 11) in Year 2 (see Figure 21). As mentioned earlier, 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 (Hoeger *et al.*, 2022). Furthermore, there was also a slight rise in the number of suspects aged 45 to 54 years old, from 19% in Year 1 to 25% in Year 2.

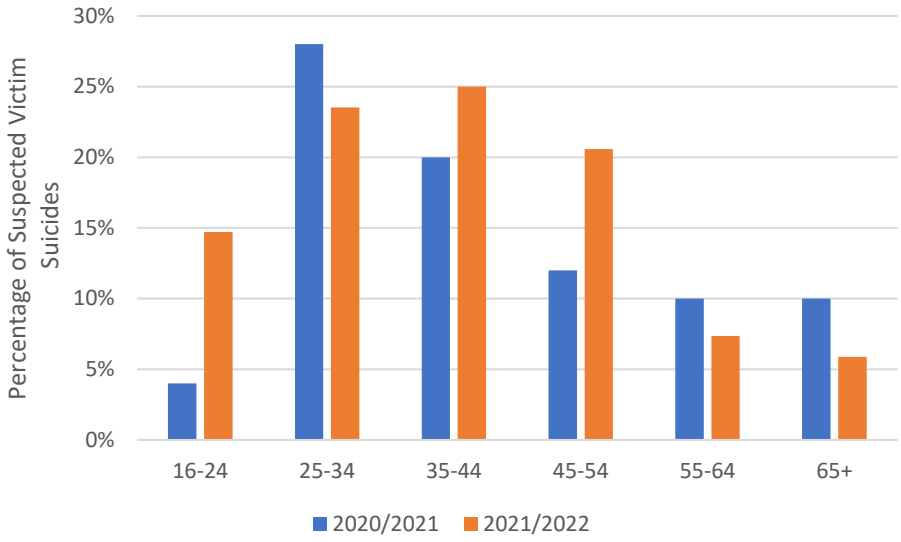
Figure 21. Proportion of intimate partner homicide suspects by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Second, within suspected victim suicide deaths, the associated prior domestic abuse perpetrators tended to be slightly older than the victims, with the majority (60% in Year 1, 69% in Year 2) aged between 25 to 54 years old (see Figure 22). When comparing the datasets, there was a greater number of domestic abuse perpetrators aged 16 to 24 (n = 8, 15% vs. n = 2, 4%) in Year 2 compared to Year 1. Again, the sample within each sub-group is small, and in 10 cases, the age of the domestic abuse perpetrator was 'not known' or not recorded.

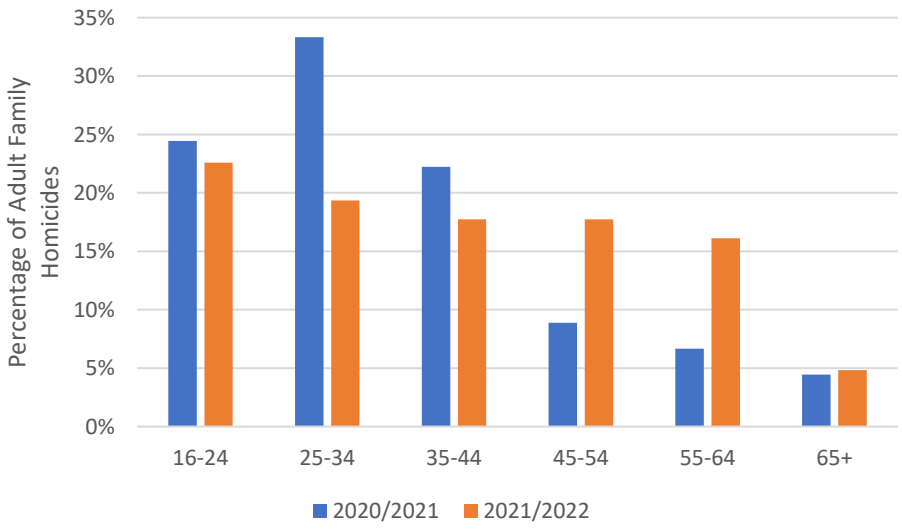
Figure 22. Proportion of prior domestic abuse perpetrators in suspected victim suicides by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Third, within adult family homicide deaths, the suspects were generally younger than the victims. In Year 1, 80% of the 45 suspects were aged 16 to 44 years old. In Year 2, the age distribution was more varied, but 60% of the 64 suspects were similarly aged 16 to 44 years old. There was a decrease in the proportion of adult family homicide suspects aged 25 to 44 (56% in Year 1, 37% in Year 2), and an increase in suspects aged 45 to 64 (16% in Year 1, 34% in Year 2) (see Figure 23). While, as found in the Year 1 report (Bates *et al.*, 2021), 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.

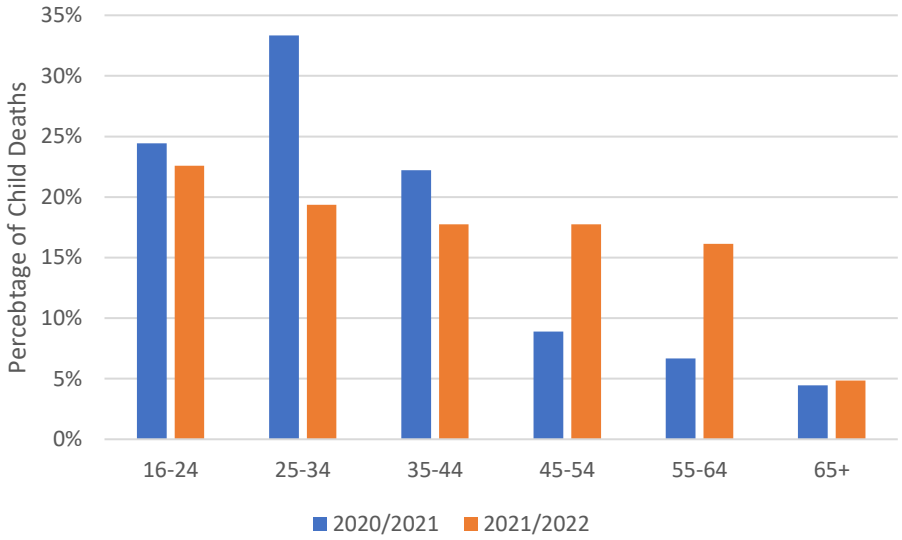
Figure 23. Proportion of adult family homicide suspects by age group – Year 1 and Year 2



Source: Domestic Homicide Project

Fourth, of the 14 suspects of child death reported to the Project in Year 2, the highest number were aged 25 to 34 (50%, n = 7). This was also the most commonly recorded age group for the 29 suspects recorded in Year 1 (45%, n = 13; see Figure 24).[15]

Figure 24. Proportion of child death suspects by age group – Year 1 and Year 2



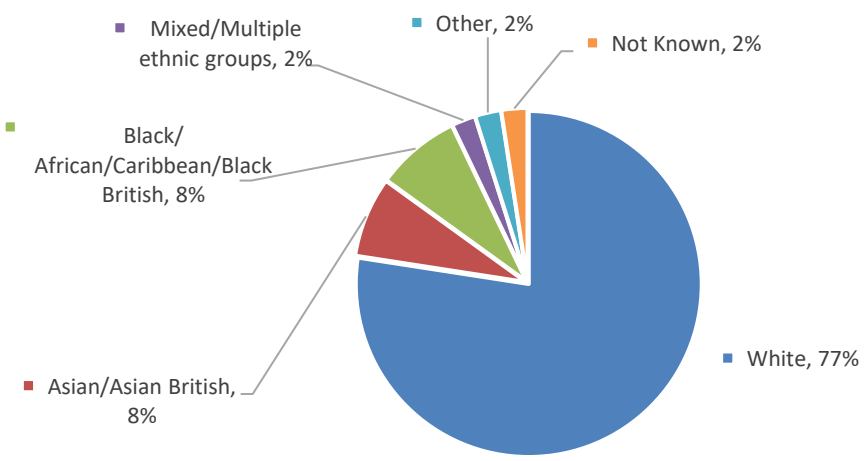
Source: Domestic Homicide Project

3.3.3 Ethnicity and Nationality

Across the Year 1 and Year 2 dataset, the ethnicity of the suspects (or prior domestic abuse perpetrators in cases of suspected victim suicide) was very similar to the victims described in the previous section. Of the 492 suspects, 78% were recorded as of white ethnicities, 8% were recorded as being of black ethnicities, 8% of Asian ethnicities, 2% of mixed ethnicities, and 2% of 'other' ethnicities. In 2% of cases the suspect's ethnicity was not recorded (see Figure 25). Taken together, those of minority ethnic heritages (other than white ethnicities) therefore comprised 20% of our combined two-year Project dataset, with a further 2% where ethnicity was unknown.

[15] As noted, some cases involve multiple suspects, whilst others may involve one suspect associated with several victims.

Figure 25. Proportion of suspects by ethnicity (April 2020 – March 2022)



Source: Domestic Homicide Project

As mentioned in the victims' section, whilst the 2021 Census figures have not yet been published for ethnicities, the 2011 Census lists the following: 86% of the population was of white ethnicities, 3% were of black ethnicities, 8% were of Asian ethnicities, 2% of mixed or multiple ethnicities, and 1% of other ethnicities (Office for National Statistics (ONS) 2018). Taken together, those of minority ethnic heritages (other than white ethnicities) comprise 14% of the general population as measured by the 2011 Census. Our Project dataset also therefore appears to include a lower proportion of suspects of white ethnicities and a higher proportion of minority ethnic heritages than the general population as measured by the 2011 Census (20% compared with 14%); and again, slightly higher proportions of suspects in of black ethnicities (8% compared with 3%). The Project's Third Spotlight Briefing on ethnicity also provides additional analysis of data collected during the first 18 months of data collection (Perry *et al.*, 2022).

Police forces were also asked to provide the suspect's nationality. Similar to data on victim nationality, of the 492 suspects, 26% (n = 126) did not have a recorded nationality. Therefore, of the 366 cases in which the suspect's nationality was known, 80% (n = 294) were recorded as British. As with victims, Polish was the next most commonly recorded nationality, including 18 suspects (5%), followed by six suspects (2%) recorded as Romanian, and five suspects (1%) recorded as Welsh. All other recorded nationalities related to 1 to 3 suspects. Data completion for nationality of the suspect increased by 9% between Year 1 and Year 2, again suggesting some potential improvement in the collection of this data within police systems. 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, 2021b).

3.3.4 Other protected characteristics and additional factors

In the overall dataset, 14 of the 492 suspects (3%) were recorded as being LGBTQ+. Notably, for 43% of suspects this characteristic was listed as 'not known' or was not recorded, whilst it was recorded as 'no' in 54% of suspects. Comparing the two years, as found within the dataset of victims, there was an increase in prior domestic abuse perpetrators recorded as being LGBTQ+ in cases of suspected victim suicide in Year 2 (from 4% to 10%). This means that the Project received more submissions in Year 2 relating to suspected suicides of victims following domestic abuse from a same-sex partner. 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 32% of suspects.

The combined Year 1 and Year 2 dataset also identified 15% of suspects (n = 74) as having a special need (physical, mental, learning or developmental, dementia, or more than one). However, this characteristic was 'not known' or not recorded in 51% of suspects. Comparing the two years, there was a rise in adult family homicide suspects with any special need (from 22% in Year 1 to 31% in Year 2) and a slight fall in intimate partner homicide suspects with any special need (from 13% to 10%).

In the Year 2 dataset, additional analysis showed that of the suspects with a recorded special need, most had a mental health (n = 66) need. There were also 12 suspects recorded as having a physical need, eight with a learning or developmental need, and one suspect was recorded as having dementia. Again, as this analysis was not conducted on Year 1 data, it is not possible to compare the figures between datasets, and some suspected had more than one recorded special need.

Furthermore, only 11 suspects were recorded as having a known religion, with the remaining 98% being 'not known,' recorded as 'no religion,' or not recorded. Finally, nine suspects (2%) were recorded as being pregnant or having given birth within the previous six months, eight of whom were suspects in child deaths.

3.4 Findings and recommendations on typologies and characteristics of victims and suspects

Findings

Finding 3: In Year 2, there was a drop in the proportion of older victims (aged 65 years and over) of intimate partner homicide (n = 18, 18% in Year 1; n = 11, 11% in Year 2). This follows our Year 1 finding of a rise in older intimate partner victims and suspects during the pandemic.

Finding 4: By contrast, in Year 2, as in Year 1, there remained a high proportion of older victims in the adult family homicide cases (n = 17, 43% in Year 1; n = 26, 42% in Year 2). As in Year 1, these were primarily killed by their adult children or grandchildren. In contrast to Year 1, where we saw more adult family homicide cases where the victim was caring for

the suspect – usually due to the suspect's mental ill health and/or substance use – in Year 2 this caring relationship reversed, and we saw a larger proportion of suspects who were caring for the victim – often due to age or infirmity.

Finding 5: In Year 2, there were slightly more male victims (although still in the minority) compared with Year 1: an increase from 28% (n = 61) to 32% (n = 79). Overall, across both years, male victims were principally associated with the child death and 'other' categories.

Finding 6: Whilst the LGBTQ+ variable was often recorded as 'not known' (n = 67, 31% in Year 1; n = 85, 34% in Year 2), the Project dataset did record a slightly higher number of LGBTQ+ victims in the second year of data collection (n = 6, 3% in Year 1; n = 10, 4% in Year 2). It is possible that officers are improving their identification of LGBTQ+ victims, especially within suspected victim suicides (n = 2, 4% in Year 1; n = 8, 13% in Year 2).

Finding 7: Whilst numbers are small, the full two-year dataset appears to include a lower proportion of victims and suspects of white ethnicities and a higher proportion of victims and suspects of minority ethnic heritages compared to the general population as measured by the 2011 Census (22% of victims and 20% of suspects were of minority ethnic heritages, compared to 14% in the Census). This was particularly true of victims and suspects of black ethnicities (8% compared with 3% in the Census).

Finding 8: Victims of Polish nationality were the second most common after victims of British nationality across the full two-year dataset, at 5% (n = 17). This mirrors findings over ten years from the Femicide Census, which highlighted Polish victims as being most represented after British victims in femicide cases. Both these findings are likely to reflect the fact that, according to the 2021 Census, Polish has been the most common non-British nationality in the UK since 2007.

Recommendations

No recommendations.

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

4.1 Overall risk factors

Police forces were asked to identify (where known to the police) the presence of 23 different potential risk factors relating to the suspect (or prior domestic abuse perpetrator in a case of suspected victim suicide). These 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 below, analysis identified a general increase in most risk factors identified between Year 1 and Year 2, of around 10% across the board. The Project team believes these overall increases may be partially explained by fuller and more accurate identification of the known risk factors in each case, due to more detailed follow-up with forces by the Project team on each submission. It is also likely to reflect better identification by police of antecedent risk factors. This in itself is a positive development which shows that police are looking for these preceding abuse indicators, and supports the conclusion drawn in our Year 1 report that these identified risk factors are overall underestimates in each case since they rely on police (a) knowing that these factors were present and (b) sharing that detailed information with this Project. However, it is also possible that the Year 2 dataset involves higher risk cases with a greater number of risk factors (see Chapter 5). It will be important to continue data collection into future years to allow consideration of broader patterns within the data.

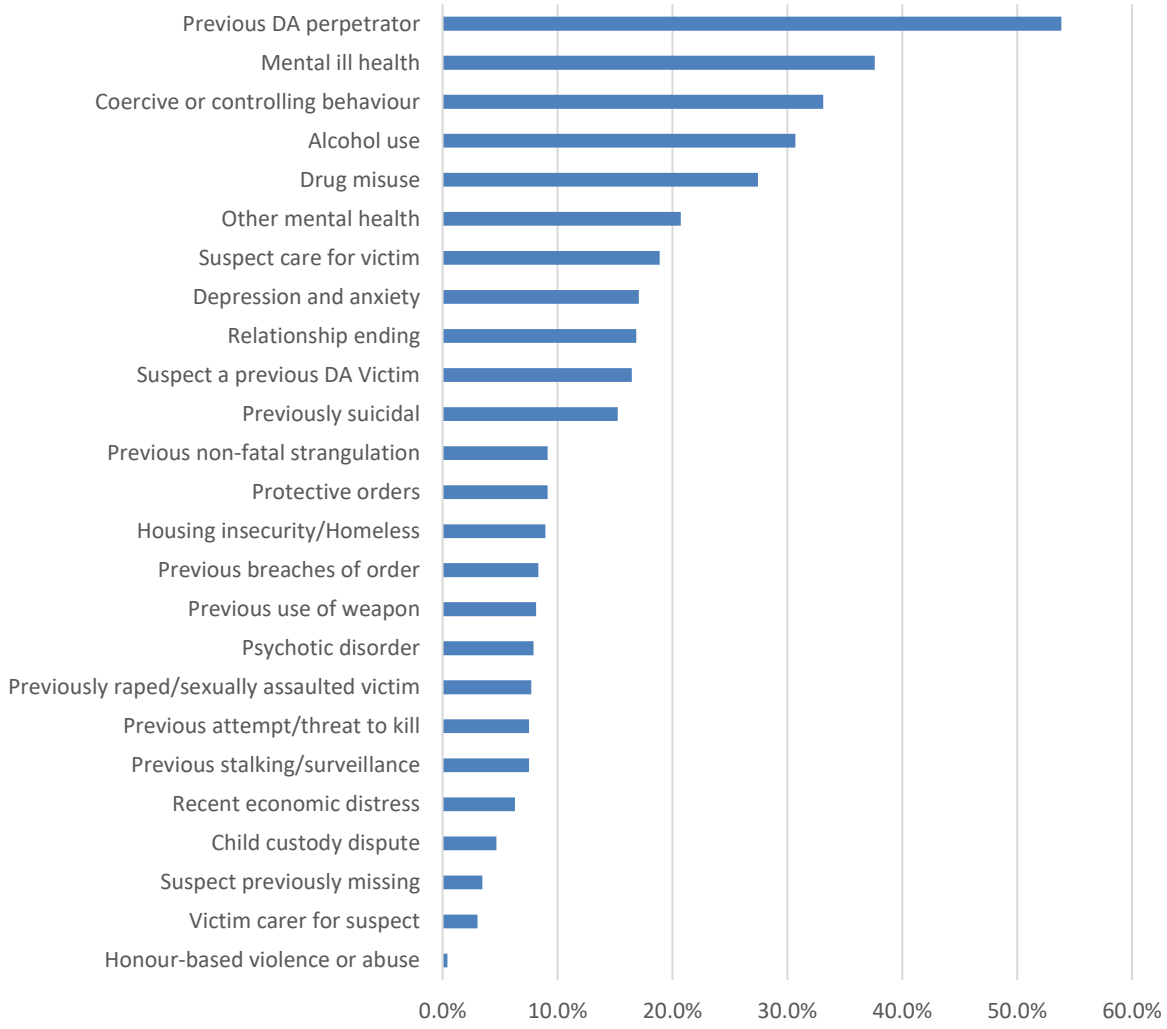
As shown in Figures 26 and 27, across the full dataset (Year 1 and Year 2), the top five most commonly recorded risk factors in relation to the suspect were identified as: being a previous domestic abuse suspect or perpetrator[16] (54%; 45% in Year 1, 62% in Year 2), any mental health condition[17] (38%; 32% in Year 1, 43% in Year 2), a history of coercive or controlling behaviour (33%; 30% in Year 1, 36% in Year 2), and alcohol (31%; 26% in Year

[16] This variable for previous domestic abuse perpetration differs from the Project teams coding of suspects known to police for domestic abuse which is described within Chapter 5. This variable within the risk factors was based on ticking a box within a checklist, whereas the variable used in Chapter 5 and throughout analysis is more robust as it was re-coded based on all details provided within the submission form.

[17] Please note that this risk factor is a combination of police-recorded mental health concerns, including depression / anxiety, psychotic disorder, previously suicidal, and 'other' mental health condition.

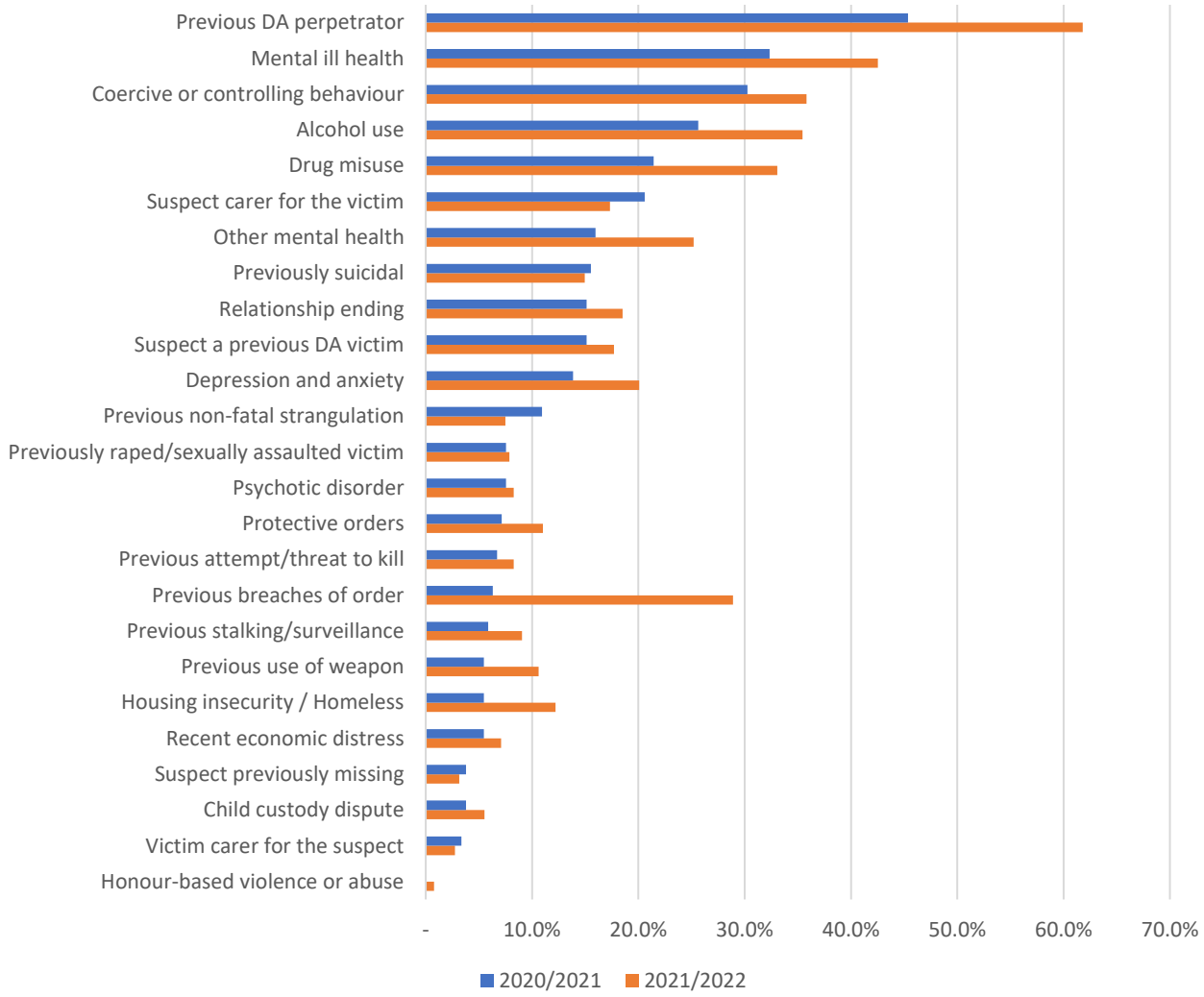
1, 35% in Year 2) and drug (27%; 21% Y1, 33% Y2) misuse (see Bates *et al.*, 2021, p. 53 for discussion of the complex interrelationship between domestic abuse, mental health, and substance misuse). Notably, some of these risk factors may also co-occur, such as previous domestic abuse and coercive or controlling behaviour. These top five factors all increased substantially in their identification in Year 2. Outside of these five factors, a larger than average increase was seen in Year 2 in identification of previous breaches of a protective order.

Figure 26. Proportion of suspects with recorded risk factors (April 2020 – March 2022)



Source: Domestic Homicide Project

Figure 27. Proportion of suspects with recorded risk factors – Year 1 and Year 2

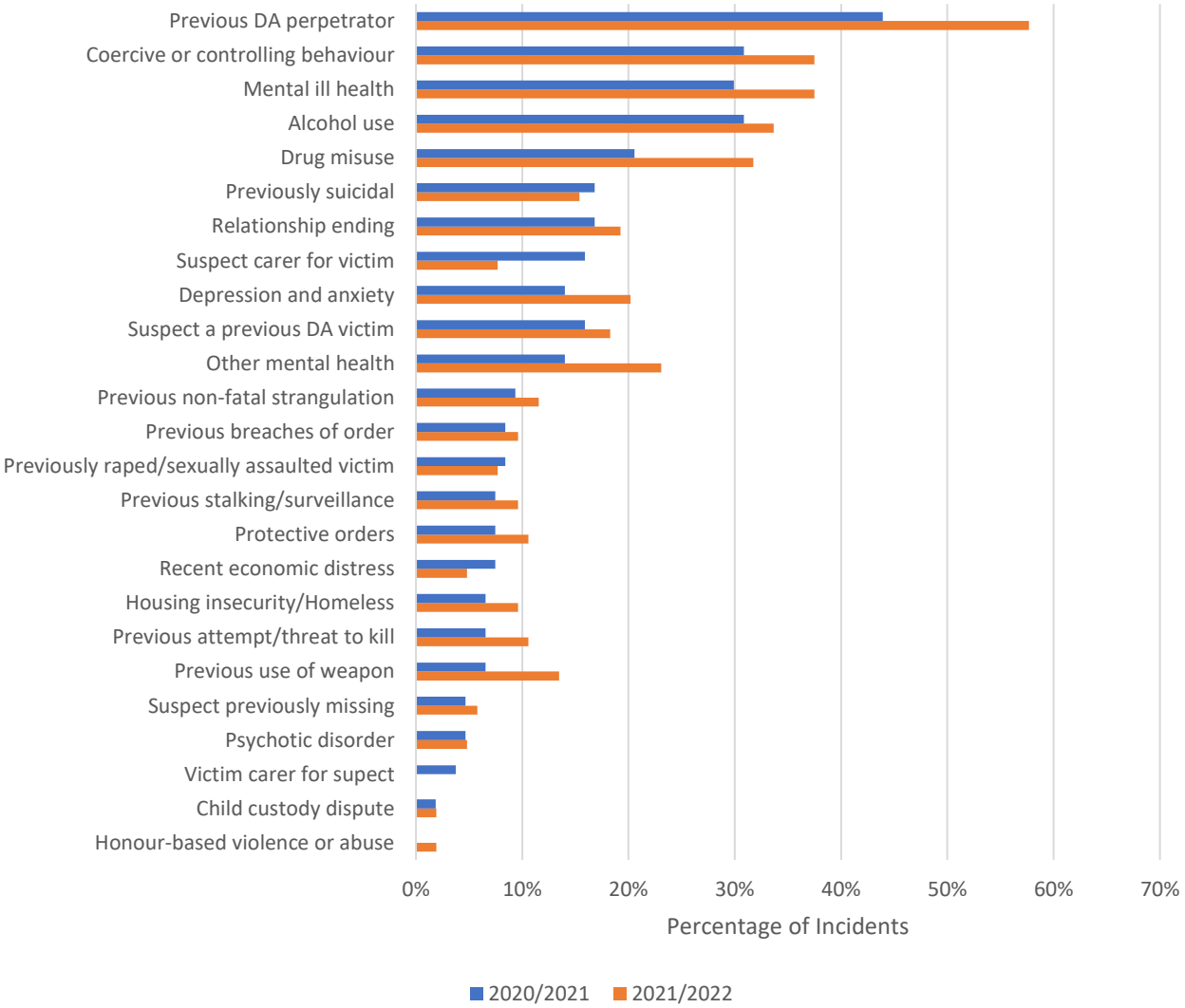


Source: Domestic Homicide Project

4.2 Risk factors by case type

Risk factors identified did vary between case types. First, within intimate partner homicides, the most commonly identified risk factors were the same five identified above in the overall dataset: a previous domestic abuse suspect or perpetrator (44% in Year 1, 58% in Year 2), a history of coercive or controlling behaviour (31% in Year 1, 38% in Year 2), any mental health condition (30% in Year 1, 38% in Year 2), and alcohol (31% in Year 1, 34% in Year 2) and drug (21% in Year 1, 32% in Year 2) misuse (see Figure 28). As with the overall dataset, all these factors increased in Year 2 by between 10 and 17 percentage points. This similarity to the overall dataset may be expected as intimate partner homicides made up the largest proportion of incidents within the overall dataset (44%, n = 203). Perhaps of interest, factors which fell in Year 2, against the overall pattern, were the victim being a carer for the suspect or vice versa – a picture which aligns with the fall in older intimate partner homicides as observed above in Chapter 3.

Figure 28. Proportion of suspects in intimate partner homicides with recorded risk factors – Year 1 and Year 2

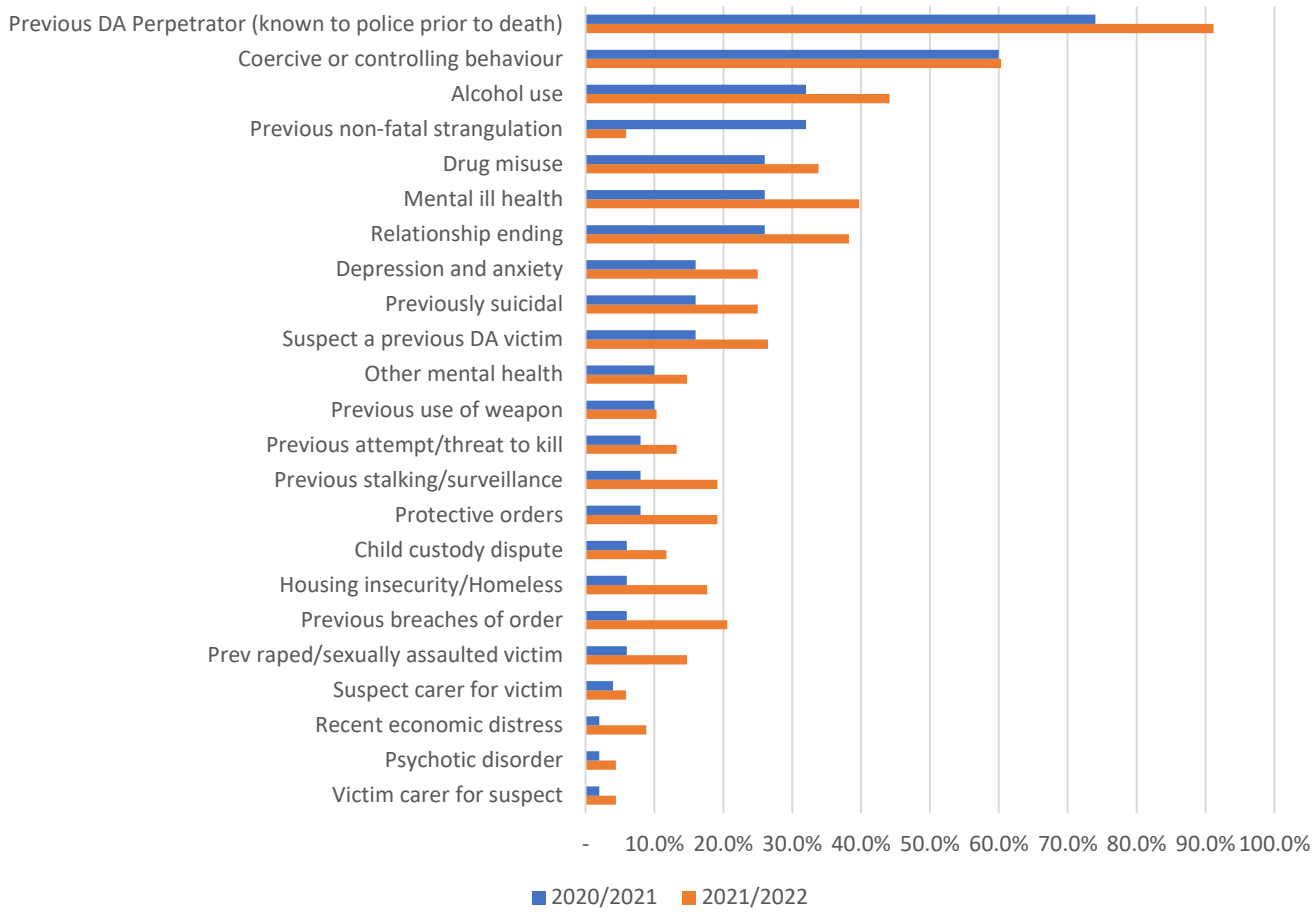


Source: Domestic Homicide Project

Next, within suspected victim suicide cases, some risk factors were more commonly identified as compared to the overall dataset. Overall, this type had the highest proportion of cases involving an identified history of coercive or controlling behaviour (see Figure 29). Additionally, please note that whilst the vast majority of suspected victim suicide cases will involve a victim who was known to the police prior to the death as a victim of domestic abuse, there will be 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. Moreover, as noted in the Year 1 report (Bates *et al.*, 2021, p. 58), the identification of coercive or controlling behaviour was higher in suspected victim suicides as compared to intimate partner homicides (60% in Year 1, 60% in Year 2 vs. 31% in Year 1, 38% in Year 2, respectively). In Year 2, there was a higher-than-average increase in breach of protective orders, and notable drop in recorded prior

non-fatal strangulation, in cases of suspected victim suicide. These risk factors are discussed in more detail in Chapter 10.

Figure 29. Proportion of suspected victim suicides with recorded risk factors relating to the prior domestic abuse perpetrator – Year 1 and Year 2



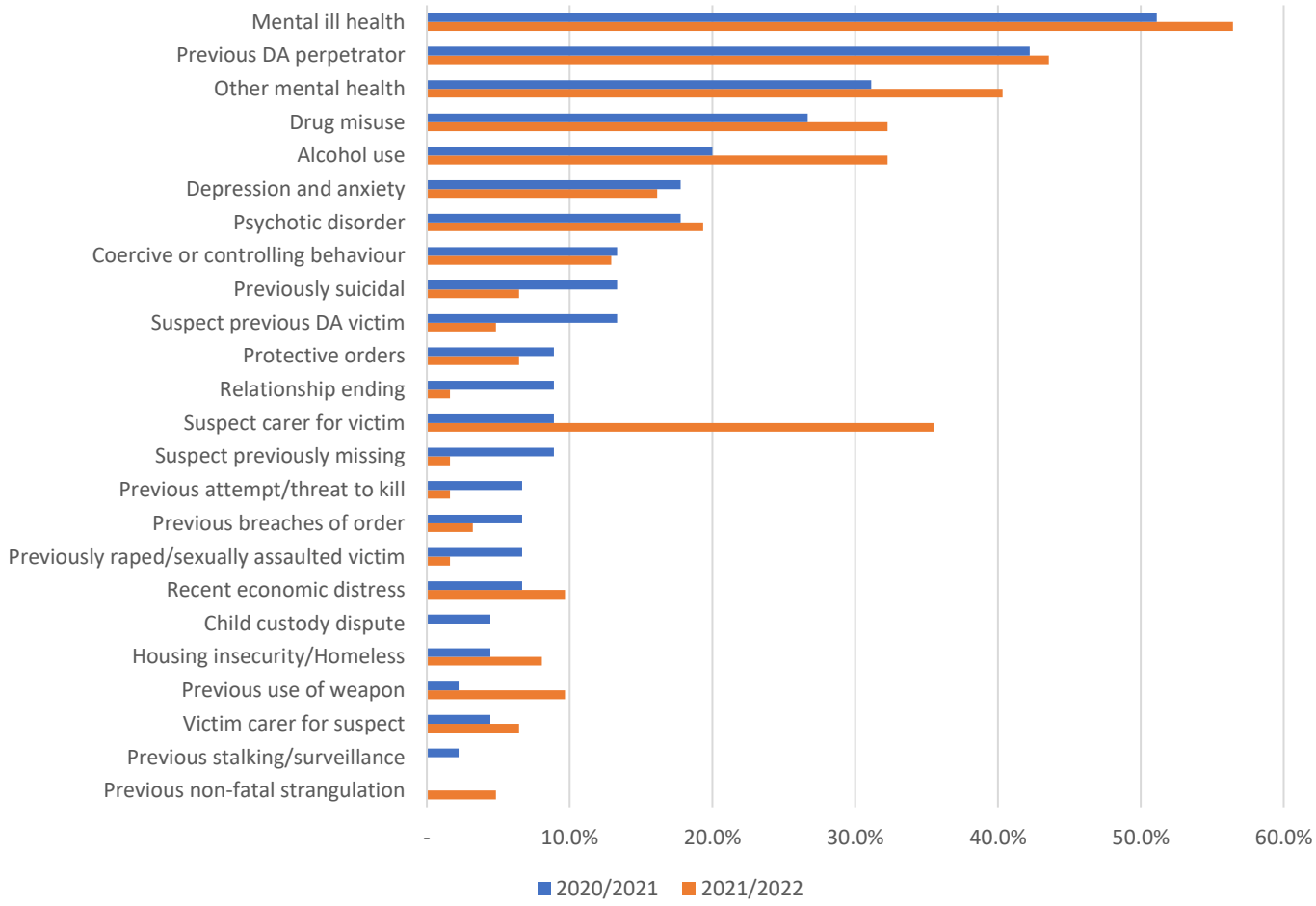
Source: Domestic Homicide Project

Turning to risk factors associated with adult family homicide deaths, in addition to previous domestic abuse (42% in Year 1, 44% in Year 2), factors relating to mental health and substance misuse were commonly identified (see Figure 30). In fact, any police-recorded mental ill health was identified as a risk factor in (over) half of the suspects associated with adult family homicide cases (51% in Year 1, 57% in Year 2). Furthermore, misuse of alcohol (20% in Year 1, 32% in Year 2) and drug (27% in Year 1, 32% in Year 2) by the suspect was also present within a high proportion of adult family homicide cases. These findings provide further support for the analysis presented in the Year 1 report (Bates *et al.*, 2021, p. 56) and the Project's First Spotlight Briefing on adult family homicide (Nguyen Phan *et al.*, 2022).

Again, comparing the Year 1 and Year 2 datasets, all top five risk factors associated with adult family homicide suspects increased. This increase ranged from 3 to 12 percentage points. There was a notable increase in suspects recorded as the victim's carer (from 9% in Year 1 to 36% in Year 2), which could reflect increased awareness raising about this

topic within policing and by the Home Office, and, to a lesser extent, an increase in the suspect's alcohol use. Risk factors in relation to adult family homicides are discussed in more detail in Chapter 8.

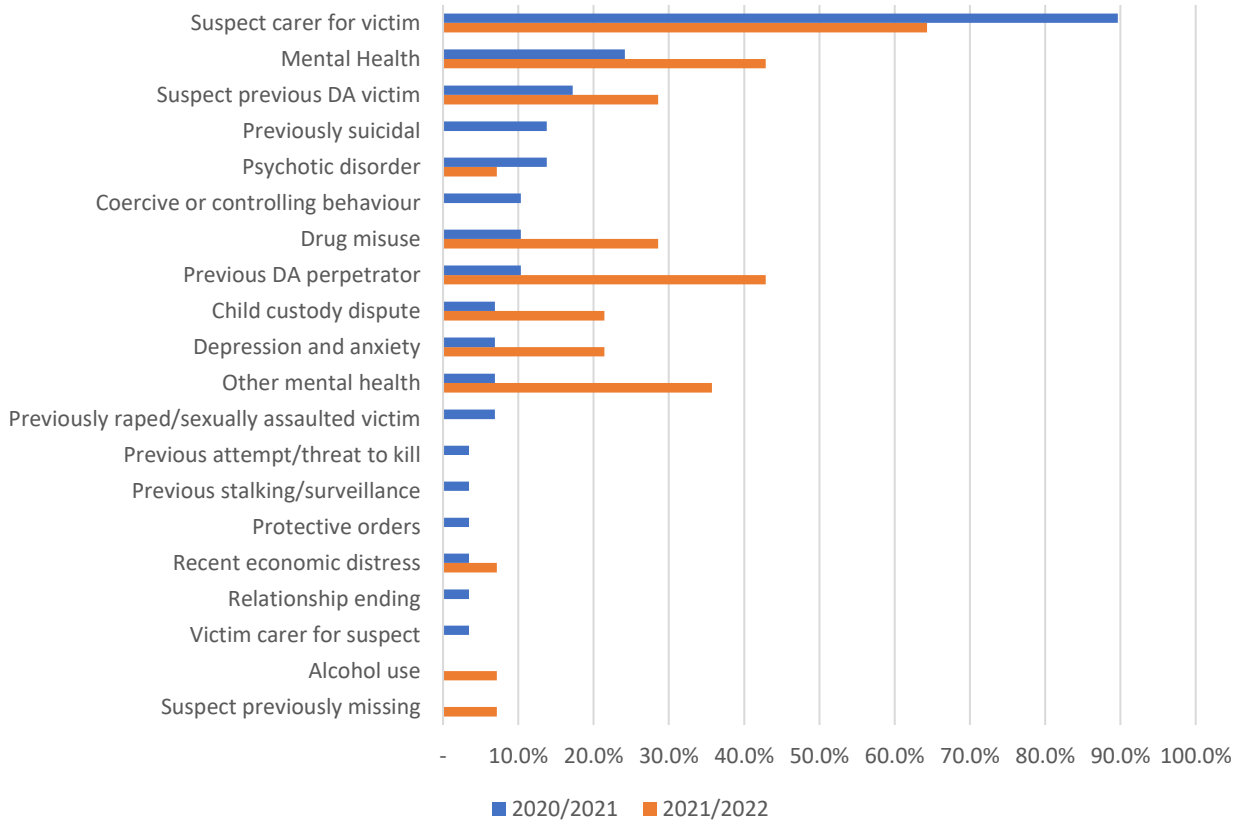
Figure 30. Proportion of suspects in adult family homicides with recorded risk factors – Year 1 and Year 2



Source: Domestic Homicide Project

Finally, within child deaths, the sample of deaths was small (n = 23 in Year 1, n = 16 in Year 2), and the suspects associated with these cases decreased between the first (n = 29) and second (n = 14) year of data collection. However, similar to the previous report findings (Bates *et al.*, 2021, p. 56), the suspect being a caregiver for the victim was the most common risk factor in child deaths. As the majority of suspects in child deaths were the victim's parent(s) or primary carers, that would help explain this high proportion of caregiving suspects. Also note that some suspects in child deaths include extended family members or siblings. The next most common factor was the presence of any mental health condition (24% in Year 1, 43% in Year 2). Moreover, suspects identified as previously being victims of domestic abuse was the third most commonly recorded risk factor in child death cases (17% in Year 1, 29% in Year 2) (see Figure 31). Whilst there were a number of changes to the recorded risk factors associated with suspects in cases of child death between years of data collection, the small sample size means these relate to single cases, which prevents meaningful commentary on the changes.

Figure 31. Proportion of suspects in child deaths with recorded risk factors – Year 1 and Year 2



Source: Domestic Homicide Project

4.3 Findings and recommendations on risk factors

Findings

Finding 9: As in Year 1, across the board, the most commonly identified antecedent risk factors for all suspects in domestic homicides and the perpetrators of prior domestic abuse in victim suicides were: prior perpetration of domestic abuse, coercive or controlling behaviour, mental health issues, alcohol and drug misuse. These risk factors did vary by type of death, with coercive or controlling behaviour and prior police record of domestic abuse being particularly prominent in intimate partner homicide and in suspected victim suicides; and mental illness, alcohol and/or drug misuse and carer relationships being more prominent in adult family homicides.

Finding 10: In Year 2, a greater number of risk factors across the board were positively identified by police as present in the suspect's history in each submission – an increase of around 10 percentage points in most risk factors. Whilst these are subject to the usual caveats about the relatively small dataset, the Project team believes these overall increases may be partially explained by the more detailed case follow-up with forces conducted in Year 2 by the Project team. It is also likely to reflect better identification by police of antecedent risk factors, which is a positive development. However, it is also

possible that the Year 2 dataset involves higher risk cases, each with a greater number of risk factors present in the history. It will be important to continue data collection into future years to allow consideration of broader patterns within the data. Risk factors which stood out as having changed by more than the 10-percentage point average in Year 2 were: for intimate partner homicide, a decrease in the proportion of victims and suspects in caring relationships; for suspected victim suicide, an increase in the recorded proportion of cases involving the domestic abuse perpetrator's known prior breach of a protective order and a decrease in the proportion of prior non-fatal strangulation; and for adult family homicide, an increase in the suspect being a carer for the victim and of suspect alcohol use.

Finding 11: This report demonstrates that risk factors present in, and therefore interventions appropriate to, intimate partner abuse and family member abuse, differ. To intervene effectively, police need to understand the 'problem profiles' of different domestic abuse related deaths in their force.

Recommendations

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.

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

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

5.1 Suspect previously known to police

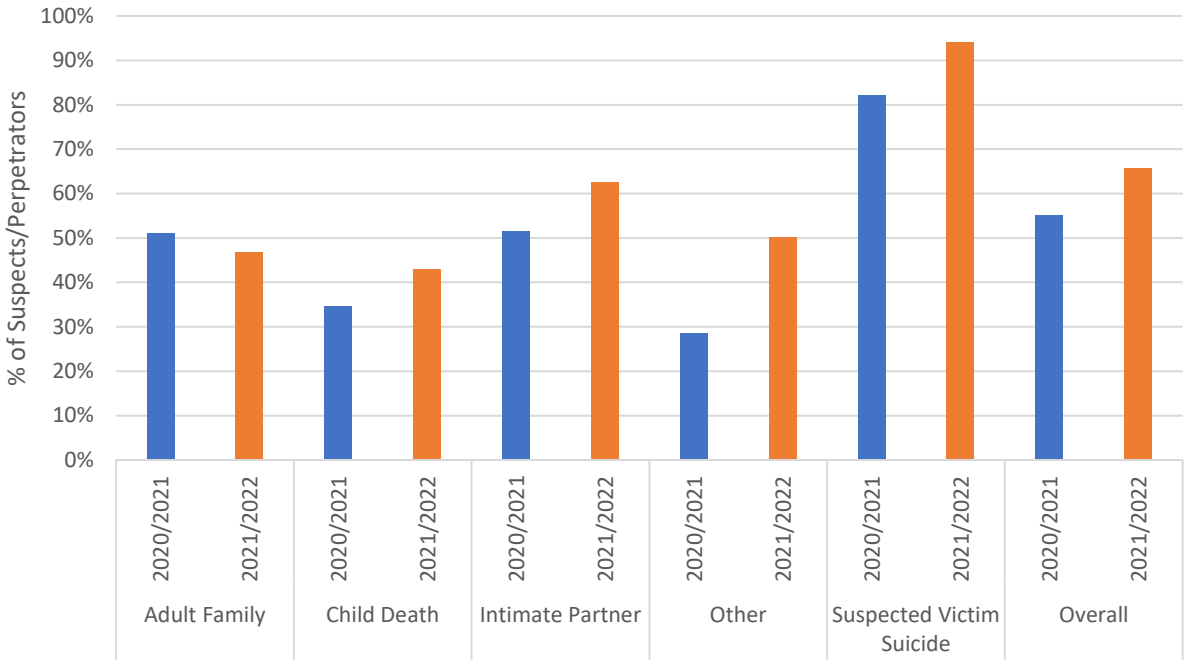
The proportion of suspects that were previously known to police for any reason, including as a victim, suspect, or vulnerable person[18] varied by typology, but included 73% (or more) suspects in intimate partner and adult family homicides, and as might be expected, almost all prior domestic abuse perpetrators in cases of suspected victim suicide (see data tables in Appendix C).

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 32). This variable found that, overall, 61% (55% in Year 1, 66% in Year 2) of suspects were known to police for domestic abuse, as a suspect or perpetrator, prior to the death. However, the inclusion of suspected victim suicides (82% in Year 1 and 94% in Year 2,) which must involve police knowledge of a history of domestic abuse perpetration (arising prior to or following the victim's death), does increase this proportion known within the overall dataset. Considered by typology, around half of suspects in adult family homicides were previously known to police for domestic abuse (51% in Year 1, 47% in Year 2). Within intimate partner homicides, the proportion of suspects previously known to police for domestic abuse increased from 51% in Year 1 to 63% in Year 2.

[18] These categories are non-exclusive, so individuals might be recorded as more than one or all.

Figure 32. Proportion of suspects known to police for domestic abuse offending by typology – Year 1 and Year 2



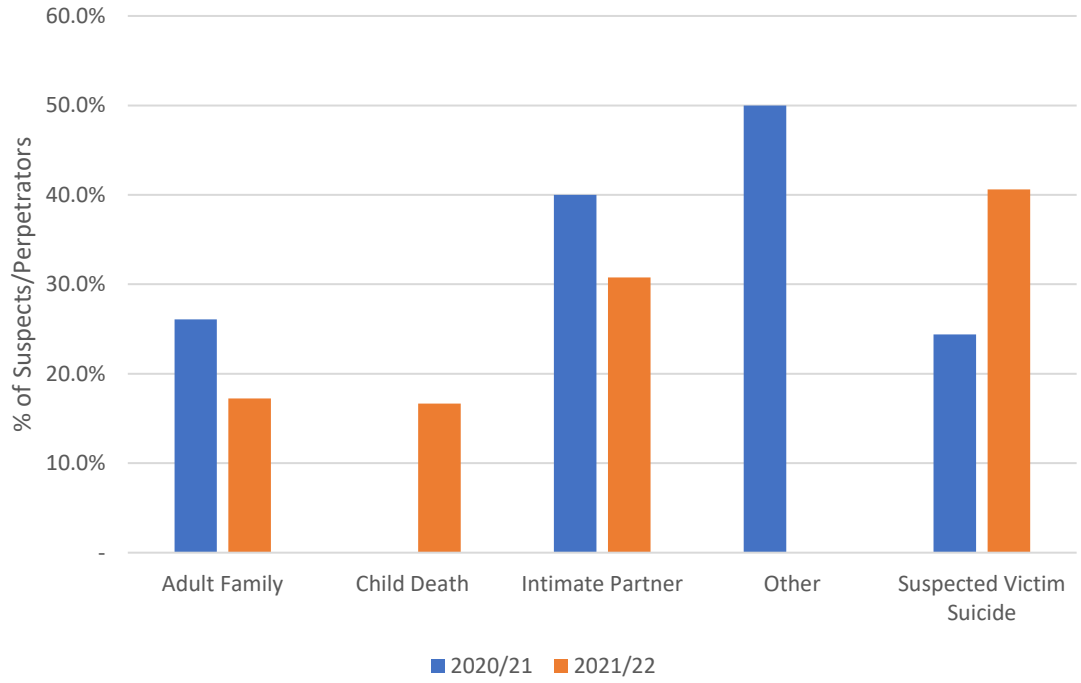
Source: Domestic Homicide Project

5.3 Suspect risk level and management

5.3.1 By case type

Data collection also captured whether the suspect was previously known to police as a high-risk or serial perpetrator, whether they were previously referred to MARAC, and whether they were being managed by police or probation at the time of the death. First, 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 33). Excluding child deaths and 'other' deaths due to the small sample size, this was lower in adult family homicides (26% in Year 1, 17% in Year 2), and higher in intimate partner homicides (40% in Year 1, 31% in Year 2) and in relation to the prior domestic abuse perpetrators in cases of suspected victim suicide (24% in Year 1, 41% in Year 2). The increase in high-risk or serial perpetrators associated with suspected victim suicide cases between the first and second year of data collection is notable, although not statistically significant.

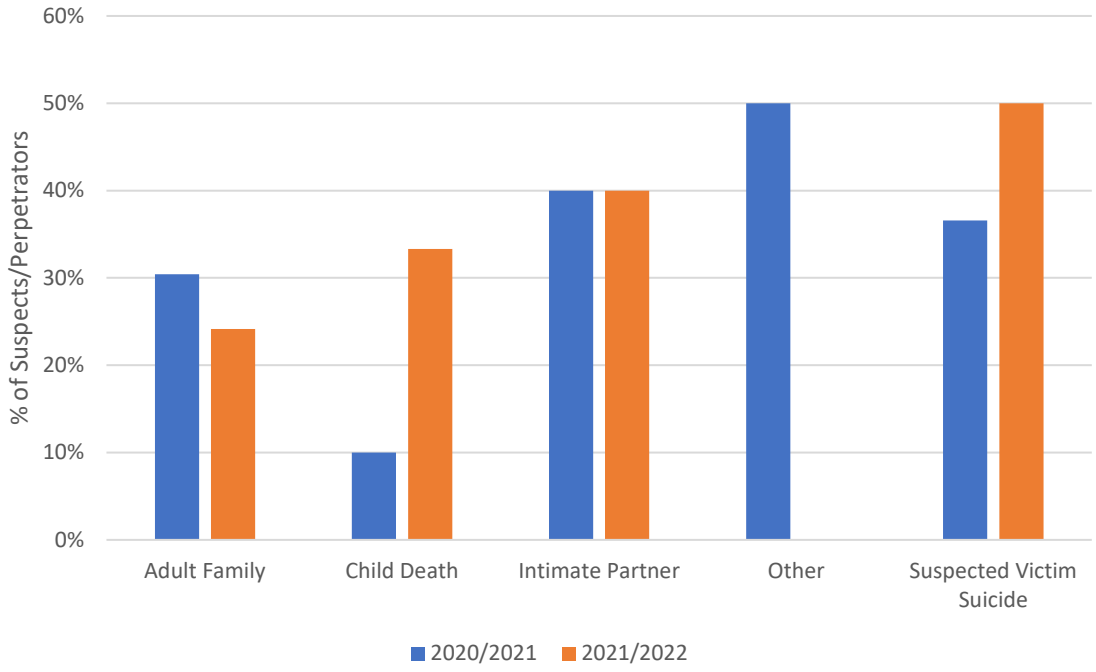
Figure 33. Proportion of suspects known to police for domestic abuse offending and identified as high-risk or serial perpetrators by typology – Year 1 and Year 2



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 34). Similar to the above, excluding child deaths and 'other' deaths, there were fewer adult family homicide suspects (30% in Year 2, 24% in Year 2) than intimate partner homicide suspects (40% across both years) and prior domestic abuse perpetrators associated with suspected victim suicides (37% in Year 1, 50% in Year 2) who had been referred to MARAC. Again, there was an increase demonstrated in the proportion of domestic abuse perpetrators associated with suspected victim suicide cases who had been referred to MARAC between Year 1 and Year 2 of data collection, although, again, this increase was not statistically significant. Considered with the above, this suggests suspects of intimate partner homicide and prior domestic abuse perpetrators in suspected victim suicides were more likely to be assessed as high-risk compared to suspects within adult family homicide cases.

Figure 34. Proportion of suspects known to police for domestic abuse offending and referred to MARAC by typology – Year 1 and Year 2



Source: Domestic Homicide Project

Third, across the full dataset (i.e., not only those known to police for domestic abuse) only a small proportion (10%) 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%.

5.3.2 By risk factors

For all suspects previously known to police as high-risk domestic abuse perpetrators, we analysed whether there were significant statistical associations with other suspect risk factors across the overall two-year dataset. Interestingly, the following risk factors were all significantly associated (at $p<0.05$) with high-risk perpetrators: coercive or controlling behaviour, previous non-fatal strangulation, suspect having made prior suicide threats, suspect having made prior threats to kill the victim, suspect having previously breached a protection order, and suspect previously known for stalking. These associations appear to be reassuring insofar as they indicate that police are using the presence of these risk factors appropriately in assessing and assigning risk in domestic abuse.

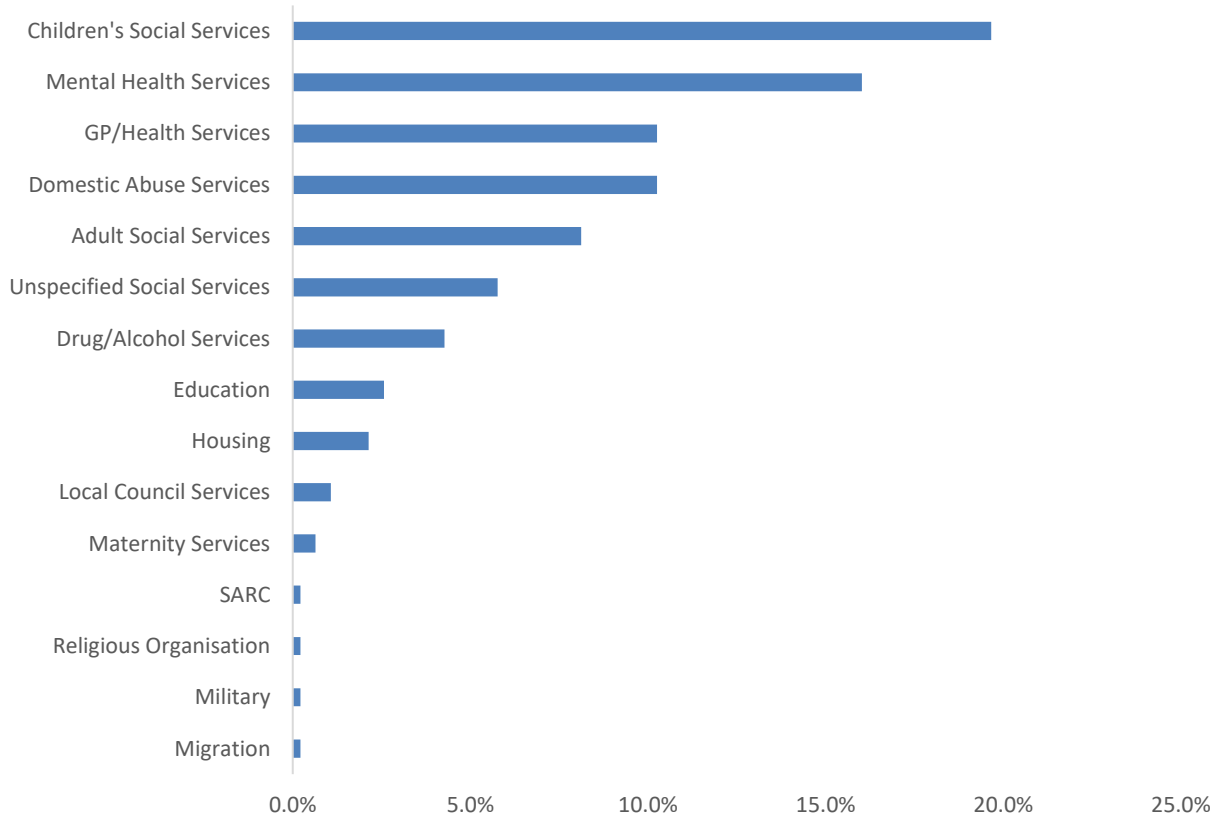
5.4 Suspect or victim previously known to other agencies

Within the overall two-year dataset, in 58% of incidents the victim and/or suspect (or prior domestic abuse perpetrator in cases of suspected victim suicide) was known to a partner agency. Moreover, in 42% of incidents where the victim and/or suspect were not previously known to police, they were known to a partner agency. Also note that in 12% of

incidents this variable (other agency contact) was listed as 'not known' or not recorded, and victims and or suspects might be known to more than one agency. The victim and/or suspect / prior domestic abuse perpetrator were most commonly known to partner agencies in suspected victim suicides (76% in Year 1, 81% in Year 2), followed by child deaths (71% in Year 1, 60% in Year 2), and was lower in adult family homicides (51% across both years) and intimate partner homicides (51% in Year 1, 49% in Year 2).

Over the whole two-year dataset, excluding the police, the agencies which the victim and/or suspect (or prior domestic abuse perpetrator) was most often known to were children's social services (20% of all cases across the combined two-year dataset; 16% of all cases in Year 1, 24% of all cases in Year 2), mental health services (16%; 17% in Year 1, 16% in Year 2), GP/Health services (10%; 12% in Year 1, 10% in Year 2), and domestic abuse services (10%; 10% in Year 1, 11% in Year 2). Figure 35 shows the proportion of cases in the whole combined two-year dataset which were known to agencies other than the police.

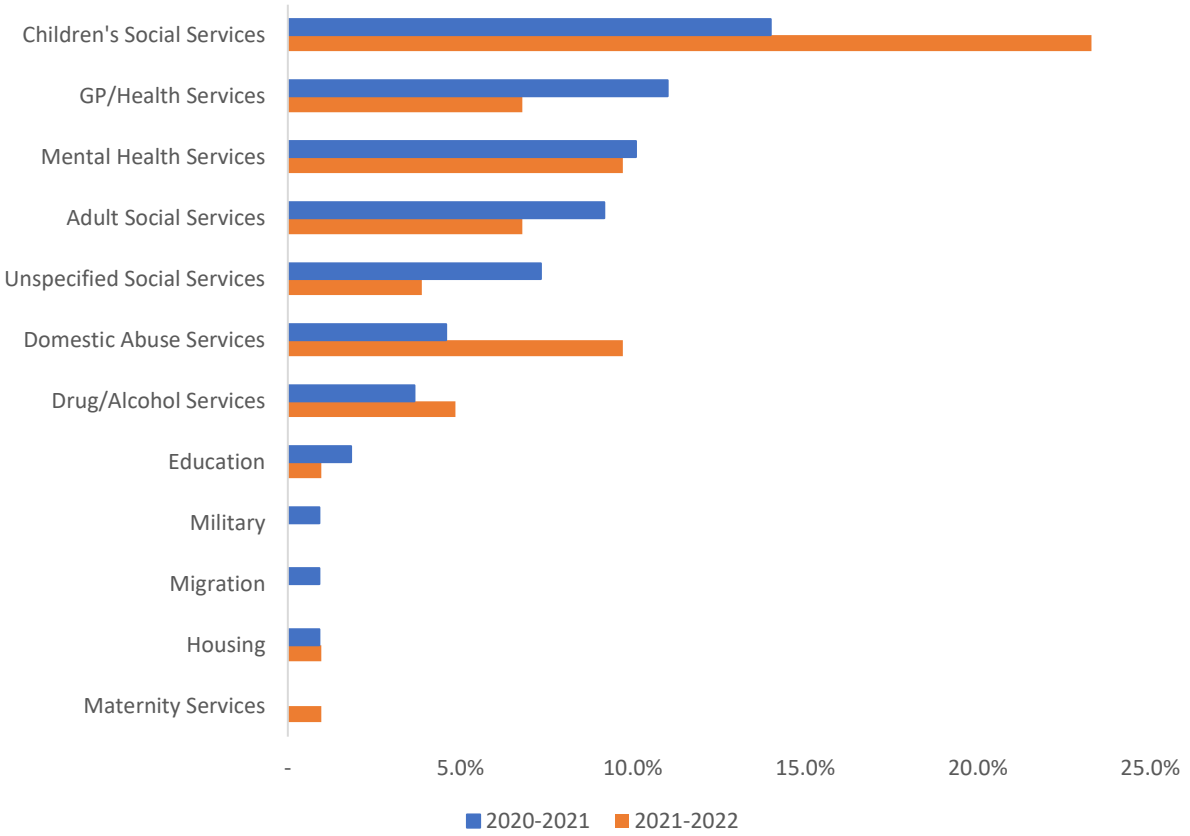
Figure 35. Proportion of victims and/or suspects known to other agencies by agency (April 2020 – March 2022)



Source: Domestic Homicide Project

Whilst most of this data was relatively consistent between Year 1 and 2 of data collection, to understand some of the differences, it is important to consider any changes within each typology of case. First, within intimate partner homicides, the agency which victims and suspects were most often known to was children's social services (14% in Year 1, 23% in Year 2), followed by GP/Health services (11% in Year 1, 7% in Year 2), mental health services (10% across both years), and adult social services (9% in Year 1, 7% in Year 2). The largest increase in agency contact between Year 1 and Year 2 within intimate partner homicides was the proportion of victims and suspects known to children's social services. Figure 36 shows the proportion of intimate partner cases in the whole dataset, by year, which were known to agencies other than the police.

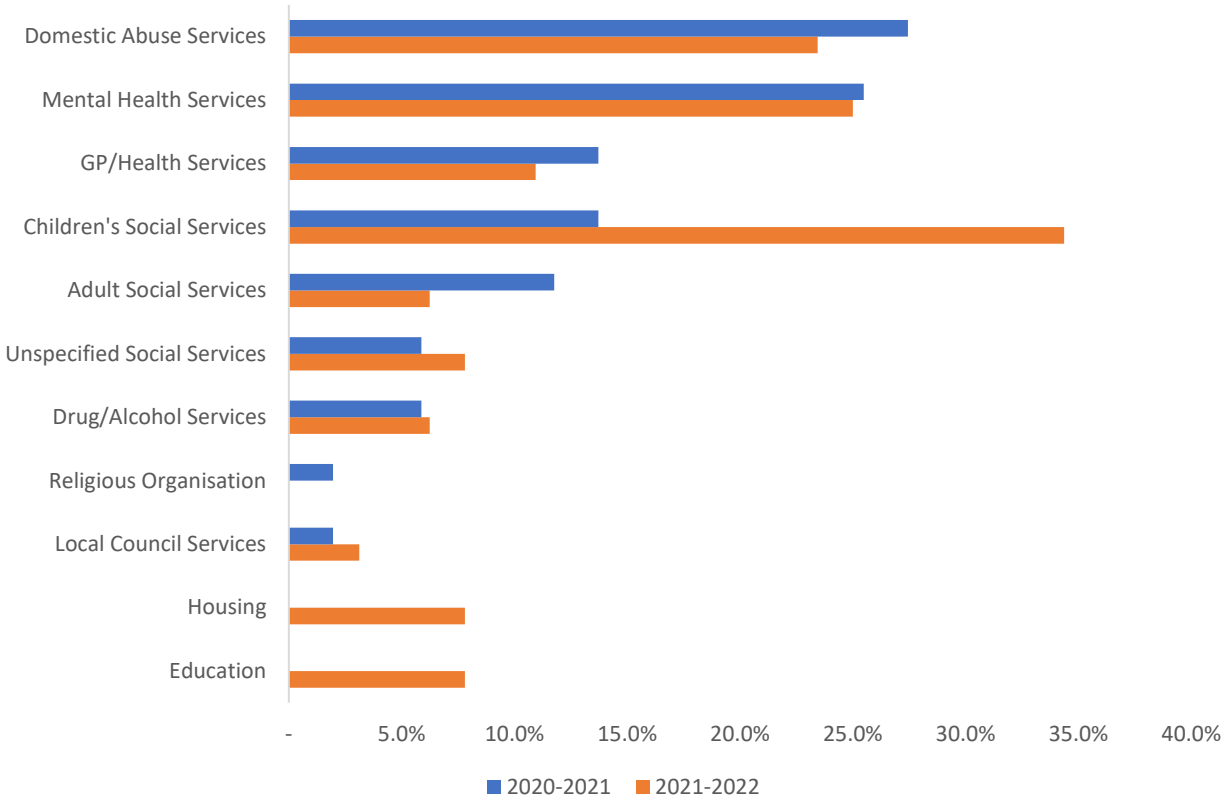
Figure 36. Proportion of intimate partner homicides by agency contact with victim and/or suspect – Year 1 and Year 2



Source: Domestic Homicide Project

Second, victims and prior domestic abuse perpetrators in suspected victim suicides were known to a similar range of agencies as intimate partner homicides. Figure 37 shows the proportion of suspected victim suicide cases in the whole dataset, by year, which were known to agencies other than the police. Importantly, as described in this report, and the Year 1 report (Bates *et al.*, 2021), suspected victim suicides and intimate partner homicides are associated with similar profiles and levels of risk (e.g., associated with previous perpetration of domestic abuse, high levels of control and violence). Prior agency contact in suspected suicide cases is discussed further in Chapter 10.

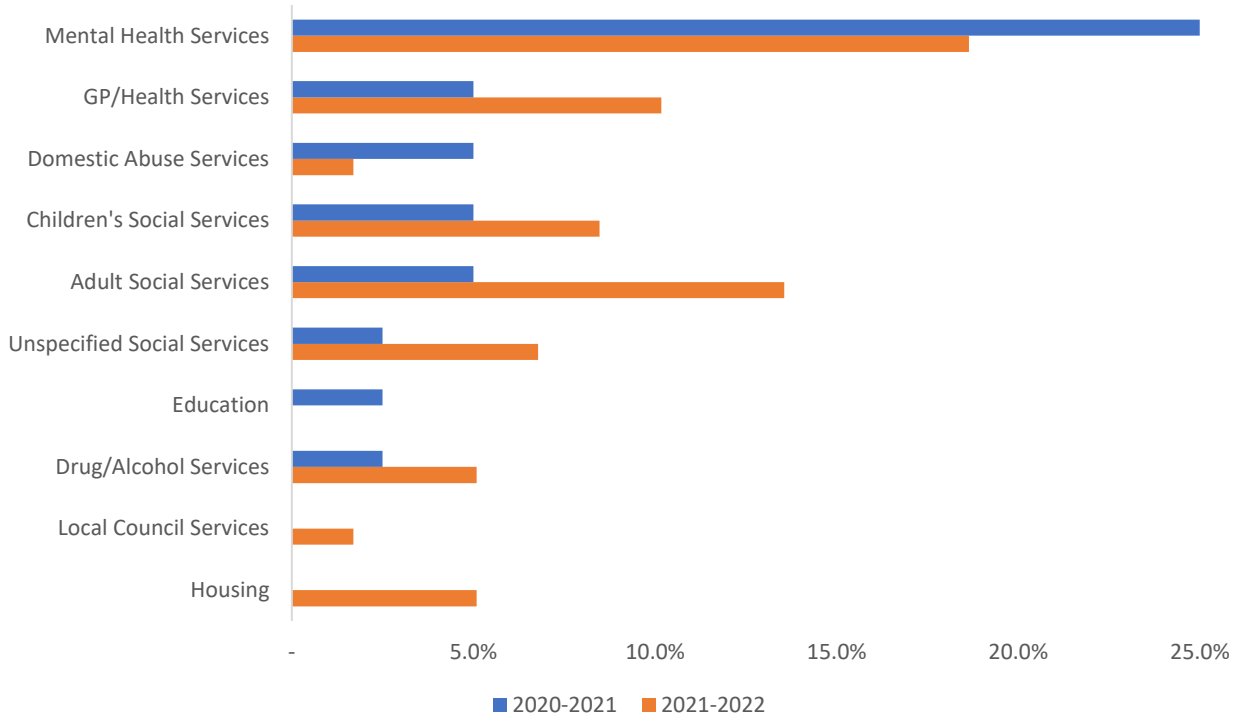
Figure 37. Proportion of suspected victim suicides by agency contact with victim and/or prior domestic abuse suspect – Year 1 and Year 2



Source: Domestic Homicide Project

Third, within adult family homicides, suspects and victims were most commonly known to mental health services (25% in Year 1, 19% in Year 2), followed by GP/Health services (5% in Year 1, 10% in Year 2), domestic abuse services (5% in Year 1, 2% in Year 2), and children's social services (5% in Year 1, 9% in Year 2). Notably, aside from mental health services, victims and suspects in adult family homicides appear to be less visible to several other agencies as compared to cases of intimate partner homicide or suspected victim suicide. Figure 38 shows the proportion of adult family cases in the whole dataset, by year, which were known to agencies other than the police. Given the overall increase in adult family homicide cases in Year 2 and the identified prevalence of risk factors around mental health, and drug and alcohol misuse in this report, the Year 1 report (Bates *et al.*, 2021), and the First Spotlight Briefing (Nguyen Phan *et al.*, 2022), one would expect the multi-agency response and mental health agency contact to be higher in these cases in attempt to support prevention.

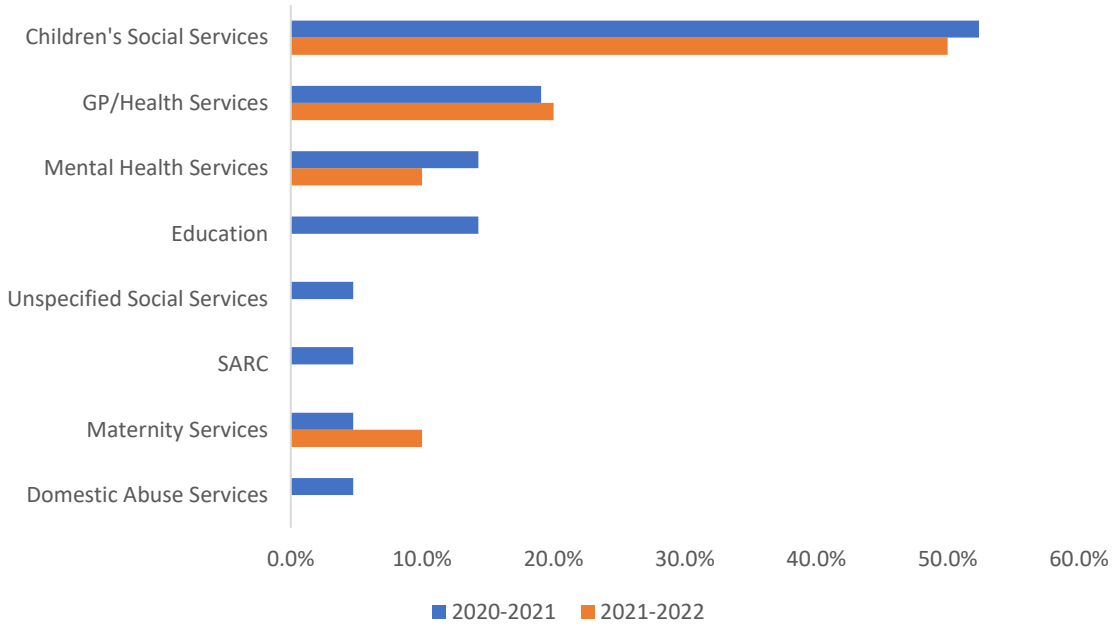
Figure 38. Proportion of adult family homicides by agency contact with victim and/or suspect – Year 1 and Year 2



Source: Domestic Homicide Project

Fourth, although child deaths included a small number of incidents (n = 21 in Year 1, n = 10 in Year 2), the three most commonly involved agencies were children's social services (52% in Year 1, 50% in Year 2), GP/Health services (19% in Year 1, 20% in Year 2), and mental health services (14% in Year 1, 10% in Year 2). Figure 39 shows the proportion of child death cases in the whole dataset, by year, which were known to agencies other than the police. Whilst it may not be surprising that children's social services would be in contact with the victim and/or suspect, these findings suggest potential opportunities for intervention.

Figure 39. Proportion of child deaths by agency contact with victim and/or suspect – Year 1 and Year 2



Source: Domestic Homicide Project

5.5 Findings and recommendations on prior contact with police and other agencies

Findings

Finding 12: In Year 2 the proportion of all suspects / perpetrators known to police for domestic abuse rose to two thirds (66%, n = 167) from just over half (55%, n = 131) in Year 1. In Year 2, fewer suspects in adult family homicide cases were previously known to police for domestic abuse (47%, n = 29/62), compared with suspects in intimate partner homicide cases (63%, n = 65/104). Suspects in intimate partner homicides and perpetrators of the previous domestic abuse in suspected victim suicide cases were much more likely to be previously known to the police as high-risk domestic abuse offenders and/or to be known to MARAC than suspects in adult family homicides.

Finding 13: We were able to show a statistical association between high-risk perpetrators and various antecedent suspect risk factors including: prior threats to kill, coercive or controlling behaviour, breach of orders, non-fatal strangulation, and stalking. These associations seem reassuring in the sense that they indicate that police are using presence of these risk factors appropriately in assessing and assigning risk in domestic abuse cases, and further confirm that these risk factors are key to understanding the most dangerous domestic abuse perpetrators.

Finding 14: Across the two-year dataset, only 10% (n = 49/492) of suspects (or perpetrators of prior abuse in suspected victim suicides) were recorded as 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 police for anything, this rose to 16% (n = 49/297). Our Year 1 report highlighted that further investigation was needed to test whether this figure is accurately capturing all offenders who are being managed – or whether there is under-reporting to this Project. Year 2's data shows that additional investigation is still needed.

Finding 15: The police alone cannot prevent domestic abuse or homicide. Of the cases in this dataset in which the individuals were not previously known to police, almost half were known to one or more non-police agency. This shows that multi-agency partnerships such as MARAC and MASH are absolutely vital to identify those most at risk and put in place appropriate interventions, especially in adult family violence cases.

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.

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'*.

Chapter 6: Domestic Homicide Reviews

6.1 DHR numbers

Every domestic homicide and every 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 Domestic Homicide Review (DHR). As in the Year 1 report (Bates *et al.*, 2021, p. 71), 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, and then whether it was accepted for a DHR.

Overall, whether or not a case had been referred to the Community Safety Partnership for a DHR was known in 82% of cases (n = 347, see Table 4 below: variable = '% of incidents known if referred'). Where this was known, 91% of these cases had been referred. Within this known sample, there was an increase in the proportion of cases referred between Year 1 (84%) and Year 2 (97%). There may be several possible explanations for this change, including an improved follow-up process by the Project team with police forces, or changes to local referral policies and practices. Of those cases that were referred, 67% were accepted for a DHR, rising slightly from 64% in Year 1 to 68% in Year 2. When cases in which the acceptance outcome was not (yet) known were removed, the acceptance rate rose to 94% overall (91% in Year 1 and 96% in Year 2). Additionally, where the referral outcome was known and recorded, only 6% of cases which were referred for DHR were not accepted: 9% in Y1 and 5% in Y2.

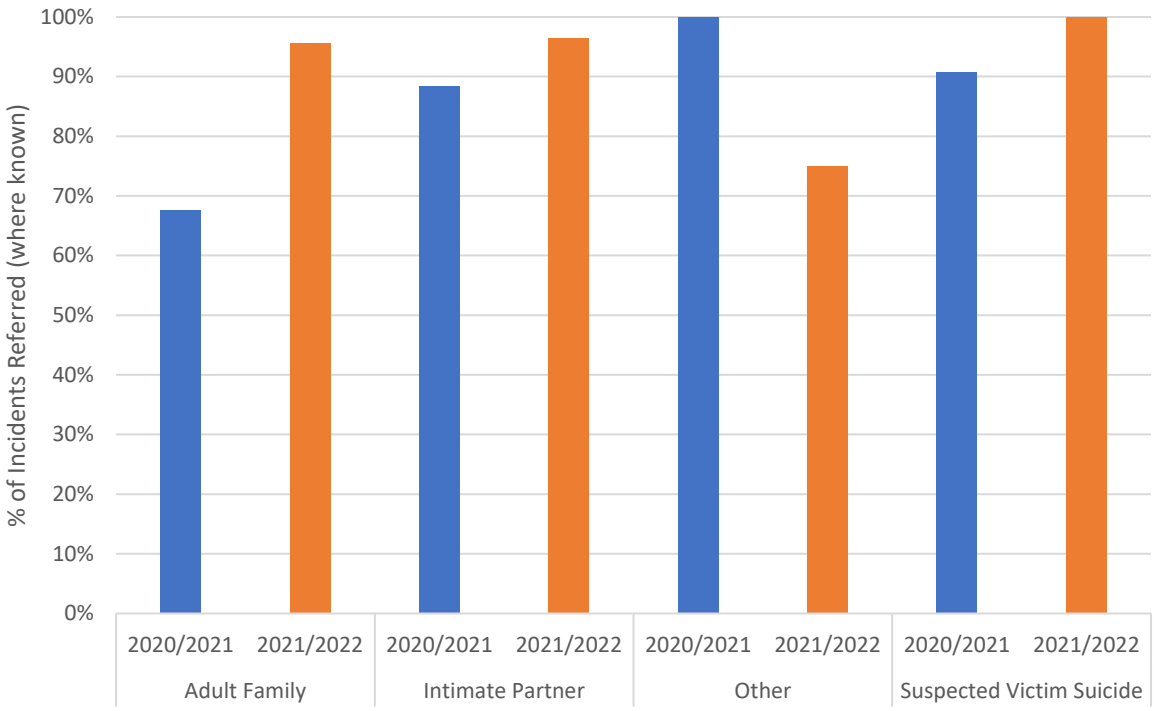
Table 4. DHR referral and acceptance status – Year 1 and Year 2

	DHR Referral Status (excluding child deaths)					
	2020/2021		2021/2022		Total	
DHR Referral Status	N	%	N	%	N	%
% of incidents known if referred	153	*79%*	194	*84%*	**347**	***82%***
% of incidents referred (where known)	129	*84%*	188	*97%*	**317**	***91%***
% of incidents accepted (where referred)	83	*64%*	128	*68%*	**211**	***67%***
% of incidents accepted (where referred and referral outcome known)	83	*91%*	128	*96%*	**211**	***94%***
% of incidents not accepted (where referred)	8	*6%*	6	*3%*	**14**	***4%***
% of incidents not accepted (where referred and referral outcome known)	8	*9%*	6	*5%*	**14**	***6%***

Source: Domestic Homicide Project

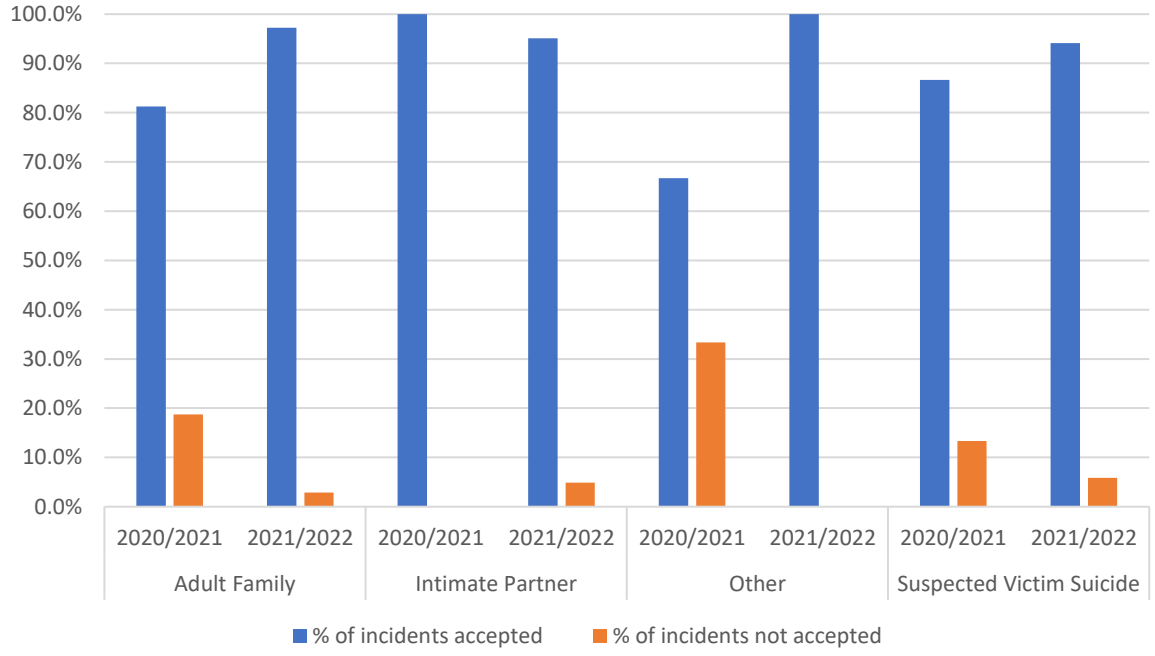
Figures 40 and 41 below present the figures for DHR referral and acceptance rate by case typology. Whilst much of this data is in line with the overall dataset, the referral and acceptance rate for suspected victim suicide cases is one area of interest given ongoing work by the Home Office to update guidance on the DHR process. The decision to refer a suspected victim suicide for a DHR is discussed further in Chapter 10.

Figure 40. DHR referral rate by typology (excluding child deaths) – Year 1 and Year 2



Source: Domestic Homicide Project

Figure 41. DHR acceptance rate by typology (excluding child deaths) – Year 1 and Year 2



Source: Domestic Homicide Project

6.2 Bereaved families' experiences of DHR and review process

We describe in Chapter 10 (10.1.4) the consultation event this Project carried out with Advocacy After Fatal Domestic Abuse (AAFDA) and families bereaved through domestic homicides and suspected victim suicides. Whilst that event was focused on suspected suicides, the families did share experiences of the DHR process more generally, which we record here. Findings and recommendations specifically relating to DHRs for suspected suicides only are listed in Chapter 10.

Some of the families described feeling poorly treated by police and other agencies, or feeling side-lined during Coronial, DHR and other review processes. Some felt they had experienced attitudes which they described as dismissive, victim-blaming or careless. In particular, families described feeling pain caused by their experiences with review panels, inquests, police and other professionals which, they felt, had in some cases: (a) got basic details about loved ones wrong (e.g. names, spellings, life stories); (b) blamed victims, for example making value judgments about their lifestyle (e.g. use of drugs or alcohol, vulnerability as lifestyle choice, sex work) and families' perception that their loved ones were given less attention and care as a result; or (c) not listened or accorded weight to the account or information given by the family members.

6.3 Findings and recommendations on DHRs

Findings

Finding 16: Where known, in Year 2 the overall number of domestic homicides and suspected victim suicides referred for Domestic Homicide Reviews (DHRs) rose from 84% in Year 1 to 97% in Year 2. The known acceptance rate also rose, from 91% to 96%. This is an encouraging development.

Finding 17: Domestic Homicide Reviews (DHRs) are the right vehicle to respond to requests we heard from bereaved families for lessons to be better learnt about agency responses in individual cases, including about whether adequate safeguarding and protection actions took place in relation to the preceding domestic abuse. Home Office Statutory Guidance on DHRs makes explicit that families and friends should be clearly involved right from the start of a DHR process. The Guidance specifies that they should be a key stakeholder, that they may have information that is not known to agencies, and that "their contributions must be afforded the same status as other contributors" (Home Office, 2016, p. 17). It advises that families should be given the opportunity to meet the review panel and the Chair, to influence the scope, content and impact of the DHR, and be given completed reports in advance of submission to the Home Office, with time to absorb the report, identify any incorrect information in it, and register any areas of disagreement (Home Office, 2016, pp. 18–19). Yet we heard from some families that they had felt side-lined in this process and that their loved ones' voices were not necessarily afforded the respect or centrality that the Guidance recommends. Whilst the Guidance is explicit and

detailed on the role family and friends should be given in DHRs, it seems that this may not always be well implemented in practice by Chairs and Review Panels.

Recommendations

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.

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.

PART B: THEMATIC LEARNING

This section delves deeper into a qualitative analysis of case submissions to the Project to examine three key areas for thematic learning: coercive or controlling behaviour (Chapter 7), adult family homicides (Chapter 8), and impact of the Covid-19 pandemic (Chapter 9).

Chapter 7: Coercive or Controlling Behaviour

7.1 Identification and reporting of coercive control

Forces were asked in their case submissions to indicate the presence and give examples of coercive or controlling behaviour which was known to have occurred prior to the death.

The coercive or controlling behaviour 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 coercive or controlling behaviour.
- Through specific crime reports of controlling or coercive behaviour (CCB) (a small number).
- Through disclosures made by friends and family of the victim as part of the homicide or suspected suicide investigation.

In Year 2, in most cases information relating to coercive control had not been previously reported to police but emerged from accounts of family and friends. This was notable in cases of suspected victim suicides, where even though the couples might have been previously known to police for domestic abuse-related reports, coercive control had either not been reported or its full extent had not been known. This may indicate that coercive control remains under-reported and consistent and skilful questioning by response officers is vital in eliciting disclosures. The Year 1 report highlighted the importance of DA Matters training in helping frontline officers identify coercive control when responding to domestic abuse incidents (Bates *et al.*, 2021).

In some Year 2 cases, no coercive control had previously been identified in police records at the time of submission to our Project, but it was later noted by the force as part of the Project team's follow-up process, either during the course of the investigation or as part of the Domestic Homicide Review process. This demonstrates the importance of information-sharing on knowledge of domestic abuse between agencies.

7.2 The presence of coercive control

In Year 2, coercive or controlling behaviour was noted in 89 cases in relation to 91 suspects and prior domestic abuse perpetrators (36%), making it the third most commonly recorded risk factor, as outlined in Chapter 4. Coercive or controlling behaviour was most prominent within intimate partner homicides (39 suspects) and suspected victim suicides (41 prior domestic abuse perpetrators) – all 41 of which were associated with intimate partner abuse (rather than adult family abuse) prior to the suspected suicide.

Coercive or controlling behaviour was also a phenomenon which was disproportionately perpetrated by males: 33/39 of the intimate partner homicide suspects were male (one of whom was in a same-sex relationship), and 32/41 of the prior domestic abuse perpetrators in suspected victim suicides were male (two of whom were in same-sex relationships). In several cases, it was the recorded male victim (deceased) who was known to have previously used coercive control against a female partner who was recorded in the submission as the suspect (in an intimate partner homicide) or perpetrator of the prior domestic abuse (in a suspected victim suicide). It is not possible to tell from the data in this Project alone if this indicates a wider issue where the primary (male) perpetrator of abuse is subsequently being identified as a victim when deceased – whether, for instance, some of these cases may involve retaliatory or defensive actions from victimised women – but this would warrant further exploration.

7.3 The various forms of coercive control

Not all cases where coercive or controlling behaviour was noted in the case history on the submission form led to crimes having been recorded or charged for the specific offence of controlling or coercive behaviour (CCB). However, aspects of this behaviour might have been recorded and charged as other domestic abuse-related offences (e.g. stalking, harassment or violence against the person) and/or have resulted in safeguarding actions. When asked in submissions to this Project to identify indicators of coercive control in the victim's history, the submitting police officers provided a remarkable level of detail, demonstrating a sophisticated understanding of coercive control and its various manifestations, and allowing the following descriptive analysis of what the coercive control consisted of. As in the figures provided in the paragraph above, please also note that the findings from this analysis relate only to those cases within the Year 2 dataset.

In line with the extant evidence base on the nature and impact of coercive control (Stark, 2007; Myhill, 2015; Barlow *et al.*, 2020; Barlow and Walklate, 2022), across all cases where it was noted by police, coercive control emerged as a pattern of abusive behaviour, encompassing various tactics that often overlapped. Many of the abusive behaviours which form part of a pattern of coercive control emerged within qualitative analysis are described within the sub-sections below.

7.3.1 Micro-regulation, monitoring, and surveillance

One of the most common forms of coercive control consisted of the suspect controlling the victim's routine, whereabouts or movement, and everyday behaviour. This included telling the victim what to wear, checking the victim's phone, constantly calling or following the victim when she was out, preventing the victim from going out, and accompanying the victim to appointments. Financial control was a frequently noted tactic by the suspect to enforce this regulation, while jealousy was often used by the suspect as a justification. In some cases, the victim's vulnerabilities and care needs were noted as a tool used by the suspect to reinforce the victim's dependence. Stalking and harassment, both in person and

digital, was noted to have escalated following separation, with breaches of protective orders mentioned.

7.3.2 Isolation of the victim from family and friends

Integral to the micro-regulation and monitoring, victims were often reported to have been isolated from family and friends, either because they were not allowed contact or because they were reluctant to socialise for fear of consequences. In some cases, it was noted by friends or family that the victim had begun to withdraw from support networks upon a suspect's release from prison or rekindling of the relationship. Isolation could also be enforced against the victim's access to professionals and essential services by exploiting the victim's additional barriers (language or faith, for instance).

7.3.3 Threats and intimidation

Alongside control and isolation, or perhaps underpinning it, the use of intimidation as a tactic of coercive control was commonly noted among suspects. This included threats of or actual physical and sexual abuse against the victim, as well as frequently recorded threats of or attempted suicide and self-harm by the suspect, as a means to instil fear in the victim or manipulate the victims into compliance. The use of children as 'weapons' was noted in several cases, including turning the children against the victim, threatening to report the victim to children's social care, or putting the victim through family court proceedings. At times, the threat or use of physical violence extended to other people related to the victim, such as the victim's family members or new partners (including those with whom the suspect believed the victim might have been in relationship).

7.3.4 Humiliation and degradation

This ranged from criticising the victim's looks, making derogatory remarks about the victim's body parts or weight, calling the victim names and making her feel worthless, to denigrating the victim's mental health difficulties and using them against her, notably encouraging the victim's own self-harm or suicide.

While not all of the above tactics were present in all cases where coercive control was identified, most examples provided by forces showed a complex array of abusive behaviours, as the two cases below illustrate:

"He would know what she had eaten during the day without even seeing her eat, he would keep tabs on her through the day by 'hounding' her with calls and texts, he made her give up smoking because she took too long smoking a cigarette and he would tell her what to wear if she went out. She said that she felt isolated form her friends and family as he would make her feel bad for seeing them, and also that he had strangled her […] when she had to hit him over the head to get him off her"

(Suspected victim suicide)

"The stalking behaviours mainly consisted of the suspect following the victim to her friends' houses in his car. He would threaten to take his own life and tell the children that it would be their fault if he succeeded. The victim reported feeling as though she was constantly being watched and was only free of this when she was at work or at the GP. She was very afraid of the suspect's reaction should he have found out she was planning to leave him"

(Intimate partner homicide)

Source: Domestic Homicide Project

Some of the most notable examples of coercive or controlling behaviour were found in cases of suspected victim suicide, even more so than in intimate partner homicides. The cases submitted to this Project suggest that the nature and extent of prior coercive control are severe in situations which culminated in a victim dying by suicide, which reinforces the importance of identifying coercive or controlling behaviour in a timely and accurate manner and implementing suicide prevention interventions in these cases.

7.4 Findings and recommendations on coercive control

Findings

Finding 18: This report presents new evidence to show that coercive controlling behaviour was strongly present in both intimate partner homicide and suspected victim suicide cases. The findings show that the nature and extent of prior coercive control are severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.

Finding 19: When asked to identify indicators of coercive control in the victim's history, a remarkable level of detail was provided in submissions, demonstrating a sophisticated understanding by police of coercive or controlling behaviour and its various manifestations. Yet there were only a small number of cases in this two-year dataset where the specific offence of controlling or coercive behaviour was recorded or charged

Recommendations

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.

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.

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.

Chapter 8: Adult Family Homicides

As outlined in Part A, Year 2 saw an increase in the overall number of adult family homicides (40 in Year 1, 62 in Year 2) and, within these homicides, a slight rise in the number of adult children killing parents (parricide). In light of this increase, and following the publication of the Project's First Spotlight Briefing on adult family homicide with learning from the Year 1 dataset (Nguyen Phan *et al.*, 2022), the Project team decided to examine these Year 2 cases in more detail in this chapter, with particular focus on cases of adult children killing parents.

8.1 Relationships

Similarly to Year 1, the most common relationship of the adult family homicide victim to the suspect in Year 2 was a parent (parricide): There were 41 parricides involving 23 mothers and 21 fathers (including a common law father-in-law) suspected to have been killed by their 41 adult children, primarily adult sons (n = 38). The second most common relationship of the victim to the suspect was a sibling: There were eight brothers suspected to have been killed by their siblings (seven brothers and one sister) (fratricide). There was one sister suspected to have been killed by her brother (sororicide). There were three adult daughters suspected to have been killed by their parents (filicide): one case involved the killing of a daughter by her father; in a second case, the victim was suspected to have died from neglect by her mother and father, and in the third case, the victim was suspected to have been killed by her mother and stepfather. There were three grandparents (two grandfathers and one grandmother) suspected to have been killed by their grandsons. Finally, there were two uncles suspected to have been killed by their nephews, and there was one aunt suspected to have died from neglect by her niece and nephew-in-law. Compared to Year 1, the higher number of parricides helped account for the increase in overall adult family homicides in Year 2.

8.2 Risk factors

The Project's Year 1 report (Bates *et al.*, 2021) and subsequent Spotlight Briefing on adult family homicides (Nguyen Phan *et al.*, 2022) observed mental ill health, substance misuse, and previous domestic abuse perpetration as some of the most prominent risk factors in relation to adult family homicide suspects. These risk factors continued to feature prominently among cases of adult family homicide during Year 2. As mentioned in Chapter 4 (4.2), the identification of any police-recorded mental health condition was recorded for (over) half of adult family homicide suspects (57%), while almost half of the suspects (44%) were previously known to police for perpetrating domestic abuse against intimate partners and/or family members. Alcohol and drug misuse by the suspect was also present within a high proportion of adult family homicide cases (32%). One notable difference with the previous year relates to dynamics of care, whereby we noted a sharp increase in the

proportion of suspects recorded as caring for victims prior to the incidents (36% in Year 2 compared to 9% in Year 1) (See Chapter 4, Figure 30).The following section examines some of these risk factors in further detail by reviewing the background information provided in submissions for adult family cases, with particular focus on parricides as they make up the biggest group of adult family homicides.

8.2.1 Mental ill health

As with all the risk factors on the submission form, mental ill health will be identified where this information is known to police. Consequently, this variable will include both formal medical diagnoses of a mental health condition (for instance, if the suspect has been sectioned or hospitalised) and also where the police record for this individual has identified mental ill health but a condition is not specified (e.g., there is a mental health marker on the person's record). In Year 2, mental ill health was recorded as a known risk factor for 35 suspects. These included 24 parricide suspects, four fratricide suspects, four filicide suspects, and three grandsons. Within this, 25 suspects were noted to suffer from 'other mental health disorder'; 12 were recorded to have a 'psychotic disorder'; 10 were recorded to have 'depression and anxiety'; and two suspects were recorded to have presented with all three types of mental health issues prior to the homicide.

Among the parricide suspects, five were noted to have experienced an acute mental health episode at the time of the homicide or shortly before and required section under the Mental Health Act following arrest. This included one case where the suspect was found at home having a mental health episode the day before the murder. He was taken to hospital for an assessment and subsequently released by the hospital the next day, when he returned home and killed his mother. In another case, the victim had collected her son, the suspect, from his home address the night before the murder due to him suffering a mental health episode so that she could support him.

Three parricide suspects were noted, as part of the follow-up process, to have pleaded guilty to manslaughter by diminished responsibility. One suspect was charged with murder but noted to be subsequently transferred to a high security psychiatric hospital. In the only two parricide cases in Year 2 where both parents were killed, the suspect (adult son) was noted to have a psychotic disorder.

Of interest is the fact that a number of individuals with mental ill health were either adult children caring for older parents or older parents caring for adult children with significant care and support needs at the time of the homicide: this was the case for 11 of the 35 suspects noted to have mental health issues. Of these, seven were adult children caring for their parents, most of whom were older (aged 65+, ranging from 68 to 89 years) and some of whom had significant or terminal physical ill health and/or dementia.

The presence of older parents (aged 65+) presenting with their own mental health challenges, while caring for adult daughters with significant care and support needs in Year 2's dataset is a notable difference compared with Year 1. In one of these cases, the submission noted a history of contact with social services and police due to several reports

of concern about the parents' ability to cope and their obstructiveness towards professionals. One of the parents was believed to be a vulnerable person with own care and support needs. Issues around care are discussed in additional detail later in this chapter.

While mental ill health was recorded for 35 suspects, only 10 of these were recorded as having been previously known to mental health services in Year 2. There were five suspects recorded as experiencing mental ill health, alcohol misuse, and drug misuse at the same time (three adult children, one brother, and one grandson). Four of these five suspects were noted to have a psychotic disorder.

Co-occurrence of mental ill health and substance misuse – a case example

The suspect was the victim's grandson and had been living with him for a number of weeks before the homicide. Police records showed previous verbal domestic incidents involving the suspect and the victim, and the suspect had been known to police for a number of years due to domestic abuse offences against his mother and other non-domestic offences, some of which had resulted in custodial sentences. At the time of the homicide, he was being managed by Integrated Offender Management. The suspect was noted to have a psychotic disorder and was known to mental health, drug and alcohol services.

Source: Domestic Homicide Project

8.2.2 Suspects caring for victims

In Year 2, 20 adult family homicide suspects were recorded as caring for the victim prior to the incidents. We looked at the different relationships between victim and suspect to gain a better understanding of the dynamics of care. Of those suspects caring for victims, there were 13 parricide suspects (adult children), four filicide suspects (parents suspected to have killed or caused the death of their adult daughters), one fratricide suspect (brother suspected to have killed or caused the death of his brother), one niece and one nephew-in-law suspected to have killed or caused the death of their aunt/aunt-in-law.

As previously mentioned, the presence of older parents (aged 65+) presenting with their own mental health (and, for some, physical health) difficulties, caring for adult daughters with significant care and support needs in the Year 2 dataset is a notable difference compared with Year 1. There were four such parents who were suspected to have caused the death of their adult daughters through neglect. In both cases, the victims passed away in hospital, having been admitted in critical condition. In one case, hospital staff raised alarm over the victim's poor physical state and visible signs of bruising and neglect. The family were not previously known to police or any other agencies in relation to abuse or

neglect, with the stepfather only known to police for an historic non-violent offence. The victim was noted to have learning difficulties, while the suspects were noted to require appropriate adults in police interview due to their low IQ. In contrast, the victim and suspects in the other case had extensive involvement with agencies, including Adult Social Care and Health agencies. There had been concerns raised by professionals about difficulties in engaging the family. Both parents were noted to be obstructive to care and support offered for the victim despite their apparent inability to cope. There were also concerns in this case about the suspects' coercive or controlling behaviour towards the victim, who was disabled.

In both cases involving a brother and a niece (alongside a nephew-in-law), there was no previous police contact with any of the parties. In both cases, the victims were found in a state of significant neglect when they died. In the former, the victim passed away in hospital, having been admitted in a critical condition and found in a very poor physical state. There were suggestions he had suffered severe neglect at home; his brother was recorded as his carer. There were no mental or physical health issues noted for the suspect. In the latter case, the victim was an elderly woman who had moved in with her niece and nephew during lockdown. No professionals were involved with the victim: she had been due to be assessed by Adult Social Care, but the family had claimed she had moved and no longer wanted to be assessed. Both suspects were reported to have autism and a learning disability.

The biggest group of adult family homicide suspects recorded with caring responsibilities in Year 2 involved adult children as suspects in the deaths of their parents: 11 were adult sons (of whom one stepson) and two were daughters caring for their parents. In 10 of these 13 cases the parents were over the age of 65. Most of the victims were recorded with some form of care and support needs, including four parents with diagnosed or suspected dementia. Some had significant physical ailments, including being bed-bound or requiring end-of-life care. 10 of the 13 suspects were noted with mental ill health and/or substance misuse. Social services/Adult Social Care were noted to be aware of or involved with the family in seven of the 13 cases, although this is of course based solely on police knowledge at time of submission, so the true number may be higher. In one case the suspect had contacted a private care service for assistance, as he had struggled to obtain help from Adult Social Care. This indicates the suspect was struggling to cope with his caring responsibilities. Reference to carer stress was made clear in another case, where the adult son was listed in Adult Social Care records as the victim's main carer, responsible for addressing the majority of her care needs in between carer visits. Case notes made reference to his depression and struggles with meeting his mother's needs. There was no indication whether any carer's assessment had been offered or carried out for the suspect, or what action was undertaken to address concerns about his coping ability. He was noted in the submission to have mental health as well as drug misuse issues.

In summary, when examining adult family homicide suspects with caring responsibilities for victims in the Year 2 dataset, the most common themes observed in these cases relate

to the victim's significant care and support needs, the suspect's additional vulnerabilities, and challenges in accessing formal care arrangements or involvement with statutory services in some cases despite a seemingly high level of need.

8.2.3 Police and other agency knowledge

Chapter 5 provides information on previous police and agency contact, including in adult family homicide cases. Within adult family homicides, just over three quarters of suspects were known to police in any capacity (i.e., as a suspect, victim, and/or vulnerable person; 77% in Year 1, 78% in Year 2). However, only around half were known to police for domestic abuse offending (51% in Year 1, 47% in Year 2; see also Appendix C). A key point of interest around the (lack of) visibility of adult family homicide suspects prior to the death is discussed further here.

We looked into the Year 2 cases in detail to examine whether, in absence of any previous police contact with the suspect, either the victim or suspect were known to any other non-police agencies. We found only six cases where this information was positively recorded. Agencies included Adult Social Care (for victims), mental health services (for suspects), and Health agencies (unspecified). It is worth noting that in the two cases where the suspects were known to mental health services, they had also had previous contact with police, but only as vulnerable persons due to concerns about their mental health (and not for any offending).

In another case, while the suspect was not previously known to police, his mother had been known to MARAC agencies due to the domestic abuse she had experienced from her male partner (victim of the homicide). The submission noted that the suspect was only known to police in connection with those incidents reported by his mother. It was recorded that upon arrest, the suspect stated he had had attacked his mother's partner to stop him from assaulting her.

In five cases, it was not known whether other agencies had any previous contact with or knowledge of the victim or the suspect.

In the remaining 12 cases, it was recorded that neither the victim nor the suspect was previously known to other agencies. As already mentioned, police will not always know whether victims or suspects were known to other agencies, especially at such an early stage after the incident. For instance, in one case, while it was recorded that neither the victim nor suspect was known to other agencies, the submission also stated that family members had advised police that the suspect had suffered mental health issues over a significant period of time, and that he had been diagnosed with severe psychotic illness. In the period leading up to the homicide, the family had become concerned that the suspect was not taking his medication as prescribed. This suggests the suspect might have been known to mental health services, although this information might not have been available to police at time of submission.

8.3 Findings and recommendations on adult family homicides

Findings

Finding 20: In Year 1, some adult family homicides were characterised by victims caring for suspects (often with mental ill health and complex substance use), whereas in Year 2, they were more characterised by suspects caring for older victims (often with ailing health and care needs).

Finding 21: A qualitative examination of risk factors in the Year 2 dataset shows that adult family homicide suspects are most commonly characterised by mental ill health, caring responsibilities, and a lack of previous police and agency contact.

Finding 22: The low number of adult family homicide suspects with mental ill health who were known to mental health services, coupled with the sizeable number acting as carers for victims at the time of the homicide, suggests a potential failure of victims and suspects to access care services and mental health services. It is unclear whether this is a short-term consequence of the pandemic and subsequent disruption of service provision, or whether it reflects more enduring structural issues, including already high thresholds for mental health services and adult social care.

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).

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.

Chapter 9: Impact of the Covid-19 pandemic and restrictions

9.1 Cases identifying a Covid-19 impact

As well as counting the number of deaths, as in Year 1, the Project looked for whether there was evidence in each death to suggest that Covid-19 restrictions or lockdown had played a part. Each submission was asked to identify in free text whether there was Covid-related insight relating to the victim and/or suspect and to specify the details of that insight.

As the Project entered its second year of data collection (from 1st April 2021), England and Wales remained in lockdowns, albeit subject to less stringent restrictions. The initial lifting of Covid-19 lockdown restrictions in England and Wales occurred (in stages) from 12th April to 19th July 2021. Whilst there was not a clear difference in the number of deaths occurring at this point in time, there was a sharp decrease in the number of submissions in the year between 1st April 2021 and 31st March 2022 which identified Covid-related insight relating to the victim and/or suspect. Submissions identifying a Covid-related insight fell to 15 for victims (6%) and 13 for suspects (5%) in Year 2, compared to 28 for victims and 31 for suspects in Year 1.

In Year 2, for almost 29% of victims and 31% of suspects it was not recorded whether or not there had been any Covid impact. It is therefore possible that Covid might have continued to have an impact in those cases, but that the impact was not visible to police. Additionally, while lockdowns and associated restrictions might no longer have applied at the time of the incident itself, such restrictions might have affected victims and suspects in the period leading up to the incident.

9.2 Thematic nature of Covid-19 impacts

During the first year of data collection, the Project analysed the case submissions to identify the nature of the impacts of the Covid-19 pandemic. Seven key themes were identified (Bates *et al.*, 2021, pp. 33–35). Of the Year 2 submissions which did positively identify an impact of the pandemic, five of these seven key themes were again identified and are summarised under the relevant headings below:

Perpetrator using Covid-19 as an excuse to control victim

- Preventing services from seeing victims
- Children not allowed in school or outside under the pretext of Covid restriction and risk of infection

Situational pressures arising from Covid exacerbating existing conflict or abuse

- Partners and/or family members moving in together during lockdown or staying together as a result of lockdown and travel restrictions
- Partners and/or family members having to be at close proximity with one another due to self-isolation, shielding, or reluctance to leave the home
- Furlough or loss of employment resulting in financial hardship
- Lockdown and associated restrictions putting paid to planned activities

Limited ability for victims to 'reach out' for help

- Victims reporting feeling extremely isolated and unsupported by relevant services during lockdown

Constrained ability of services to see abuse or 'reach in'

- Services not offering face-to-face support

Reduced ability to manage conditions at home

- Victims and/or suspect mental health deteriorating as a result of Covid and related pressures
- Reported feelings of anxiety and tension in the home, resulting in reduced ability to cope

This shows that, where an impact of the pandemic on the circumstances of death was still identified in Year 2, the nature of those impacts was consistent with Year 1.

9.3 Findings and recommendations on the impact of the Covid-19 pandemic

Findings

Finding 23: As mentioned earlier, the pandemic and its after-effects may have had an impact on the deaths reported to this Project. As would be expected following the lifting of lockdown, there were fewer victims and suspects identified by police as having potentially been impacted by the Covid-19 pandemic and related restrictions in Year 2 (n = 15 victims, 13 suspects from 1st April 2021 to 31st March 2022) as compared with Year 1 (n = 28 victims, 31 suspects from 1st April 2020 to 31st March 2021). However, of those that did identify a potential Covid impact, thematic analysis showed that five of the seven themes arising from Year 1 analysis were similarly present in the Year 2 dataset.

Recommendations

No recommendations.

PART C: SPOTLIGHT ON SUSPECTED VICTIM SUICIDE

Chapter 10: Suspected Victim Suicides Following Domestic Abuse

10.1 Introduction

Chapters 2 to 9 of this report present information about suspected victim suicides alongside domestic homicides and child deaths. This Chapter (10) draws together into one place findings about suspected victim suicides, highlighting key numbers of interest and presenting a more in-depth examination of anonymised cases for themes and learning. It then presents recommendations specific to the topic of suspected victim suicides. This chapter does not re-present all the data findings from Chapters 2 to 9, but highlights points of interest from across the combined two-year dataset and from comparing Year 1 (2020-21) with Year 2 (2021-22).

10.1.1 Project definition of suspected victim suicide following domestic abuse (SVSDA)

The Project asks the police to include in submissions: *"apparent suicides and unexplained[19] or suspicious deaths that appear to be as a result of / following domestic abuse (e.g. non homicide cases with long-term missing person, deaths from drug overdoses in suspicious circumstances)"*. As noted in Chapter 1, 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.

10.1.2 Aims

As the Project has been systematically counting suspected victim suicides with a history of domestic abuse victimisation in England and Wales for the first time, it presents a unique opportunity to better identify and understand these cases. In this second Project year, we focused in greater depth on these deaths, with the following aims:

1. To improve general understanding of the scale and nature of SVSDA in England and Wales

2. To improve police understanding, identification, and responses to SVSDA

[19] In the definition of relevant deaths on our Project submission forms and during our deep dives into suspected victim suicide we use the term 'unexplained deaths' as this was the terminology in use at the time. The NPCC and College of Policing have subsequently moved to using the term 'unexpected deaths' rather than 'unexplained deaths', a shift in terminology which will be reflected in forthcoming guidance from the College of Policing. In the recommendations in this report, we use the new terminology, namely 'unexpected deaths'; elsewhere in this report we may use 'unexplained'.

3. To identify promising multi-agency practice at a local level to identify and learn from SVSDA

4. To contribute to the development of DHRs and related reviews for SVSDA

5. To improve reporting of SVSDA to this Project

This chapter summarises our analysis and recommendations for future policing practice, drawing on these five sources below and addressing the four research aims above.

10.1.3 Methods

To answer these questions, we undertook the following data collection and analysis:

(i) Quantitative analysis of the 114 suspected victim suicides submitted to the Project over both years (the 24-month period between 1st April 2020 and 31st March 2022)

(ii) Qualitative thematic case analysis of 64 suspected victim suicides submitted in Year 2 (the 12-month period between 1st April 2021 and 31st March 2022), to understand case characteristics, risk factors, and draw out learning for identification.

(iii) Five 'deep dives' conducted with police forces in England and Wales – including data reconciliation between their records of suspected victim suicides and our Project numbers.

(iv) A data reconciliation exercise with the British Transport Police's overall national suicide project, which collects data on all suicides across police in England and Wales since April 2021.

(v) A short survey with police which received responses from 13 forces, to identify current and promising practice on identifying SVSDA, investigating and prosecuting cases, multi-agency working, and learning from DHRs and reviews.

(vi) A consultation and listening event held with advocacy organisation Advocacy After Fatal Domestic Abuse (AAFDA) and a number of families bereaved following domestic abuse.

10.1.4 Our consultation with families and Advocacy After Fatal Domestic Abuse

As part of our deeper investigation into suspected victim suicides following domestic abuse, police leaders, the Project team and representatives from the Home Office met for the day with the organisation Advocacy After Fatal Domestic Abuse (AAFDA) and a number of bereaved families they support. AAFDA, led by Frank Mullane, ably supports bereaved families in navigating Coronial and Domestic Homicide Review processes after

domestic homicides and suspected victim suicides, providing specialist advocacy and peer support for families.

The aim of the event was to hear about families' and their loved ones' experiences, and to listen to families' suggestions about how they felt police, government and other agencies might improve the response to victims/survivors experiencing domestic abuse and improve agencies' responses after a death occurred. We are immensely grateful to all the families for giving their time and sharing their experiences. Their resilience, courage and determination to lift up the voices and honour the lives of their loved ones is remarkable. At the event, the families were clear that they did not want sympathy or kind words – they wanted action. Some said that they had shared their experiences and views with a range of agencies before but that had not led to action, and they felt that a raising and dashing of hopes was hard to bear. To respect this wish, we want to acknowledge that not every suggestion made by families is in the remit of the police or of this Project to take forward – for instance, because they relate to the handling of individual cases, or because they are for agencies other than police, or because they relate to responses to domestic abuse more broadly rather than deaths. However, many of the suggestions we have been able to take forward, and they have closely informed the recommendations made throughout this report. We hope and believe that the conclusions and recommendations in this report can help improve experiences for other victims/survivors and families in future.

10.1.5 Research limitations

There are limitations of course to the methods employed in this Project. Firstly, we can only draw on information known to police (both prior to, and at/after, a death) in conducting this analysis. In some cases undisclosed domestic abuse may be known to non-police agencies only, or to family and friends, or perhaps to no-one. We address the importance of police reaching out to other agencies and to family and friends in our practice recommendations, but the analysis of cases here is necessarily dependent only on police data. Secondly, in discussing suspected victim suicides, we cannot attribute the cause of the suicide definitively to domestic abuse, we can only identify the history of abuse. The Project has deliberately cast a wide definitional net, allowing police themselves to determine the relevance of the prior domestic abuse in choosing whether to submit the case to this Project. Following the approach to suicide DHRs taken by the Home Office, we have encouraged police to submit cases where there was any previous record of domestic abuse, rather than drawing a narrow or causal link (e.g., recency or domestic abuse mentioned in suicide notes). Yet the causes and triggers of suicide are often complex, and it is not possible in this work to ascertain a definitive link.

10.1.6 Acknowledgements

The Project team would like to thank the police forces which generously took part in the 'deep dives' and responded to the survey. The police have been very supportive of the Project's work and open to learning from its findings. Most importantly, we would like to thank all the families, ably supported by Frank Mullane, Nicki Norman and AAFDA, who

generously gave their time and shared with us the stories of their loved ones and their own experiences with the police and other agencies.

10.2 Background: The role of police, Coroners and other agencies in sudden and unexplained deaths – current policy and guidance

10.2.1 Investigating suspected suicides as sudden or unexplained deaths

First, it is important to clarify that the police in England and Wales do not determine whether a death is the result of suicide, as this is the remit of the Coroner and associated inquest proceedings. However, the police initially attend the scene of all sudden and unexpected deaths and have a responsibility to investigate the death on behalf of the Coroner. The system of death investigations in England and Wales currently fits into one of three pathways (College of Policing, 2019):

- Death which is anticipated due to ill health and where a medical doctor is able to issue a Medical Certificate of the Cause of Death (MCCD).
- Death where a doctor is unable to issue an MCCD because they had not been recently treating the deceased or because the death was unexpected. This will lead to an initial police investigation on behalf of the Coroner to determine whether the death is suspicious or non-suspicious. If the outcome of the investigation is that the case is not suspicious, the Coroner will continue with the investigation.
- Death where the outcome of the initial police investigation is that the case is suspicious. The police will take on primacy of the investigation, assisted by a Home Office forensic pathologist to conduct the post-mortem examination.

Recently, in response to the Prevention of Future Deaths (PFD) report issued by the Coroner following the inquest into the Stephen Port murders, the NPCC and College of Policing have proposed a new classification for death investigations into Expected, Unexpected – Under Investigation, Unexpected – Investigated and not suspicious, and Homicide. These new classifications are intended to ensure a clear and consistent approach to death investigation, namely that ‘all unexpected deaths should be investigated and treated as suspicious until the police investigation has established it is not suspicious’ (NPCC and College of Policing, 2022). As such, they will help mitigate any potential to ‘miss’ a homicide. The College of Policing is preparing to issue guidance on this new classification system (College of Policing, 2022) (forthcoming).

The College of Policing guidance (2019) explains the importance of the initial police investigation to establish whether or not the death is suspicious:

> ‘if the outcome of an initial police investigation is flawed, and the decision by the police is that the case is not suspicious, there will be no forensic examination of the body and a potential homicide could be missed. A report published by the Forensic Science Regulator in December 2015 highlights the potential to ‘miss’ a homicide. In order to reduce the likelihood of such a miss, it is essential that the police service deals with death in a ‘systematic and professional manner’ (College of Policing, 2019, p. 5).

In line with College of Policing guidance, force-level death investigation policies stress the importance of treating a sudden unexpected death as suspicious until otherwise identified, including cases of suspected suicide. These policies include actions such as: inspecting the scene for any signs of a disturbance, examining the body for any marks or wounds, ensuring the body is not disturbed until a CID supervisor attends the scene, and preserving any note for fingerprints handwriting comparison, or other forensic examination.

10.2.2 Identifying domestic abuse in suspected suicides

The College of Policing has made clear that a police investigation into a suspected suicide may reveal evidence suggestive of coercive or controlling behaviour or other forms of domestic abuse as background to the suicide (College of Policing, 2021). However, there is no standard guidance or Authorised Professional Practice (APP) on how such evidence may be obtained or used towards potential criminal prosecutions, and the APP on suicide and bereavement response, situated within the APP on mental health, does not make any reference to domestic abuse (College of Policing, 2020). Following the publication of the Project’s Year 1 report, work is ongoing at the College of Policing to ensure the APP on suicide explicitly includes references to domestic abuse.

The NPCC is currently working with the Home Office to develop a new consistent approach to recording homicide and death investigations across police forces in England and Wales. Within this new approach, unexpected deaths, including suspected suicides, will be recorded on each force’s crime recording system. This may, in turn, allow any information on previously recorded domestic abuse crimes or incidents relating to the deceased and associated persons to be identified more quickly and consistently.

10.2.3 Reviewing suspected suicides where there is domestic abuse

In 2016, deaths by suicide where ‘the circumstances give rise to concern’ were included in the scope of the Domestic Homicide Review (DHR) process in England and Wales (Home Office, 2016). However, no additional guidance was provided on what might constitute such ‘concern’, and as a result suicide DHRs have remained ill-defined both conceptually and practically (Rowlands, 2020). More importantly, this lack of clear national guidance has meant that local police forces and Community Safety Partnerships (CSPs) apply a considerable amount of discretion in ‘screening’ deaths by suicide for a DHR or commissioning a suicide DHR. In its Tackling Domestic Abuse Plan, the Home Office has pledged to update the existing statutory guidance to ‘give clearer information to local bodies on conducting DHRs where the victim has died by suicide’ (Home Office, 2022b, p. 67).

10.3 Project findings: The scale and nature of suspected victim suicide following domestic abuse (SVSDA) in England and Wales

10.3.1 Scale

In the 24 months from 1st April 2020 to 31st March 2022, the Project received submissions relating to 114 suspected victim suicides following domestic abuse, a monthly average of five. This includes 50 victims in the first year and 64 in the second year, an increase of 28%. For comparison, this was a greater rise in numbers between the years than the Project saw in intimate partner homicides, but less than the rise in adult family homicides.

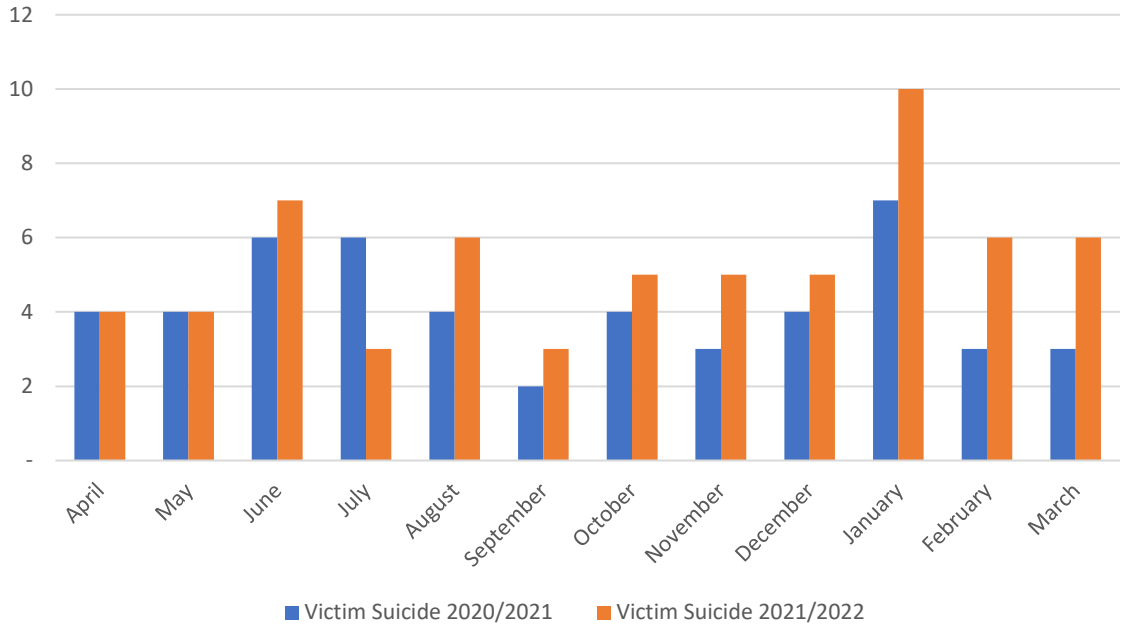
This increase in suspected victim suicides in Year 2 may be attributed to improved police awareness of the issue overall, and greater awareness of this Project, meaning that more cases are being identified. However, it may also be that the number of suspected victim suicides did empirically rise in 2021-22. We cannot put these numbers in any longer-term context, since this Project is the first to systematically collect such deaths. Whilst the sample size is too small to test for statistical significance, broadly, the monthly figures appear to illustrate a similar yearly pattern, with the exception of a drop in July 2021. In both years, there was a small rise in January, in line with overall seasonal patterns in police-reported domestic abuse (see Table 5 and Figure 42 below, see also Section 2.3).

Table 5. Number of suspected victim suicides by month – Year 1 and Year 2

	2020/2021	**2021/2022**
Month	**Number**	
April	4	4
May	4	4
June	6	7
July	6	3
August	4	6
September	2	3
October	4	5
November	3	5
December	4	5
January	7	10
February	3	6
March	3	6
Total	**50**	**64**

Source: Domestic Homicide Project

Figure 42. Suspected victim suicides by month – Year 1 and Year 2



Source: Domestic Homicide Project

In terms of the nature of the preceding domestic abuse, 95% was from an intimate partner, with just 5% from a family member. This makes the profile of the suspected victim suicide cases closest to that of intimate partner homicides, and we compare these two groups at various points throughout this section.

10.3.2 Victim characteristics

A full list of victim characteristics for SVSDA cases can be found Chapter 3 and Appendix C of this report. Points of interest however are:

10.3.2.1 Sex

Whilst female victims were by far the most common across both years (85%), the number of male victims of SVSDA rose from 10% (n = 5) in Year 1 to 19% (n = 12) in Year 2. In 10 of the 12 cases in Year 2 involving a male victim, the perpetrator of the prior domestic abuse was an intimate partner; the other two cases involved family members. Two of these 10 cases of suspected victim suicide following domestic abuse perpetrated by an intimate partner involved LGBTQ+ relationships in which both the victim and perpetrator of the prior domestic abuse were male; the other eight cases involved female perpetrators with male victims.

Notably, in all eight suspected victim suicide cases involving a male victim and female intimate partner who was on record as having previously perpetrated domestic abuse against that male victim, the male victim was *also* noted to have a record of perpetrating domestic abuse against either this partner (in seven cases) or against a previous partner (in one case). In two cases, the male suspected suicide victim appeared to have been the primary perpetrator of the prior domestic abuse, including coercive or controlling

behaviour, assaults, threats to kill their partner and threats to kill themselves. In another case, while there was limited information on the domestic abuse history between the suspected suicide victim and his most recent partner, except for a third-party report of assault, the male victim was previously known to police for an extensive history of perpetrating abuse against three previous partners, including assaults, coercive or controlling behaviour, harassment, and breach of a non-molestation order.

In both male victim cases where the prior domestic abuse perpetrator was a male intimate partner in Year 2, the known history of domestic abuse indicated that the suspected suicide victim was the primary victim of domestic abuse. In one case, two days before the suspected suicide, the victim had been risk assessed and classified as a high-risk victim, which resulted in referral to MARAC and IDVA support. While this was the only recorded incident by police, following the suspected suicide, concerns were raised to police about a wider history of domestic abuse by the perpetrator. In the other case, while the suspected suicide victim and his partner were not previously known to police for any domestic abuse, the victim's sister disclosed after his death that his partner had been abusive, and that the victim had been trying to separate from him for several years. A further disclosure had been made by the victim's friend stating similar concerns about the relationship. These disclosures led to an investigation being undertaken by the police.

At present, a similarly detailed analysis of the much larger number of suspected victim suicide cases with female victims has not been carried out. This would be a useful exercise in future analysis, to examine whether the victim of the suspected suicides was also known as a perpetrator of prior domestic abuse in these cases, as has been identified with the male victim cases.

10.3.2.2 Ethnicity

Victims were overwhelmingly of white ethnicities across both years (88%). There was a rise in the number of victims of black ethnicities in Year 2 (from n = 1 in Year 1, to n = 5 in Year 2), albeit these are very small numbers and may reflect natural fluctuation. Most other ethnicities remained the same.

10.3.2.3 Age

Whilst the most common age range of victims across both years was consistently between 25 and 44 years, the proportion of younger victims aged 16-24 years went up in Year 2 (from 8% (n = 4) to 16% (n = 10)). Correspondingly, the proportion of older victims aged 65 years and over went down in Year 2 (from 10% (n = 5) to 2% (n = 1)). In our Year 1 report we commented on the higher than usual rate of homicides and suspected suicides in the older age group during the first year of the pandemic (2020-21), and corresponding suppression of deaths amongst younger age groups in that same year. It is noteworthy, then, that these age profiles seem to have reversed during Year 2, when the country was mostly out of, or emerging from, pandemic restrictions. This may support the conclusions in our Year 1 report, that the pandemic put additional pressure on older victims and corresponded with a drop in support and care help, which may have driven a spike in older victim deaths during this period.

In Year 2, the only suspected suicide victim in the '65 and over' age group was a 69-year-old male who was reportedly unable to cope with his wife's mental health deterioration, which included physical and verbal abuse from her towards him over the previous two months. There was one historic previous incident on police record where he had assaulted his wife, but the majority of incidents of abuse on record were from her to him. The male suspected suicide victim was noted to suffer from arthritis and brain injury, whilst the female perpetrator of the prior domestic abuse was recorded to have a diagnosis of schizophrenia. The couple were said to be known to mental health services and adult social care. The victim's death occurred in April 2021, before the lifting of the last Covid lockdown in England. It is therefore possible that restrictions might have impacted the couple's access to support and the prior domestic abuse perpetrator's engagement with services, especially as all 5 police call-outs in the two months preceding the suicide were due to the victim's inability to cope with his wife's verbal and physical aggression, itself a result of her inability or unwillingness to take her medication.

10.3.2.4 Younger victims

In terms of the younger age group (16-24 years), seven of the 10 victims in this age group in Year 2 were female and three were male. The youngest was a 17-year-old male and also identified as LGBTQ+. Two prior perpetrators of domestic abuse were associated with his death, his step-father and his male partner.

In Year 2, in three cases amongst this younger age group, the suspected suicide victim was a university student who had either started or continued a relationship with the perpetrator of the prior domestic abuse while away from home at university (in two cases they met at university, in the third the couple were together prior to the victim going to university). In two of these three student cases, the victim had had significant contact with their university, either due to incidents being dealt with by the university community safety team or through seeking counselling support for their deteriorating mental health (although it was not known whether domestic abuse issues were disclosed within that setting). Notably, in the case where the university community safety team had been called to incidents, no report or safeguarding referral had been made to police, who only became aware of the history of domestic abuse as part of the investigation into the death. When police contacted the suspected suicide victim's family, the family shared further concerns about the coercive or controlling behaviour by the perpetrator of domestic abuse. As a result, an early learning point identified by police was to ensure a better working relationship between the force and the university, so that all domestic abuse incidents can be fully investigated, and all vulnerable persons safeguarded.

In four cases in Year 2, the submission specifically noted that the suspected suicide victim had had a number of mental health concerns and were known to mental health services (both NHS and private). In one of these cases, the 19-year-old victim had had significant contact with police since she was a child due to mental health and child protection concerns, and prior to the suspected suicide, she had come to the attention of police on several occasions as a missing person and suicide/self-harm ideation or attempts. One suspected suicide victim was noted to be a vulnerable new mother; another was noted to

be particularly vulnerable due to her learning difficulties; while another was noted to have suffered from body dysmorphia, which had been exploited by her partner by targeting his abuse at specific areas of her body of which the victim had been most self-conscious, or for which she had been bullied in the past.

Coercive or controlling behaviour was identified in eight of the 10 cases of suspected victim suicide involving victims aged 16-24 in Year 2, with numerous examples provided. Most notably, in one case, the submission noted that the perpetrator of the prior domestic abuse had introduced and encouraged ideas of both self-harm and suicide into the relationship and into the victim's life. The victim described in a report made several months before her death that she was rarely alone as they had spent almost all their time together during the entirety of their short relationship. She had started to miss university lectures, work and stopped going to the gym, so that her partner could be with her. He often picked her up from university unannounced. He would regularly self-harm and threaten to kill himself in order to control the victim and would ask her not to leave him to go to university or work. The victim in this case had been encouraged by police to access counselling from her university. It is not known whether this was taken up, or to what extent the university was aware of the issues. In another case, it was noted that during the relationship, the perpetrator of domestic abuse had been very manipulative. While they were together, the victim stated the perpetrator would not let her see her friends and family and was very isolated from them. The perpetrator would also take money from her to pay for his drugs and alcohol, which stopped her from being able to buy food for herself. The perpetrator would also make threats to harm her mother, brother and her mother's then-partner, including threats to burn down her mother's house with everyone inside. He also made threats to her and her unborn baby while she was pregnant. The perpetrator killed himself three months before the victim took her own life, with information suggesting that she had struggled to cope with his death.

10.3.2.5 LGBTQ+

Whilst most victims were not identified as LGBTQ+ across both years (82%), there was a rise in LGBTQ+ victims in Year 2 (13% (n = 8) compared with 4% (n = 2)). Of these eight LGBTQ+ victims in Year 2, five were female and three male. In seven of the eight cases, the perpetrator of the prior domestic abuse was an intimate partner; in the eighth case (with a male victim), the perpetrator was the step-father and also the male partner.

In four of the five LGBTQ+ cases in Year 2 where the suspected suicide victim was female, the perpetrators of the prior domestic abuse were also female. In two of these cases, both the suspected suicide victim and the domestic abuse perpetrator were previously known to police for a number of reports, with both recorded as victim and perpetrator. In one of these two cases, however, the suspected suicide victim appeared to be the primary perpetrator of domestic abuse against her partner and was known to be a high-risk perpetrator. In the other of these two cases, there was only one previous recorded incident whereby the perpetrator of the prior domestic abuse had assaulted the victim during an argument, having accused her (the victim) of having an affair. Following the suspected suicide, the victim's family and friends raised concerns with police about

coercive or controlling behaviour by the perpetrator, which they believed had caused the victim to kill herself. In another case, the suspected suicide victim and the domestic abuse perpetrator were only known to police for a verbal argument, with no offences alleged. The submission noted concerns about the victim and perpetrator being engaged within a short period of time and the perpetrator's jealousy towards the victim on the night of the death.

In the fifth LGBTQ+ case with a female victim in Year 2, the perpetrator of the prior domestic abuse was a male partner. In this case, the suspected suicide victim and perpetrator of prior domestic abuse were known to police for numerous reports of domestic abuse, with both recorded as victim and perpetrator on different occasions, with the suspected suicide victim having been identified as a high-risk victim of abuse from the perpetrator. She had also been known as a high-risk victim of domestic abuse from a previous female partner.

In two of the three LGBTQ+ cases involving male victims in Year 2 whereby the prior perpetrator of domestic abuse was a male intimate partner, the known history of domestic abuse indicated that the suicide victim was the primary victim of domestic abuse. (See the description of these two cases above, under male victims.) In the third case where the suspected suicide victim was male, the domestic abuse perpetrators were both a family member (step-father) and intimate partner (male partner). Here, the recorded history of domestic abuse was quite limited. In relation to the step-father, there was only one report of assault against the suspected suicide victim prior to the death. However, it was noted that the assault by the step-father was against both the victim and his partner. It is unknown to what extent homophobia might have played a part in this assault. With regard to the male partner, he and the suspected suicide victim had only been known to police for an argument where no offences were alleged.

Coercive or controlling behaviour was identified in five cases of suspected victim suicide involving LGBTQ+ victims in Year 2, which most commonly disclosed to police by family and friends of the suicide victim.

10.3.2.6 Special needs

Special needs (physical, learning and mental health) identified in relation to the victim remained steady in both years at 16% (n = 8 in Year 1, n = 10 in Year 2).

10.3.3 Characteristics of the perpetrator of the prior domestic abuse

A full list of characteristics for the perpetrators of the prior domestic abuse in suspected suicide cases can be found in Chapter 3 and Appendix C of this report. Points of interest however are:

10.3.3.1 Sex

Whilst male perpetrators of the preceding domestic abuse were by far the most common across both years (84% across both years), the number of female perpetrators rose from 8% (n = 4) in Year 1 to 18% (n = 12) in Year 2. Some of these female perpetrators were in cases with male victims, and some in cases with female victims.

10.3.3.2 Ethnicity

As with victims, whilst the majority of perpetrators were of white ethnicities (87% across both years), the proportion of perpetrators of black ethnicities went up from 2% (n = 1) in Year 1 to 9% (n = 6) in Year 2.

10.3.3.3 Age

As with victims, whilst the majority of perpetrators were aged 25-44 years, there was a rise in the proportion aged 16-24 years in Year 2 (from 4% (n = 2) to 15% (n = 10)). There was also a rise in those aged 45-54 years (from 12% (n = 6) to 21% (n = 14)). Also, as with victims, there was a slight drop in the older age perpetrators, 65 years and over, from 10% (n = 5) to 6% (n = 4).

10.3.3.4 LGBTQ+

As with victims, whilst the majority of perpetrators were not identified as LGBTQ+ (60% across both years; with 32% not known), there was a rise in those identified as LGBTQ+ in Year 2 (from 4% (n = 2) in Year 1 to 13% (n = 8) in Year 2).

10.3.4 Case characteristics

A full list of case characteristics for suspected victims suicide cases can be found in Chapter 3 and Appendix C of this report. Points of interest however are:

10.3.4.1 Location of death

The location of death was most commonly the Victim's Home, with 57% of cases across both years occurring there; followed by Outside, with 19% of cases; then Hospital (9%) and Other Residential Building (9%). Comparing the years, there was a rise in deaths occurring in Other Residential Buildings in Year 2 (from 2% (n = 1) to 14% (n = 9)); the numbers in all other settings remained similar.

10.3.4.2 Method of death

The method of death was most commonly strangulation (including hanging), accounting for 55% of cases across both years. This was followed by poison or drugs (26%). Comparing the years, there was a rise in deaths by strangulation (including hanging) in Year 2 (from 46% (n = 23) to 63% (n = 40)). This difference between years was not statistically significant.

10.3.4.3 Victim-perpetrator relationship

The relationship between victim and perpetrator was most commonly current partner (61%), then ex-partner (31%) across both years. The proportion of current partner rose in Year 2 (from 54% (n = 27) to 67% (n = 43). The proportion of ex-partners dropped slightly (from 34% (n = 17) to 28% (n = 18)).

10.3.5 Risk factors

A full list of risk factors for suspected victim suicide cases including a chart setting out the change in risk factors identified between Year 1 and Year 2 can be found in Chapter 4 and Appendix C of this report. Points of interest however are:

The recorded prevalence of a history of coercive control in suspected suicide cases remained level between the years (60% in Year 1, 60% in Year 2), indicating some stability in recording and identification of this pattern of behaviour. Other risk factors in suspected victim suicides increased between the years, including: the domestic abuse perpetrator's previous suicidality (from 16% in Year 1 to 25% in Year 2), recent economic distress (from 2% in Year 1 to 9% in Year 2), housing insecurity or homelessness (from 6% in Year 1 to 18% in Year 2), recent child custody dispute (from 6% in Year 1 to 12% in Year 2), stalking or surveillance (from 8% in Year 1 to 19% in Year 2), sexual violence (from 6% in Year 1 to 15% in Year 2), subject of a protection order (from 8% in Year 1 to 19% in Year 2), and breach of protective order(s) (from 6% in Year 1 to 21% in Year 2). Of these factors, the increase in breach of protective order was the largest percentage point increase to Year 2, although this increase was not statistically significant.

The increase in factors around economic distress and homelessness may indicate a potential residual impact of Covid and /or the ongoing cost of living crisis. Stalking, surveillance, and sexual violence were also risk factors identified prior to the victim's death by suicide in these cases. The proportion of cases involving protection orders and breaches of protection orders suggest the safeguarding of victims and enforcement of breaches as an area of police practice which could be developed for intervention or prevention of suspected victim suicide.

Overall, across the combined two-year dataset, a higher rate of previous non-fatal strangulation was significantly associated with suspected victim suicide (as opposed to other case types), at $p<0.05$. However, this was the one risk factor for suspected victim suicide which fell in Year 2, against the general pattern of an increase in identified risk factors. Previous non-fatal strangulation was identified in 32% of cases (n = 16) in Year 1 but only in 6% of cases (n = 4) in Year 2, and this drop was a statistically significant finding at $p<0.05$. This is a surprising finding, especially considering that there was an increased awareness of non-fatal strangulation during this period, arising from the debate surrounding it and its subsequent inclusion in the Domestic Abuse Act, which received Royal Assent in April 2021, with the provisions of a new criminal offence of non-fatal strangulation brought into force in June 2021.

10.3.6 Police and other agency knowledge

A full list of prior police and other agency knowledge for suspected victim suicide cases can be found in Chapter 5 and Appendix C of this report. Points of interest however are:

The perpetrator being known by police as a previous perpetrator of domestic abuse rose from 82% in Year 1 (n = 41) to 94% in Year 2 (n = 64). This is probably unsurprising as most of these cases will involve known prior domestic abuse since that is how the cases

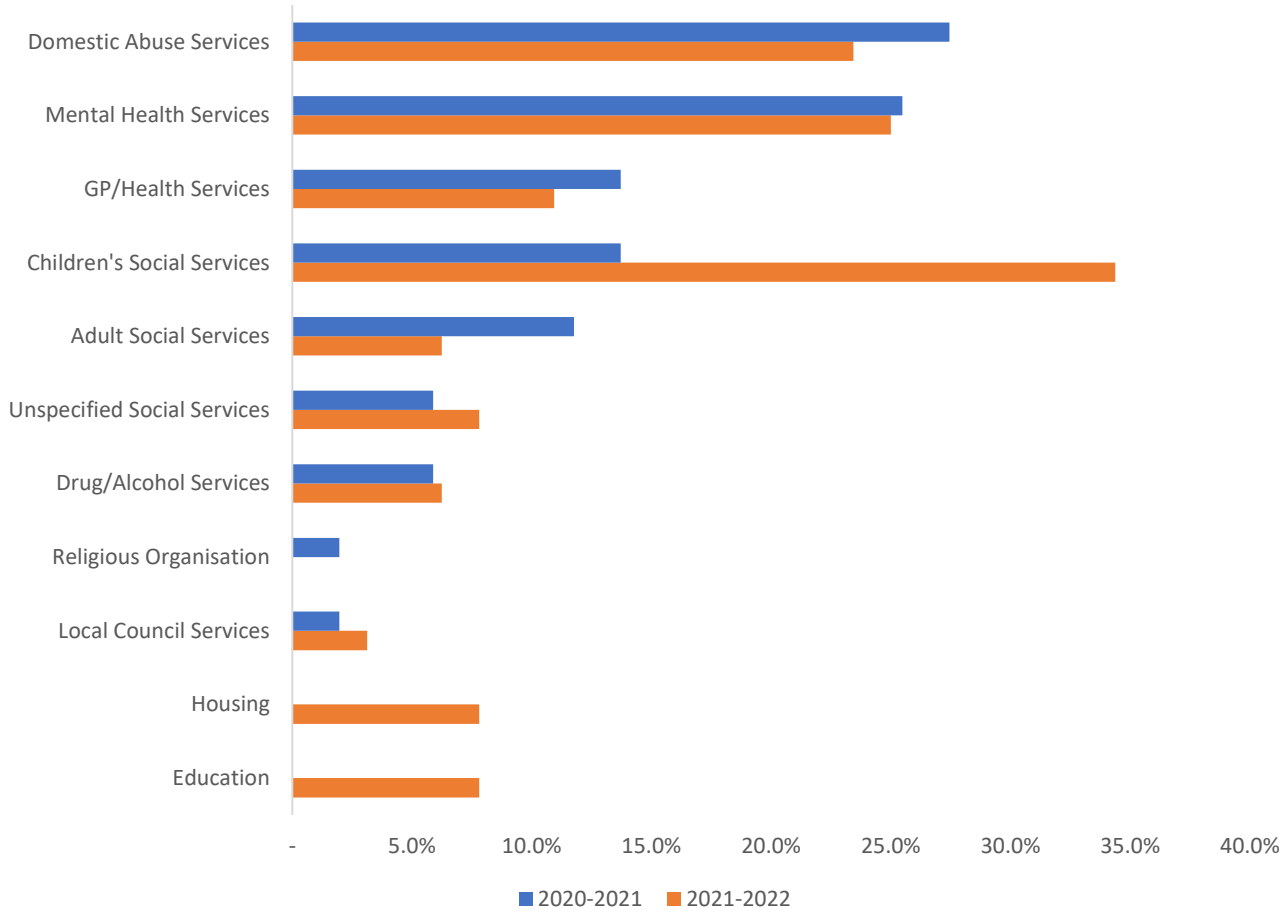
will have been identified to this Project as suspected victim suicides – but it does show better data capture in the submissions.

Across both years, 31% of perpetrators (n = 36) were identified as high-risk or serial domestic abuse perpetrators. As a proportion of perpetrators known to police for domestic abuse, those known to be high-risk or serial perpetrators rose from 24% (n = 10) in Year 1 to 41% (n = 26) in Year 2. This may reflect improved identification and recording of this variable as a result of closer follow-up with police forces by the Project team.

Across both years, 40% of perpetrators (n = 47) were already known to MARAC for domestic abuse. As a proportion of perpetrators known to police for domestic abuse, those known MARAC rose from 37% (n = 15) in Year 1 to 50% (n = 32) in Year 2.

In terms of other agencies, victims and domestic abuse perpetrators in suspected victim suicides were most commonly known to domestic abuse services (27% in Year 1, 23% in Year 2), GP/health services (14% in Year 1, 11% in Year 2), mental health services (25% across both years), and children's social care (14% in Year 1, 34% in Year 2). Comparing the two years, there was a big rise in cases known to children's social care – alongside this, there was an increase in cases identified as involving a recent child custody dispute. There were also rises in cases know to housing and education services. There was a drop in Year 2 in the proportion of cases known to domestic abuse services, mental health services, GP/health services and adult social services (see Figure 43).

Figure 43. Proportion of suspected victim suicides by agency contact with victim and/or prior domestic abuse suspect – Year 1 and Year 2



Source: Domestic Homicide Project

10.3.7 Impact of the Covid-19 pandemic or restrictions on suspected victim suicide cases

As described in Chapter 9, submissions were asked to identify any impacts on the death arising from the Covid pandemic. Regarding the suspected victim suicide cases within the Year 2 data, the main impacts identified during thematic analysis are described below, alongside case studies.

Situational pressures arising from Covid exacerbating existing conflict or abuse

Case A (August 2021) – It was noted that the victim wanted to divorce the perpetrator but was unable to leave the family home in 2020 due to Covid lockdown measures. She also lost work due to inability to hold appointments during lockdown. As for the perpetrator, it was noted that he was present at the family home far more often due to Covid lockdown affecting his work. He therefore had far more contact with the victim than he had prior to Covid restriction(s).

Case B (November 2021) – It was noted that when the victim had reported a non-crime domestic incident in 2020, she expressed concerns to police officers about the domestic

abuse perpetrator, her ex-partner, attending her address despite Covid lockdown restrictions in place and the victim being vulnerable.

Case C (April 2021) – The victim had found the pressures of lockdown difficult as none of the household would leave the home due to concerns over Covid. The victim had described lockdown as a pressure cooker which was made even more intense by the fact that she regularly witnessed the domestic abuse her mother suffered at the hands of her father.

Limited ability for victims to 'reach out' for help

Case D (August 2021) – It was noted that both the victim and the perpetrator, her partner, were self-isolating together during the pandemic. He was a registered sex offender, and it was noted that the pandemic had disrupted visits to him by the sex offender team.

Case E (June 2021) – The submission reported that the victim's family was suffering from a lack of support during lockdown, as the victim struggled with caring for her children as well as handling the harassment by her ex-partner. The victim's mental health was recorded as deteriorating during this period as she felt isolated and unsupported by mental health services that were promised but not resourced. It is not known if she was aware of plans by children's social services to remove the children from her care, but this was also listed as a related concern.

10.4 Police understanding, identification and responses to suspected victim suicides following domestic abuse

This and the following sections present findings from the Project's deep dives and survey with police forces about current police practices on suspected victim suicides following domestic abuse, as well as drawing on suggestions made by the families we consulted.

10.4.1 Initial response

This section focuses on police practice during the initial response to a sudden or unexplained death regarding the identification of a potential history of domestic abuse.

10.4.1.1 Sudden and unexplained death policies[20]

The Background section describes the pathways and guidance documents that inform the police initial response to, and investigation of, a suspected suicide. In practice, however, whilst there is ongoing work to develop a consistent approach, we found that individual forces differed considerably in their policies and treatment of suspected suicides, including in the use of terminology. For instance, Force #3's Standard Operating Procedures (SOP) on Investigating Deaths made a distinction between 'Sudden' and 'Suspicious' Deaths and

[20] Note that whilst these terminologies throughout this section reflect current national and force-level policing guidance and procedures, terms such as 'sudden' and 'unexplained' deaths are likely to be superceded by the College of Policing's forthcoming new classifications around expected and unexpected deaths.

clearly stipulated that suspected suicides should always be treated as Suspicious Deaths, while the Death Investigation Policy in Force #4 referred to a suspected suicide as an example of 'non-suspicious sudden death'.

Individual force policies also varied in their guidance on how to account for domestic abuse as part of the evidence-gathering process in a suspected suicide. Some had specific guidelines on dealing with suspected suicides, which included a requirement to 'identify whether there is any history of domestic violence' (Force #4's Death Investigation Policy) or to carry out 'intelligence checks on the deceased and other subjects, [which] will be particularly important where any domestic violence issues are present and may inform decisions as to any suspicion' (Force #5's Guidance in Dealing with Suspected Suicides).

10.4.1.2 Checks on the scene

The initial police response to the report of an unexpected or sudden death is completed by a first responder who attends the scene to determine what lines of enquiry or investigative procedures to follow. These officers also consider whether there are any suspicious circumstances surrounding the death. Forces described these officers as conducting an initial check on the victim (and the address) via the Police National Computer (PNC), and the force crime recording system, but how and when these checks were completed was thought to differ. For instance, some force representatives believed that response officers completed the checks before attending (e.g. en-route), or while on the scene, whereas others mentioned the possibility that these system checks were conducted after leaving the scene, during the completion of their initial reports. Based on our 'deep dive' analysis, there was varied practice among forces in terms of when checks were completed, which individual checks were completed, whether checks encompassed both crime and non-crime incidents, and on which national and force databases checks were run.

10.4.1.3 Supervisory review

Most of the 'deep dive' forces said they had a policy for a supervisory officer to review the responding officer's actions. However, not all force representatives were able to find a copy of this policy. Although it was not clear why this would be the case, it suggests that frontline officers may also be unable to locate the policy. Additionally, some suggested that practice may differ in reality from the policy. Others were unclear as to whether this policy resulted in supervision in-person on the scene, or was a review of the initial case file, with the approach seemingly dependent on the circumstances of the death and resource availability. In practice, forces described that if the circumstances at the scene were not perceived to be suspicious, the initial investigation would be paused at that point when all initial investigative avenues were exhausted at the scene. Therefore, if a history of abuse was not identified within the early stages of the investigative response, future opportunities to hold the perpetrator to account could be limited. Importantly, in some cases new information did come to light after the initial response, including when officers completed an investigation on behalf of the Coroner, and this did inform the police re-looking at the case. The 'deep dive' interview participants identified the need for a shift in investigative mindset, to really underpin professional curiosity amongst all officers attending and reviewing such deaths.

10.4.2 Reporting

Following the initial response to a sudden or unexplained death, officers notify the local Coroner of the death by completing a form which, in some areas, is termed a Sudden Death report. These forms differ by local area and fall within the remit of the Coroner rather than the police regarding the name of the form, its format, and requested contents. In this way, local Coroners may differ in what they request officers to complete. The Project team are not currently aware of any Sudden Death forms which ask specifically about a history of domestic abuse, but most forms did request some level of the PNC and force level system checks described above. Again, if frontline response officers receive supervision based on filed case reports, this is (one of) the report(s) the supervisor would review. As mentioned, updated guidance and policies recommend this as standard practice (NPCC and College of Policing, 2022). Forces will differ in their available resources and demands. However, ensuring that details about the case and initial response were available in this way within the force recording system was described as facilitating later investigation requests for the coronial inquest.

Furthermore, in Force #4, an interviewee raised a concern that attending officers might not be routinely recording all individuals present in the household at the time of the death. This interviewee suggested that not doing so might prevent the identification of domestic abuse, appropriate enquiry relating to that individual, and evidence-gathering in relation to later coronial inquest investigations. A surveyed force highlighted learning from a case of suspected victim suicide where there was a missed opportunity to identify abuse known to friends and family members because the perpetrator of the domestic abuse had listed himself as the victim's next of kin on the Sudden Death report. Thus the domestic abuse perpetrator was in some ways able to control the narrative and was given a potential opportunity to manipulate relevant practitioners, including the police. Particularly within cases involving coercive control, a victim may have been isolated from friends and family, which would make the identification of broader next of kin more difficult.

10.4.3 Gathering wider intelligence on domestic abuse history

The gathering of relevant information from family and friends came across within the 'deep dives' and survey as particularly important to the process of identifying a history of domestic abuse. As shown within several cases included in the Project dataset, these individuals may have information about the abuse which was not previously disclosed or known to police or other partner agencies. Relatedly, Force #1 had created a specific role for a member of staff who worked between public health and the police on suicides more generally. Part of this individual's role was to monitor the Real Time Suicide Surveillance (RTSS), engage with a victim's friends and family members when notifying them of the death, develop a working relationship with the Coroner's office to identify any deaths which had not already come to the attention of police (e.g. within hospital following an attempted suicide), and facilitate necessary investigations by the police for coronial inquest proceedings. This individual would share with the Coroner and investigating officers if the friends and family members described the victim as experiencing domestic abuse.

However, in terms of generalisability, this initiative does rely on a single individual and the development of local partnerships that may not be realistic.

10.4.4 Promising Practice #1: Real Time Suicide Surveillance systems

One notable piece of promising practice was the increasingly widespread use of Real Time Suicide Surveillance (RTSS) systems in local areas. As the name suggests, this creates a real-time record of all suspected suicides (not just those involving a history of domestic abuse) that occur within a force area. Some RTSS systems are police-led, others are public health-led. Whilst not all forces utilised these systems, and some currently only collate police data in their RTSS system, we learned that several force area RTSS systems brought together reports of suicides and information known by local partner agencies such as health, social services, and specialist domestic abuse services. The use of these systems will be dependent on available funding and resources within the local area, including the existing partnership between the police, local health agencies and the Office for Health Improvement and Disparities (OHID).

These RTSS systems not only can track the number of deaths and attempted suicides locally, but also capture information such as the location and method to help identify patterns or changes for suicide prevention interventions. We heard several examples of their applied use to identify, and in some cases intervene preventatively in, suicide cases involving domestic abuse. For instance, Force #3 mentioned being the first area in the country to amend their RTSS system to add questions to capture the victim's history of domestic abuse. Force #3 also described the RTSS partnership conducting thematic analysis on the data and sharing learning locally – for instance, on suicides of children and young people, and on male victims; the same partnership had thematically reviewed suicide DHRs for learning. Moving towards prevention, Force #2 discussed implementing a process whereby attempted suicides of a victim of domestic abuse were reported to a local Independent Domestic Violence Advocate (IDVA) partner service, who then contacted that individual to provide additional support. The same force explained that their next planned stage of development would be to use the data in their RTSS system to trigger other preventative interventions.

10.4.5 Promising Practice #2: Posthumous prosecutions: making the perpetrator 'visible' and accountable

The second key piece of promising practice related to forces proactively prosecuting the domestic abuse perpetrator after a victim suicide. Of the five forces interviewed during the 'deep dives,' three recalled cases of suspected victim suicide following domestic abuse in which they considered or attempted to pursue posthumous prosecution for the offence of controlling or coercive behaviour (CCB), other domestic abuse-related offences, or manslaughter. The representatives from the remaining two forces were not aware of any active (or prior) posthumous investigations following a suspected victim suicide, but confirmed that prosecution would be considered for any relevant cases. The survey data similarly identified several forces with ongoing, attempted, and (at least two) successful posthumous prosecutions. Several survey responses indicated that the force planned to

include updated guidance on posthumous prosecution, particularly in relation to CCB and whether this abuse could be considered a contributing factor in the death.

Our dataset also identified cases in which evidence of domestic abuse, which was previously unknown to police, was uncovered following the victim's death but did not appear to result in a criminal investigation – highlighting that there may be potential for greater action in this area. There were also examples of forces choosing to re-open investigations into the death when they identified suspicious circumstances (e.g. the position or state of the deceased), or when new information came to light (e.g. during an inquest or DHR). Additionally, there were several cases in which forces proactively reached out to the victim's family and friends after the death as part of their routine investigation.

The forces we interviewed and surveyed identified challenges reaching the Crown Prosecution Service (CPS) evidential threshold for charge after a suspected victim suicide, and several highlighted this as a barrier in practice.

Some forces utilised their Real Time Suicide Surveillance (RTSS) system partnerships to contact local health, social care, and specialist domestic abuse services who might have information about previous domestic abuse that was not reported to the police. As in the case below (#1), another force described contacting the domestic abuse perpetrator's ex-partners when the initial posthumous charging attempt was unsuccessful. Finally, many forces appeared to actively seek out promising practice in this area to emulate. These interviewees and survey respondents mentioned speaking to other forces who successfully achieved posthumous prosecutions for controlling or coercive behaviour or manslaughter to inform their guidance or ongoing investigation; and many were open to further advice and promising practice.

Case examples: Posthumous prosecutions

According to the overall Project dataset, only 2% of the perpetrators of the prior domestic abuse in suspected victim suicide incidents received a charge following the death (0 in Year 1, 3% in Year 2).

Our analysis of force survey responses identified several attempts by forces to pursue posthumous prosecution for the offence of controlling or coercive behaviour (CCB), or other domestic abuse-related offences. In some cases, these forces also considered pursuing prosecution for manslaughter. The survey data facilitated the identification of relevant submissions to the Project for case studies. In case example #1, although rape and other offences were investigated for posthumous prosecution, the CPS found there was insufficient evidence to proceed. Nevertheless, this case illustrates the importance of consulting friends and family members who may have relevant information about domestic abuse that was not reported to the police.

In addition to the cases identified within the Project dataset (2020/21 and 2021/22), forces shared examples from previous cases. Case example #2 demonstrates promising practice that resulted in a posthumous prosecution and conviction of CCB. Whilst the

circumstances of each case differ, successful prosecutions and developed case law present learning that may support effective future practice.

Case example #1

Case #1 involved a female victim and male domestic abuse perpetrator, both in their 60s. The domestic abuse perpetrator was the victim's ex-husband, who had recently moved out. The victim was suspected to have died by suicide (drowning). Importantly, the perpetrator was not previously known to police for any offending (domestic abuse-related or otherwise). After the victim's death, her family members disclosed that she had been a victim of domestic abuse from her ex-husband, including rape. The family informed police as they believed this abuse was a 'catalyst' for the victim's death.

The victim was known to police as a vulnerable adult due to her mental health, including a prior attempted suicide, and also as a victim of domestic abuse from a previous ex-partner. It is not known if the victim and/or domestic abuse perpetrator were known to any partner agencies. However, the police and local Community Safety Partnership referred this case for a DHR following correspondence from an advocacy organisation on behalf of the victim's family. Whilst the case did not result in a charge and prosecution for the offences disclosed by family members (i.e. rape, sexual assault), the police force responded to this disclosure, completed an investigation, engaged with the advocacy organisation, and submitted the case for a DHR. This example shows both that information from family and friends is vital to understanding the context of suspected suicides, and that police responded to this changing information and amended their actions accordingly.

Source: Domestic Homicide Project

Case example #2

Case #2 also involved a female victim and male perpetrator of domestic abuse. The victim died in hospital after the removal of life support following a brain injury associated with her apparent suicide (by hanging). Around the time of the victim's death, her family raised concerns about the victim's relationship, stating that the perpetrator had been very controlling and possessive. The family also revealed that although the couple had been together for a short time, the perpetrator had very quickly moved into the victim's home and identified subtle but cumulative changes in the victim's behaviour. Officers initially arrested the perpetrator for CCB on the day after the victim's death. He denied these allegations and was later bailed.

The officers in this case demonstrated professional curiosity and explored several evidential opportunities even after the initial arrest did not result in a charge by the CPS. For instance, the investigation utilised body-worn camera footage from the arrest of the perpetrator. It is force policy to use body-worn cameras when attending domestic abuse incidents, but these are often turned off following the arrest of a suspect. This footage allowed identification of conflicting statements within the perpetrator's account of the events leading up to the victim's death and how he discovered the victim's body.

Moreover, the investigative officers drew on additional evidence including mobile phone data, ANPR, statements from family and friends (identified unreported assaults), house to house enquiries, medical records, and a history of police-recorded domestic abuse by the perpetrator against two previous partners. Additionally, officers recovered deleted messages between the victim and perpetrator leading up to the victim's death, which they identified as crucial to successful prosecution. Together, this evidence helped demonstrate a pattern of behaviour and illustrated its 'serious effect' on the victim. The force's efforts were successful, and the perpetrator was convicted of and received a significant custodial sentence for CCB.

Source: Domestic Homicide Project

10.4.6 Promising Practice #3: Suicide prevention posts and partnerships

Several forces described innovative practice in investing strategically in posts and multi-agency partnerships to prevent suicide related to domestic abuse. Force #1 had implemented a Suicide Prevention and Vulnerability Officer post – as well as monitoring and identifying relevant deaths, this person had run safeguarding events for police and partners, and established training as part of police officer continued professional

development (CPD). Force #3 had enshrined domestic abuse as a priority within their local Suicide Prevention Strategy. One force which responded to our survey had established a dedicated multi-agency Domestic Abuse Suicide Prevention Working Group. Another force responding to our survey told us that they conducted a weekly review of all suspected suicides to learn lessons about prevention, trends and support needs.

10.4.7 Promising Practice #4: Coroner relationships

Forces described innovative practice in relation to working with the Coroner locally to identify relevant deaths. In Force #1 the Suicide Prevention Officer had cultivated strong lines of communication with the Coroner, which meant that relevant information could be shared. For instance, he would let the Coroner know if the deceased's family mentioned past domestic abuse; the Coroner in turn would alert him of overnight deaths in hospital where the police might not otherwise have known about the death (but might have information on domestic abuse history). Force #5 described proactively identifying previously unknown domestic abuse from family and friends' witness statements to the Coroner for inquest.

10.5 Domestic Homicide Reviews (DHRs) for suspected victim suicides

10.5.1 Domestic Homicide Reviews

The Project team asked forces how identified cases of suspected victim suicide were reviewed, such as through a local DHR. As noted in the Background section, local Community Safety Partnerships (CSPs) currently have discretion in the DHR criteria to commission a review for a suspected suicide following domestic abuse, but the Home Office (2022) plans to provide updated, clear guidance in this area. Most forces described a process whereby a case review team conducted a daily check of a 'Chief's Log' that was updated overnight with all deaths and serious incidents occurring within the force to determine if there were any relevant cases that should be referred to the local CSP for a DHR, Child Safeguarding Practice Review (CSPR), or another type of review. The reviewing individuals who reviewed cases for the force were often the same who submitted cases to this Project. This specialist team had access and a specific remit that made them well-placed to identify relevant deaths.

Overall, where it was known in submissions to the Project whether or not a suspected victim suicide case had been referred to the CSP for a DHR, 96% of cases were referred. The proportion of suspected victim suicide cases referred for a DHR (as a proportion of those cases where it was known) was higher in Year 2 (100% (n = 58) compared with 91% (n = 39) in Year 1). This increase from an already high referral rate is a welcome development. However, based on findings from our deep dives, it seems that many police forces are using referral for a DHR as an informal criterion to identify cases of suspected victim suicide cases to submit to this Project. In this case, whilst an increase in referrals of suspected victim suicide cases to DHRs remains welcome, there may be other cases which have neither been referred for DHRs nor submitted to this Project.

Of those suspected victim suicide cases referred for DHRs across the two-year dataset (n= 97), overall, 60% (n = 58) were accepted by the CSP, and only 6% (n = 6) were not accepted. The proportion of those accepted for DHR from referral went down in Year 2 (from 67% (n = 26) in Year 1, to 55% (n = 32) in Year 2). However, the proportion of those not accepted also went down (from 10% (n = 4) to 3% (n = 2)). The rate of as-yet unknown outcomes rose to 41% (n = 24) in Year 2 from 18% (n = 7) in Year 1. This indicates that the DHR referral acceptance rate in Year 2 reflects the fact that more cases were still awaiting a decision, being more recent – rather than the acceptance rate having dropped. Thus, the proportion of cases accepted for a DHR rises when the referrals that were either waiting to hear or the outcome was not known at the point of data analysis are removed (91%; 87% in Year 1, 94% in Year 2; see Figures 40 and 41 in Chapter 6).

Analysis of data from the 'deep dives' and survey revealed mixed experiences in terms of referrals of suspected victim suicide cases for a review. There was a general sense that broader strategic changes at the national level (e.g., encouragement by the Home Office to carry out more DHRs in response to police seeking advice on individual cases) may be driving an increase in prospective referrals. However, limited resources in some CSPs to fund these types of reviews meant that some forces experienced a lower acceptance rate in proportion to their referrals.

10.5.2 Multi-agency learning on suspected victim suicides from DHRs

Finally, we asked forces how any learning from reviews involving suspected victim suicides was shared. Some forces described a specific process to gather and review all relevant learning and actions for police arising from DHRs and related reviews once the reviews were completed, with individuals within the team demonstrating expertise in identifying patterns in their local force area cases. Furthermore, after the Project's 'deep dives', the case review team in Force #1 decided to create a separate folder for all cases submitted to the Project to create some separation between traditional review processes and the cases which meet the Project's wider definition of relevant deaths.

Some of these specialist teams also shared insight about the frontline officer response to suspected victim suicides based on their review of the case files. For instance, a team of specialists in Force #4 described having undertaken resource-intensive additional investigations at the direction of the Coroner when their review of the case revealed that appropriate enquiries had not been conducted during the initial response to the suspected suicide (sudden death). They suggested that having a minimum Standard Operating Procedure for attending sudden or unexpected deaths, including suspected suicides, would help decrease demand and improve outcomes later in the process. Relatedly, it is important to note that not all forces have the resources for a case review team, particularly one dedicated to the force area's coronial inquest needs.

10.6 Improving reporting of suspected victim suicides to this Project

Regarding the reporting of relevant deaths to this Project, we found that the deliberately wide definition of relevant deaths adopted by the Project[21] appeared to have led forces to develop their own informal criteria to determine which suspected suicides with a history of domestic abuse were relevant to submit to the Project. In most cases, these informal criteria were: a referral of that case for a DHR or another type of review, reports of domestic abuse having occurred within a certain time period prior to the death (e.g. 6 months, 12 months, 'non-historic' etc.), or other informal judgment by officers identifying a potential link between the abuse and the suspected suicide, all three of which often tied together.

Furthermore, in 2021 the British Transport Police (BTP) began a Real Time Suicide Surveillance (RTSS) project for the National Police Chiefs Council (NPCC), to record all suicides in England and Wales since April 2021 (hereafter 'the BTP RTSS project'). The BTP RTSS project dataset differs from this dataset in that it records information about all types of suicide, draws on aggregated counts rather than case-level data, and records whether the victim of the suspected suicide was known to police as a victim, suspect, and or witness of domestic abuse. This methodology means that the BTP RTSS project does not include in-depth information about the case history as that is not a main focus of the data collection. Comparative analysis conducted by the Domestic Homicide Project within the deep dive forces found that individuals in forces submitting cases to our Project and the BTP RTSS project were not always aware of the other project. This is potentially symptomatic of a disjunction between the teams working on domestic abuse and suicide prevention, as compared to the more closely linked association between domestic abuse and homicide specialist teams, as well as the existing strategic guidance.

During data reconciliation between both projects carried out for this analysis, whilst the BTP RTSS project dataset was found to include a higher number of cases of suspected suicide in which domestic abuse was a feature, both datasets included cases that were not submitted to the other project, highlighting the (deliberately) differing sources of data and methodology adopted by the two projects. The deep dives suggested that another reason for the difference in numbers between the projects was that the BTP RTSS project counts all cases where a domestic abuse 'flag' has been applied to the victim or perpetrator's record; whereas the Domestic Homicide Project relies on the submitting police force to make a professional judgement about the potential link between the death and the prior experience of domestic abuse. The process of data reconciliation carried out as part of this Project's deep dive on suspected suicide has strengthened the relationship between

[21] 'The death of a person, any age (including under 16), that has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves. This includes where it appears that a person has committed suicide or there is an unexplained death as a result of / following domestic abuse.'

suicide prevention and case review teams in individual forces, which will improve future data quality across both projects.

10.7 Findings and recommendations on suspected victim suicide following domestic abuse

Findings

Finding 24: There was a rise of 28% (n = +14) in the number of submissions for suspected victim suicide in Year 2. This was a greater rise than intimate partner homicides, but less than adult family homicides. At least part of the increase in suspected victim suicides we think can be attributed to improved police awareness of the issue overall and greater awareness of this Project, meaning that more cases are being identified. Overwhelmingly, the domestic abuse which preceded the suspected suicide in these cases was from an intimate partner (92%, n = 46/50 in Year 1; 95%, n = 61/64 in Year 2).

Finding 25: Comparing the two years, there was a rise in male victims of suspected victim suicide, from 10% (n = 5) in Year 1 to 19% (n = 12) in Year 2, although the great majority of victims were still female (n = 45 (90%) in Year 1, n = 52 (81%) in Year 2). Within these 12 cases in Year 2, the majority (n = 10) had experienced prior abuse from an intimate partner. In two cases this abuse was from a male partner and in eight cases from a female partner. There is perhaps an interesting dynamic in these eight cases involving prior female-to-male abuse: in all eight, the male victim was previously known to police as both a victim and as a perpetrator of abuse. A more detailed exploration of primary perpetration in these suspected suicide cases is an important area for future research.

Finding 26: In Year 2, the proportion of suspected victim suicides amongst younger people (aged 16-24 years) increased, whilst the proportion of suspected victim suicides of older people (aged 65+) decreased. This may support the conclusions in our Year 1 report, that the pandemic put additional pressure on older victims and corresponded with a drop in care support. With the younger victims, coercive or controlling behaviour was present in almost all cases; in almost half, the victim was known to mental health services; and in a third, the victim was at university, several of which had had contact with university support services.

Finding 27: There was a rise in the number of LGBTQ+ victims of suspected victim suicide identified in Year 2 (13%, n = 8, compared with 4%, n = 2 in Year 1). Just under half these victims were male (n = 3), of whom two had experienced domestic abuse from a same-sex male partner. Just over half (n = 5) were female, of whom four had experienced abuse from a same-sex female partner.

Finding 28: In relation to prior risk factors in suspected victim suicides, as mentioned above, the most common factor was a history of coercive or controlling behaviour, which was even higher than in intimate partner homicides. In Year 2, whilst acknowledging the small overall numbers of cases for analysis for each risk factor, there was a higher-than-average increase in breach of protective orders (6% (n = 3) in Year 1, up to 21% (n = 14)

in Year 2), and a notable drop in recorded prior non-fatal strangulation (32% (n = 16) in Year 1, down to 6% (n = 4) in Year 2). This is a surprising finding, especially considering that there was an increased awareness of non-fatal strangulation during this period, arising from its inclusion as a new criminal offence in the Domestic Abuse Act 2021.

Finding 29: Across both years, one-third (n = 36) of the perpetrators of the prior domestic abuse in suspected victim suicides were known to police as high-risk or serial perpetrators. This rose from a quarter (n = 10) in Year 1 to over two-thirds (n = 26) in Year 2. Across both years, over two-thirds (n = 47) of perpetrators in these cases were known to MARAC; this rose from one-third (n = 15) in Year 1 to one-half (n = 32) in Year 2.

Finding 30: In terms of other agencies, victims and/or domestic abuse perpetrators in suspected victim suicides were most commonly known to domestic abuse services, GP/health services, mental health services, and children's social care. In Year 2 there was a noticeable rise in cases known to children's social care (14%, n = 7 in Year 1 and 34%, n = 22 in Year 2); alongside this there was an increase in cases identified as involving a recent child custody dispute (6%, n = 3 in Year 1 and 12%, n = 8 in Year 2).

Arising from our 'deep dives' with forces, the following conclusions were reached about police practice in understanding, identifying and responding to unexplained deaths and suspected victim suicides:

Finding 31: Whilst there is ongoing work to develop a consistent approach, we found that individual forces differed considerably in their policies and treatment of suspected suicides as unexpected deaths, including in the use of terminology.

Finding 32: Individual force policies varied in their guidance on how to account for domestic abuse as part of the evidence-gathering process in an unexpected death or suspected suicide. Some had specific guidelines; others did not.

Finding 33: How and when system checks for any prior knowledge of domestic abuse were conducted on the individuals and the address differed among forces. Some forces said that response officers completed checks before attending or when at the initial scene, whilst others said system checks might be conducted after leaving the scene and during the write up of the initial report.

Finding 34: Most forces had a policy for a supervisory officer to review the attending officer's actions, although this policy could not always be located. Several suggested that practice might differ from the policy. Others were unclear as to whether this policy resulted in supervision in-person on the scene, or if it was a desk-based review of the initial case file, with the approach taken seemingly dependent on the circumstances of the death and resource availability.

Finding 35: In practice, forces described that if the circumstances at the scene were not perceived to be suspicious, the initial investigation would be paused at that point when all initial investigative avenues were exhausted. Therefore, if a history of abuse was not identified within the early stages of the investigative response, future opportunities to hold

the perpetrator to account could be limited. Importantly, in some cases new information did come to light after the initial response, including when officers completed an investigation on behalf of the Coroner, and this did inform the police re-looking at the case. The 'deep dive' interview participants identified the need for a shift in investigative mindset, to really underpin professional curiosity amongst all officers attending and reviewing such deaths.

Finding 36: Following the initial response to a sudden or unexpected death, officers notify the local Coroner by completing a form as specified by the Coroner (often called a Sudden Death form). The format and contents of these forms are not standardised and, whilst they ask for information of the circumstances of the death, there is no routine prompt about domestic abuse history. There is an opportunity here to consider standardising this form, or at least to urge all forces to consider and record domestic abuse history on it.

Finding 37: One force raised a concern that attending officers might not be routinely recording all individuals present in the household at the time of the death. This interviewee suggested that not doing so might prevent the identification of domestic abuse, of appropriate enquiry relating to that individual, and of evidence-gathering in relation to later coronial inquest investigations.

Finding 38: Following an unexpected death or suspected suicide, in the vast majority of cases where there is a co-habiting couple, the spouse or partner would be considered next of kin. Some interviewees suggested that in cases where a suspect of domestic abuse had isolated a victim from their family and friends, as next of kin, this suspect could be in a position to manipulate the narrative and any future criminal justice and/or coronial process. This demonstrates the importance of police always consulting wider family and friends in initial enquiries, as they may have information about abuse which had not been disclosed previously to the police or other agencies. Several police forces raised this as an important issue.

Finding 39: We found several examples of promising police practice, including: use of Real Time Suicide Surveillance (RTSS) systems; attempted posthumous prosecutions in suspected victim suicide cases, including for controlling or coercive behaviour and for manslaughter; dedicated suicide prevention partnerships; and good early information-sharing with local Coroners.

Finding 40: Home Office clarifications to Community Safety Partnerships on when to commission Domestic Homicide Reviews (DHRs) in suspected suicide cases seems to have given police and local partners the confidence to push for more suicide DHRs.

Recommendations

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 suicide following domestic abuse 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.

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.

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.

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.

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.

Recommendation 17 [to the police]: In line with forthcoming guidance from the College of Policing on unexpected deaths, a PIP 3 Senior Investigating Officer (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.

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.

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.

Recommendation 20 [to the CPS]: We recommend that the CPS include guidance on prosecuting the domestic abuse perpetrator posthumously for controlling or coercive behaviour 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.

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**

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.

Recommendation 23 [to this Project]: We recommend that this Project co-ordinate a learning event for police on suicide following domestic abuse 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.

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.

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

11. Report Conclusion

In summary, this report has presented new and important analysis of domestic homicides, child deaths and suspected victim suicides following domestic abuse, drawing on two years' worth of data collected by the Domestic Homicide Project. It has discussed changes to the numbers of deaths, victim and suspect characteristics (e.g., age, sex, ethnicity), case characteristics, risk factors, and police and other agency contact associated with these deaths between the first (1st April 2020 to 31st March 2021) and second (1st April 2021 to 31st March 2022) year of data collection.

The findings, such as the unique risk profile of adult family homicide and demonstrable prevalence of coercive or controlling behaviour in both intimate partner homicides and suspected victim suicides, highlight the importance of considering typological differences between cases. Notably, Chapter 10 presented an in-depth focus on suspected victim suicides following domestic abuse which begins to fill a critical gap in knowledge and understanding about the scale, nature, and police and other agency responses to these cases, facilitating recommendations for practice.

Across all its themes, this report has offered practical recommendations to provide direction for future work by the police (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, as well as for the continued work of this Project team.

The findings detailed throughout this report demonstrate 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 victim suicides.

References

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

Barlow, C. *et al.* (2020) 'Putting Coercive Control into Practice: Problems and Possibilities', *The British Journal of Criminology*, 60(1), pp. 160–179. doi: 10.1093/bjc/azz041.

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

Bates, L. *et al.* (2021) *Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021*. Vulnerability Knowledge and Practice Programme (VKPP). Available at: https://cdn.prgloo.com/media/02d412c416154010b5cebaf8f8965030.pdf.

Card, D and Dahl, G.B. (2011) 'Family Violence and Football: The Effect of Unexpected Emotional Cues on Violent Behavior,' *The Quarterly Journal of Economics*, 126(1), pp.103–143.

Cavanaugh, C. E. *et al.* (2011) 'Prevalence and Correlates of Suicidal Behavior among Adult Female Victims of Intimate Partner Violence', *Suicide and Life-Threatening Behavior*, 41(4), pp. 372–383. doi: https://doi.org/10.1111/j.1943-278X.2011.00035.x.

Christodoulou, C. *et al.* (2012) 'Suicide and seasonality', *Acta Psychiatrica Scandinavica*, 125(2), pp. 127–146. doi: https://doi.org/10.1111/j.1600-0447.2011.01750.x.

College of Policing (2019) *Practice advice: Dealing with sudden unexpected death*. College of Policing. Available at: https://library.college.police.uk/docs/appref/Dealing-with-sudden-unexpected-death-(COP)-v1.0.pdf.

College of Policing (2020) *Authorised Professional Practice on Mental Health*. College of Policing. Available at: https://www.college.police.uk/app/mental-health/suicide-and-bereavement-response.

College of Policing (2021) *Authorised Professional Practice on Domestic Abuse*. College of Policing. Available at: https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/.

College of Policing (2022) *Categories for unexpected death investigations*. College of Policing.

Devries, K. M. *et al.* (2013) 'Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies', *PLoS medicine*, 10(5).

Femicide Census (2020) *UK Femicides 2009-2018*. Femicide Census. Available at: www.femicidecensus.org/reports.

Gangoli, G., Bates, L. and 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), pp. 3119–3135, doi: 10.1080/1369183X.2019.1650010.

Hoeger, K. *et al.* (2022) *Domestic Homicide Project - Spotlight Briefing #2: Older Victims*. Vulnerability Knowledge and Practice Programme (VKPP).

Home Office (2016) *Domestic homicide reviews: statutory guidance*. Available at: 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*. Available at: 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*. Available at: https://www.gov.uk/government/publications/tackling-domestic-abuse-plan.

Kafka, J. M. *et al.* (2022) 'Intimate partner violence victimization and perpetration as precursors to suicide', *SSM - Population Health*, 18. doi: https://doi.org/10.1016/j.ssmph.2022.101079.

MacIsaac, M. B. *et al.* (2017) 'Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia', *Asia Pacific Journal of Public Health*, 30(1), pp. 36–44. doi: 10.1177/1010539517743615.

MacIsaac, M. B., Bugeja, L. C. and 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), pp. 61–69. doi: https://doi.org/10.1111/1753-6405.12594.

McManus, S. *et al.* (2022) 'Intimate Partner Violence, Suicidality, and Self-Harm: A Probability Sample Survey of the General Population in England,' *The Lancet Pre-Prints*. Available at SSRN: https://ssrn.com/abstract=4052660 or http://dx.doi.org/10.2139/ssrn.4052660

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

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

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

Nguyen Phan, T. T. *et al.* (2022) *Domestic Homicide Project - Spotlight Briefing #1: Adult Family Homicides*. Vulnerability Knowledge and Practice Programme (VKPP).

National Police Chiefs Council (NPCC) and College of Policing (2022) *Response to Regulation 28 report on action to prevent future deaths*.

Office for National Statistics (2018) *Population of England and Wales*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest.

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

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

Office for National Statistics (2022) *Homicides in England and Wales: year ending March 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021#the-most-common-methods-of-killing.

Perry, P. *et al.* (2022) *Domestic Homicide Project - Spotlight Briefing #3: Ethnicity*. Vulnerability Knowledge and Practice Programme (VKPP).

Rowlands, J. (2020) *Reviewing domestic homicide: international practice and perspectives*. Winston Churchill Memorial Trust. Available at: https://www.wcmt.org.uk/fellows/reports/reviewing-domestic-homicide-international-practice-and-perspectives.

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

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

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

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

White, R. A. *et al.* (2015) 'Does suicide have a stronger association with seasonality than sunlight?', *BMJ Open*, 5(6). doi: 10.1136/bmjopen-2014-007403.

Woo, J. M. *et al.* (2012) 'Pollen counts and suicide rates. Association not replicated', *Acta Psychiatrica Scandinavica*, 125(2), pp. 168–175. doi: https://doi.org/10.1111/j.1600-0447.2011.01813.x.

Appendix A: List of recommendations to the Police (NPCC) from Year 1 report with Progress Updates

Our Year 1 report made a series of recommendations for the police (NPCC). During August 2022, the NPCC provided updates against the implementation of these recommendations, as follows:

Recommendation

The Domestic Abuse Matters training programme has been shown to improve officers' identification of coercive control and of patterns of domestic abuse – both of which are important in identifying prospective domestic homicides. The DA Matters programme should be adopted as widely as possible by forces.

Response

More than 30 forces have adopted this training, two forces are currently mid delivery and six more have set out a clear intention to achieve delivery in the coming year. Five forces have elected to adopt an alternative training programme that they believe achieves comparable learning outcomes. These forces will be contacted to ensure they are aware of the extensive evaluation of DA Matters which is not matched by alternatives.

Recommendation

Forces should ensure that they are applying the College of Policing's principles for managing serial and dangerous perpetrators as a priority in domestic abuse cases.

Response

Forces have provided assurance that they are aware of these principles and actively applying them in their approach to domestic abuse perpetrator management.

Recommendation

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.

Response

Forces have provided assurance that their multi agency public protection arrangements are used effectively to manage the most dangerous perpetrators and your research appears to have prompted an increase in referrals.

Three recommendations (with joint response):

Police forces should all ensure that they are familiar with and closely implement the Authorised Professional Practice on Suicide.

Police should ensure that all suspected victim suicides where there is a history of domestic abuse are considered for, and where they meet the criteria are referred for, a Domestic Homicide Review.

In cases of (especially female) unexplained death or suspected suicide, police should consider whether domestic abuse may be a contributory factor, and if so, whether any criminal offence has been committed.

(Joint) Response

Your research has triggered work within forces to ensure Authorised Professional Practice is appropriately applied and referred to by those responding to and investigating incidents of suicide. More recent work led by the NPCC lead for homicide and a refresh of APP for the response to sudden and unexpected death will drive further improvement in the police response. Forces have provided assurance that domestic abuse is actively considered when responding to incidents of suicide and multi-agency safeguarding partnerships are supportive of greater use of Domestic Homicide Reviews.

Recommendation

[For police and partner agencies] All agencies involved in any MARAC process should consider the risk of victim suicide following domestic abuse alongside the risk of homicide, where risk factors which indicate coercive controlling abuse – including a history of non-fatal strangulation and attempts to separate – are present.

Response

Forces have provided assurance that suicide risk is actively considered when safeguarding plans are discussed in multi-agency safeguarding arrangements. It is clear that there is local variation in multi-agency safeguarding arrangements and police forces are having to navigate a myriad of differing agency strategies and policies, but I am reassured that your recommendations have resonated with police domestic abuse leads and they have made great efforts to influence local arrangements and ensure improvement. My NPCC Staff Officer, Angela Whitaker, has collated detailed responses to your recommendations from each force and, alongside her position with your research project, she will ensure we continue to drive improvement activity.

Appendix B: List of recommendations to the College of Policing from Year 1 report with Progress Updates

Our Year 1 report made a series of recommendations for the College of Policing. During August 2022, the College provided updates on the implementation of these recommendations, as follows:

Recommendation

The College should review the Authorised Professional Practice on Suicide to ensure that it explicitly includes references to domestic abuse. The College should ensure that both the Authorised Professional Practice on Suicide and the Authorised Professional Practice on Domestic Abuse make reference to each other.

Response

This work is scheduled for progressing during 22/23. Resources have not been available in 21/22 because of demands in other areas.

Recommendation

The National Police Chiefs Council and College of Policing should take forward work to support policing to help reduce the risks of suicide in cases involving domestic abuse.

Response

The changes to APP will support this work. In addition, we have highlighted suicide in the DA Matters training product.

Recommendation

We recommend a review of risk assessment tools DASH and DARA is carried out, to ensure that they are adequately able to identify the risks involved in adult family abuse. In particular, to make sure that these tools can identify risks posed by adult sons and grandsons to older relatives, especially where there is significant mental illness and/or drug use. A review should consider whether further guidance for police and partner agencies on understanding risk in adult family abuse cases is needed.

Response

Having reviewed risk assessment, we do not consider that changes are required to risk assessment tools – the College does not ‘own’ DASH and could not make changes to it in any event.

The College has recently published new evidence-based risk assessment guidelines. These guidelines support the DARA tool in setting out the requirement to obtain as much information as possible from as many sources as possible to inform professional judgement about risk in all DA cases. Risk assessment tools can only ever support

investigation and decision making. It is highly unlikely that, in investigating any DA cases, the relevance of mental ill health or substance abuse would be overlooked or not mentioned by the victim or witness.

In developing DARA, the College was particularly concerned not to try to cover every possible situation because research indicated that, where this did happen, the risk assessment process turned into a tick box exercise and assessors did not engage effectively with victims, being ‘eyes down’ looking at the very long form. DARA is constructed to encourage a more open questioning style that supports more comprehensive investigation and looking beyond the obvious. The supporting training for DARA sets out the DA situations where it should be used, including family situations and already covers the need to treat the tool as an aid to decision making, rather than a defined script.

We feel that the issues here are more related to pathways to support once specific needs have been identified.

Appendix C: Selected data tables

Victim Characteristics	Main Typology (2020/2021)											
	Adult Family		Child Death		Intimate Partner		Other		Suspected Victim Suicide		Overall	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Victims	**40**	**18.2%**	**23**	**10.5%**	**100**	**45.5%**	**7**	**3.2%**	**50**	**22.7%**	**220**	**100.0%**
Sub-Typology												
Familicide	1	2.5%	1	4.3%	2	2.0%	-	-	-	-	**4**	**1.8%**
Filicide / Child	1	2.5%	20	87.0%	-	-	-	-	-	-	**21**	**9.5%**
Fratricide/Sororicide / Sibling	7	17.5%	-	-	-	-	-	-	-	-	**7**	**3.2%**
Intimate Partner	1	2.5%	-	-	98	98.0%	-	-	-	-	**99**	**45.0%**
Other	-	-	-	-	-	-	7	100.0%	-	-	**7**	**3.2%**
Other - Family	6	15.0%	2	8.7%	-	-	-	-	-	-	**8**	**3.6%**
Parricide / Parents	24	60.0%	-	-	-	-	-	-	-	-	**24**	**10.9%**
Suicide - Family	-	-	-	-	-	-	-	-	3	6.0%	**3**	**1.4%**
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	46	92.0%	**46**	**20.9%**
Suicide - No Suspect	-	-	-	-	-	-	-	-	1	2.0%	**1**	**0.5%**
Sex												
Female	19	47.5%	11	47.8%	83	83.0%	1	14.3%	45	90.0%	**159**	**72.3%**
Male	21	52.5%	12	52.2%	17	17.0%	6	85.7%	5	10.0%	**61**	**27.7%**
Ethnicity												
White	28	70.0%	11	47.8%	78	78.0%	5	71.4%	45	90.0%	**167**	**75.9%**
Asian/Asian British	3	7.5%	5	21.7%	8	8.0%	-	-	2	4.0%	**18**	**8.2%**
Black/African/Caribbean/Black British	9	22.5%	2	8.7%	8	8.0%	-	-	1	2.0%	**20**	**9.1%**
Mixed/Multiple ethnic groups	-	-	2	8.7%	1	1.0%	-	-	-	-	**3**	**1.4%**
Other	-	-	2	8.7%	2	2.0%	2	28.6%	1	2.0%	**7**	**3.2%**
Not Known	-	-	1	4.3%	3	3.0%	-	-	1	2.0%	**5**	**2.3%**
Age Group (Years)												
Under 16	-	-	19	82.6%	-	-	-	-	-	-	**19**	**8.6%**
Under 1	-	-	7	30.4%	-	-	-	-	-	-	**7**	**3.2%**
16-24	1	2.5%	4	17.4%	6	6.0%	-	-	4	8.0%	**15**	**6.8%**
25-34	5	12.5%	-	-	24	24.0%	-	-	14	28.0%	**43**	**19.5%**
35-44	5	12.5%	-	-	20	20.0%	-	-	15	30.0%	**40**	**18.2%**
45-54	4	10.0%	-	-	18	18.0%	4	57.1%	8	16.0%	**34**	**15.5%**
55-64	8	20.0%	-	-	14	14.0%	2	28.6%	4	8.0%	**28**	**12.7%**
65+	17	42.5%	-	-	18	18.0%	1	14.3%	5	10.0%	**41**	**18.6%**
Not Known	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Gender Reassignment												
Yes	-	-	-	-	-	-	-	-	-	-	**-**	**-**
No	25	62.5%	22	95.7%	54	54.0%	1	14.3%	26	52.0%	**128**	**58.2%**
Not Known	15	37.5%	1	4.3%	48	48.0%	6	85.7%	24	48.0%	**94**	**42.7%**
Religious Beliefs												
Yes	-	-	1	4.3%	2	2.0%	-	-	1	2.0%	**4**	**1.8%**
No	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Not Known	40	100.0%	22	95.7%	98	98.0%	7	100.0%	49	98.0%	**216**	**98.2%**
LGBTQ+												
Yes	-	-	2	8.7%	2	2.0%	-	-	2	4.0%	**6**	**2.7%**
No	21	52.5%	13	56.5%	61	61.0%	4	57.1%	48	96.0%	**147**	**66.8%**
Not Known	19	47.5%	8	34.8%	37	37.0%	3	42.9%	0	0.0%	**67**	**30.5%**
Pregnancy and Maternity												
Yes	-	-	-	-	3	3.0%	-	-	-	-	**3**	**1.4%**
No/Not Applicable	39	97.5%	22	95.7%	68	68.0%	7	100.0%	25	50.0%	**161**	**73.2%**
Not Known	1	2.5%	1	4.3%	29	29.0%	-	-	25	50.0%	**56**	**25.5%**
Special Needs												
Yes	4	10.0%	7	30.4%	20	20.0%	1	14.3%	8	16.0%	**40**	**18.2%**
No	16	40.0%	7	30.4%	36	36.0%	2	28.6%	17	34.0%	**78**	**35.5%**
Not Known	20	50.0%	9	39.1%	44	44.0%	4	57.1%	25	50.0%	**102**	**46.4%**

Victim Characteristics	Main Typology (2021/2022)											
	Adult Family		Child Death		Intimate Partner		Other		Suspected Victim Suicide		Overall	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Victims	**62**	**24.8%**	**16**	**6.4%**	**103**	**41.2%**	**5**	**2.0%**	**64**	**25.6%**	**250**	**100.0%**
Sub-Typology												
Familicide	-	-	3	18.8%	2	1.9%	-	-	-	-	**5**	**2.0%**
Filicide / Child	3	4.8%	12	75.0%	-	-	-	-	-	-	**15**	**6.0%**
Fratricide/Sororicide / Sibling	9	14.5%	1	6.3%	-	-	-	-	-	-	**10**	**4.0%**
Intimate Partner	-	-	-	-	101	98.1%	-	-	-	-	**101**	**40.4%**
Other	-	-	-	-	-	-	1	20.0%	-	-	**1**	**0.4%**
Other - Family	6	9.7%	-	-	-	-	4	80.0%	-	-	**4**	**1.6%**
Parricide / Parents	44	71.0%	-	-	-	-	-	-	-	-	**6**	**2.4%**
Suicide - Family	-	-	-	-	-	-	-	-	3	4.7%	**47**	**18.8%**
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	61	95.3%	**61**	**24.4%**
Suicide - No Suspect	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Sex												
Female	29	46.8%	3	18.8%	86	83.5%	1	20.0%	52	81.3%	**171**	**68.4%**
Male	33	53.2%	13	81.3%	17	16.5%	4	80.0%	12	18.8%	**79**	**31.6%**
Ethnicity												
White	48	77.4%	6	37.5%	77	74.8%	5	100.0%	55	85.9%	**191**	**76.4%**
Asian/Asian British	4	6.5%	-	-	13	12.6%	-	-	1	1.6%	**18**	**7.2%**
Black/African/Caribbean/Black British	6	9.7%	2	12.5%	5	4.9%	-	-	5	7.8%	**18**	**7.2%**
Mixed/Multiple ethnic groups	2	3.2%	4	25.0%	2	1.9%	-	-	1	1.6%	**9**	**3.6%**
Other	1	-	-	-	5	4.9%	-	-	-	-	**6**	**2.4%**
Not Known	1	1.6%	4	25.0%	1	1.0%	-	-	2	3.1%	**8**	**3.2%**
Age Group (Years)												
Under 16	-	-	16	100.0%	-	-	-	-	-	-	**16**	**6.4%**
Under 1	-	-	4	25.0%	-	-	-	-	-	-	**4**	**1.6%**
16-24	2	3.2%	-	-	9	8.7%	-	-	10	15.6%	**21**	**8.4%**
25-34	-	-	-	-	25	24.3%	-	-	17	26.6%	**42**	**16.8%**
35-44	3	4.8%	-	-	27	26.2%	1	20.0%	22	34.4%	**53**	**21.2%**
45-54	14	22.6%	-	-	25	24.3%	1	20.0%	9	14.1%	**49**	**19.6%**
55-64	16	25.8%	-	-	6	5.8%	-	-	5	7.8%	**27**	**10.8%**
65+	26	41.9%	-	-	11	10.7%	3	60.0%	1	1.6%	**41**	**16.4%**
Not Known	1	1.6%	-	-	-	-	-	-	-	-	**1**	**0.4%**
Gender Reassignment												
Yes	-	-	-	-	-	-	-	-	-	-	**-**	**-**
No	53	85.5%	16	100.0%	88	85.4%	5	100.0%	54	84.4%	**216**	**86.4%**
Not Known	9	14.5%	-	-	15	14.6%	-	-	10	15.6%	**34**	**13.6%**
Religious Beliefs												
Yes	3	4.8%	-	-	3	2.9%	1	20.0%	-	-	**7**	**2.8%**
No	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Not Known	59	95.2%	16	100.0%	100	97.1%	4	80.0%	64	100.0%	**243**	**97.2%**
LGBTQ+												
Yes	1	1.6%	-	-	1	1.0%	-	-	8	12.5%	**10**	**4.0%**
No	33	53.2%	5	31.3%	68	66.0%	4	80.0%	45	70.3%	**155**	**62.0%**
Not Known	28	45.2%	11	68.8%	34	33.0%	1	20.0%	11	17.2%	**85**	**34.0%**
Pregnancy and Maternity												
Yes	-	-	-	-	1	1.0%	-	-	-	-	**1**	**0.4%**
No/Not Applicable	58	93.5%	16	100.0%	85	82.5%	5	100.0%	42	65.6%	**206**	**82.4%**
Not Known	4	6.5%	-	-	17	16.5%	-	-	22	34.4%	**43**	**17.2%**
Special Needs												
Yes	12	19.4%	1	6.3%	13	12.6%	2	40.0%	10	15.6%	**38**	**15.2%**
No	21	33.9%	7	43.8%	35	34.0%	2	40.0%	18	28.1%	**83**	**33.2%**
Not Known	29	46.8%	8	50.0%	55	53.4%	1	20.0%	36	56.3%	**129**	**51.6%**

Suspect Characteristics	Main Typology (2020/2021)											
	Adult Family		Child Death		Intimate Partner		Other		Suspected Victim Suicide		Overall	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**45**	**18.9%**	**29**	**12.2%**	**107**	**45.0%**	**7**	**2.9%**	**50**	**21.0%**	**238**	**100.0%**
Sub-Typology												
Familicide	-	-	-	-	2	1.9%	-	-	-	-	**2**	**0.8%**
Filicide / Child	1	2.2%	27	93.1%	-	-	-	-	-	-	**28**	**11.8%**
Fratricide/Sororicide / Sibling	8	17.8%	-	-	-	-	-	-	-	-	**8**	**3.4%**
Intimate Partner	1	2.2%	-	-	102	95.3%	-	-	-	-	**103**	**43.3%**
Other	2	4.4%	-	-	3	2.8%	7	100.0%	-	-	**12**	**5.0%**
Other - Family	7	15.6%	2	6.9%	-	-	-	-	-	-	**9**	**3.8%**
Parricide / Parents	26	57.8%	-	-	-	-	-	-	-	-	**26**	**10.9%**
Suicide - Family	-	-	-	-	-	-	-	-	3	6.0%	**3**	**1.3%**
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	46	92.0%	**46**	**19.3%**
Suicide - No Suspect	-	-	-	-	-	-	-	-	1	2.0%	**1**	**0.4%**
Sex												
Female	5	11.1%	17	58.6%	17	15.9%	1	14.3%	4	8.0%	**44**	**18.5%**
Male	40	88.9%	11	37.9%	90	84.1%	6	85.7%	43	86.0%	**190**	**79.8%**
Not Known	-	-	1	3.4%	-	-	-	-	3	6.0%	**4**	**1.7%**
Ethnicity												
White	32	71.1%	17	58.6%	84	78.5%	6	85.7%	46	92.0%	**185**	**77.7%**
Asian/Asian British	4	8.9%	3	10.3%	9	8.4%	-	-	2	4.0%	**18**	**7.6%**
Black/ African/Caribbean/Black British	9	20.0%	2	6.9%	8	7.5%	-	-	1	2.0%	**20**	**8.4%**
Mixed/Multiple ethnic groups	-	-	4	13.8%	1	0.9%	-	-	-	-	**5**	**2.1%**
Other	-	-	2	6.9%	2	1.9%	1	14.3%	1	2.0%	**6**	**2.5%**
Not Known	-	-	1	3.4%	3	2.8%	-	-	0	0.0%	**4**	**1.7%**
Age Group (Years)												
Under 16	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Under 1	-	-	-	-	-	-	-	-	-	-	**-**	**-**
16-24	11	24.4%	3	10.3%	7	6.5%	1	14.3%	2	4.0%	**24**	**10.1%**
25-34	15	33.3%	13	44.8%	19	17.8%	2	28.6%	14	28.0%	**63**	**26.5%**
35-44	10	22.2%	9	31.0%	25	23.4%	3	42.9%	10	20.0%	**57**	**23.9%**
45-54	4	8.9%	2	6.9%	20	18.7%	-	-	6	12.0%	**32**	**13.4%**
55-64	3	6.7%	1	3.4%	17	15.9%	1	14.3%	5	10.0%	**27**	**11.3%**
65+	2	4.4%	-	-	18	16.8%	-	-	5	10.0%	**25**	**10.5%**
Not Known	-	-	1	3.4%	1	0.9%	-	-	8	16.0%	**10**	**4.2%**
Gender Reassignment												
Yes	-	-	-	-	-	-	-	-	-	-	**-**	**-**
No	26	57.8%	10	34.5%	55	51.4%	2	28.6%	25	50.0%	**118**	**49.6%**
Not Known	19	42.2%	19	65.5%	52	48.6%	5	71.4%	25	50.0%	**120**	**50.4%**
Religious Beliefs												
Yes	-	-	2	6.9%	3	2.8%	-	-	-	-	**5**	**2.1%**
No	-	-	-	-	1	0.9%	-	-	-	-	**1**	**0.4%**
Not Known	45	100.0%	27	93.1%	103	96.3%	7	100.0%	50	100.0%	**232**	**97.5%**
LGBTQ+												
Yes	-	-	1	3.4%	2	1.9%	-	-	2	4.0%	**5**	**2.1%**
No	16	35.6%	9	31.0%	59	55.1%	3	42.9%	24	48.0%	**111**	**46.6%**
Not Known	29	64.4%	19	65.5%	46	43.0%	4	57.1%	24	48.0%	**122**	**51.3%**
Pregnancy and Maternity												
Yes	-	-	6	20.7%	1	0.9%	-	-	-	-	**7**	**2.9%**
No/Not Applicable	45	100.0%	14	48.3%	100	93.5%	7	100.0%	43	86.0%	**209**	**87.8%**
Not Known	-	-	9	31.0%	6	5.6%	-	-	7	14.0%	**22**	**9.2%**
Special Needs												
Yes	10	22.2%	5	17.2%	14	13.1%	3	42.9%	4	8.0%	**36**	**15.1%**
No	16	35.6%	11	37.9%	38	35.5%	2	28.6%	15	30.0%	**82**	**34.5%**
Not Known	19	42.2%	13	44.8%	55	51.4%	2	28.6%	31	62.0%	**120**	**50.4%**

Suspect Characteristics	Main Typology (2021/2022)											
	Adult Family		Child Death		Intimate Partner		Other		Suspected Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**62**	**24.4%**	**14**	**5.5%**	**104**	**40.9%**	**6**	**2.4%**	**68**	**26.8%**	**254**	**100.0%**
Sub-Typology												
Familicide	-	-	-	-	2	1.9%	-	-	-	-	**2**	**0.8%**
Filicide / Child	-	-	12	85.7%	-	-	-	-	-	-	**12**	**4.7%**
Fratricide/Sororicide / Sibling	5	8.1%	2	14.3%	-	-	-	-	-	-	**7**	**2.8%**
Intimate Partner	9	14.5%	-	-	102	98.1%	-	-	-	-	**111**	**43.7%**
Other	-	-	-	-	-	-	5	83.3%	-	-	**5**	**2.0%**
Other - Family	7	11.3%	-	-	-	-	1	16.7%	-	-	**8**	**3.1%**
Parricide / Parents	41	66.1%	-	-	-	-	-	-	-	-	**41**	**16.1%**
Suicide - Family	-	-	-	-	-	-	-	-	3	4.4%	**3**	**1.2%**
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	65	95.6%	**65**	**25.6%**
Suicide - No Suspect	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Sex												
Female	7	11.3%	7	50.0%	16	15.4%	-	-	12	17.6%	**42**	**16.5%**
Male	55	88.7%	7	50.0%	88	84.6%	6	100.0%	56	82.4%	**212**	**83.5%**
Not Known/Not Recorded	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Ethnicity												
White	48	77.4%	7	50.0%	78	75.0%	6	100.0%	57	83.8%	**196**	**77.2%**
Asian/Asian British	4	6.5%	-	-	13	12.5%	-	-	2	2.9%	**19**	**7.5%**
Black/ African/Caribbean/Black British	6	9.7%	2	14.3%	5	4.8%	-	-	6	8.8%	**19**	**7.5%**
Mixed/Multiple ethnic groups	2	3.2%	1	7.1%	2	1.9%	-	-	1	1.5%	**6**	**2.4%**
Other	1	1.6%	-	-	5	4.8%	-	-	-	-	**6**	**2.4%**
Not Known	1	1.6%	4	28.6%	1	1.0%	-	-	2	2.9%	**8**	**3.1%**
Age Group (Years)												
Under 16	-	-	2	14.3%	-	-	-	-	-	-	**2**	**0.8%**
11-15	-	-	2	14.3%	-	-	-	-	-	-	**2**	**0.8%**
16-24	14	22.6%	2	14.3%	6	5.8%	-	-	10	14.7%	**32**	**12.6%**
25-34	12	19.4%	7	50.0%	22	21.2%	1	16.7%	16	23.5%	**58**	**22.8%**
35-44	11	17.7%	3	21.4%	28	26.9%	2	33.3%	17	25.0%	**61**	**24.0%**
45-54	11	17.7%	-	-	26	25.0%	1	16.7%	14	20.6%	**52**	**20.5%**
55-64	10	16.1%	-	-	11	10.6%	1	16.7%	5	7.4%	**27**	**10.6%**
65+	3	4.8%	-	-	10	9.6%	-	-	4	5.9%	**17**	**6.7%**
Not Known/Not Recorded	1	1.6%	-	-	1	1.0%	1	16.7%	2	2.9%	**5**	**2.0%**
Gender Reassignment												
Yes	-	-	-	-	-	-	-	-	-	-	**-**	**-**
No	53	85.5%	12	85.7%	88	84.6%	5	83.3%	58	85.3%	**216**	**85.0%**
Not Known/ Not Recorded	9	14.5%	2	14.3%	16	15.4%	1	16.7%	10	14.7%	**38**	**15.0%**
Religious Beliefs												
Yes	3	4.8%	-	-	3	2.9%	-	-	-	-	**6**	**2.4%**
No	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Not Known/ Not Recorded	59	95.2%	14	100.0%	101	97.1%	6	100.0%	68	100.0%	**248**	**97.6%**
LGBTQ+												
Yes	1	1.6%	-	-	1	1.0%	-	-	7	10.3%	**9**	**3.5%**
No	29	46.8%	6	42.9%	66	63.5%	5	83.3%	47	69.1%	**153**	**60.2%**
Not Known/ Not Recorded	32	51.6%	8	57.1%	37	35.6%	1	16.7%	14	20.6%	**92**	**36.2%**
Pregnancy and Maternity												
Yes	-	-	2	14.3%	-	-	-	-	-	-	**2**	**0.8%**
No/Not Applicable	61	98.4%	10	71.4%	100	96.2%	6	100.0%	64	94.1%	**241**	**94.9%**
Not Known/ Not Recorded	1	1.6%	2	14.3%	4	3.8%	-	-	4	5.9%	**11**	**4.3%**
Special Needs												
Yes	19	30.6%	3	21.4%	10	9.6%	-	-	6	8.8%	**38**	**15.0%**
No	14	22.6%	4	28.6%	39	37.5%	3	50.0%	23	33.8%	**83**	**32.7%**
Not Known/ Not Recorded	29	46.8%	13	50.0%	7	50.0%	55	52.9%	3	50.0%	**39**	**57.4%**

Case Characteristics	Main Typology (2020/2021)											
	Adult Family		Child Death		Intimate Partner		Other		Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Incidents	**39**	***18.1%***	**21**	***9.7%***	**100**	***46.3%***	**6**	***2.8%***	**50**	***23.1%***	**216**	***100.0%***
Sub-Typology												
Familicide	-	-	-	-	2	*2.0%*	-	-	-	-	2	*0.9%*
Filicide / Child	1	*2.6%*	19	*90.5%*	-	-	-	-	-	-	20	*9.3%*
Fratricide/Sororicide / Sibling	7	*17.9%*	-	-	-	-	-	-	-	-	7	*3.2%*
Intimate Partner	-	-	-	-	98	*98.0%*	-	-	-	-	98	*45.4%*
Other	-	-	-	-	-	-	6	*100.0%*	-	-	6	*2.8%*
Other - Family	7	*17.9%*	2	*9.5%*	-	-	-	-	-	-	9	*4.2%*
Parricide / Parents	24	*61.5%*	-	-	-	-	-	-	-	-	24	*11.1%*
Suicide - Family	-	-	-	-	-	-	-	-	3	*6.0%*	3	*1.4%*
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	46	*92.0%*	46	*21.3%*
Suicide - No Suspect	-	-	-	-	-	-	-	-	1	*2.0%*	1	*0.5%*
Location of Incident												
Urban	34	*87.2%*	21	*100.0%*	91	*91.0%*	6	*100.0%*	40	*80.0%*	192	88.9%
Rural	5	*12.8%*	-	-	8	*8.0%*	-	-	10	*20.0%*	23	10.6%
Not Known/ Not Recorded	-	-	-	-	1	*1.0%*	-	-	-	-	1	0.5%
Location of Death												
Victim's Home	27	*69.2%*	13	61.9%	68	68.0%	4	66.7%	27	54.0%	139	64.4%
Suspect's Home	1	*2.6%*	-	-	4	4.0%	-	-	-	-	5	2.3%
Other Residential Building	3	*7.7%*	-	-	3	3.0%	-	-	1	2.0%	7	3.2%
Business Premises	-	-	2	9.5%	-	-	-	-	-	-	2	0.9%
Hospital	1	*2.6%*	3	14.3%	11	11.0%	-	-	6	12.0%	21	9.7%
Outside	5	*12.8%*	-	-	3	3.0%	-	-	10	20.0%	18	8.3%
Not Known	2	*5.1%*	3	14.3%	11	11.0%	2	33.3%	6	12.0%	24	11.1%
Method of Death												
Blunt Instrument	5	*12.8%*	1	4.8%	5	5.0%	1	16.7%	-	-	12	5.6%
Burning or scalding (Incl. Arson)	1	*2.6%*	1	4.8%	3	3.0%	-	-	2	4.0%	7	3.2%
Drowning	-	-	1	4.8%	-	-	-	-	3	6.0%	4	1.9%
Kicking or hitting	5	*12.8%*	6	28.6%	10	10.0%	-	-	-	-	21	9.7%
Other	3	*7.7%*	2	9.5%	8	8.0%	1	16.7%	2	4.0%	16	7.4%
Poison or Drugs	-	-	2	9.5%	6	6.0%	-	-	15	30.0%	23	10.6%
Sharp instrument	18	*46.2%*	2	9.5%	35	35.0%	4	66.7%	-	-	59	27.3%
Shooting	-	-	-	-	3	3.0%	-	-	-	-	3	1.4%
Strangulation (Incl. Hanging)	3	*7.7%*	1	4.8%	11	11.0%	-	-	23	46.0%	38	17.6%
Suffocation	-	-	1	4.8%	2	2.0%	-	-	1	2.0%	4	1.9%
Not Known	4	*10.3%*	4	19.0%	17	17.0%	-	-	4	8.0%	29	13.4%
Suspect Relationship to Victim												
Current Partner/Spouse	-	-	-	-	85	85.0%	-	-	27	54.0%	112	51.9%
Ex-Partner/Spouse	-	-	-	-	15	15.0%	-	-	17	34.0%	32	14.8%
Child	24	*61.5%*	-	-	-	-	-	-	1	2.0%	25	11.6%
Parent	1	*2.6%*	17	81.0%	-	-	-	-	-	-	18	8.3%
Sibling	7	*17.9%*	-	-	-	-	-	-	1	2.0%	8	3.7%
Other Family	7	*17.9%*	1	4.8%	-	-	1	16.7%	-	-	9	4.2%
Other	-	-	1	4.8%	-	-	-	-	1	2.0%	2	0.9%
Not Known/ Not Recorded	-	-	2	9.5%	-	-	5	83.3%	3	6.0%	10	4.6%
Living Together												
Yes	21	*53.8%*	17	81.0%	71	71.0%	6	100.0%	24	48.0%	139	64.4%
No	15	*38.5%*	1	4.8%	28	28.0%	-	-	19	38.0%	63	29.2%
Not Known/ Not Recorded	3	*7.7%*	3	14.3%	1	1.0%	-	-	7	14.0%	14	6.5%
Suspect Charged												
Yes	25	*64.1%*	7	33.3%	54	54.0%	3	50.0%	-	-	89	41.2%
No	12	*30.8%*	11	52.4%	32	32.0%	-	-	48	96.0%	103	47.7%
No - Suspect Suicide	0	-	3	14.3%	11	11.0%	-	-	-	-	14	6.5%
Not Known or N/R	2	*5.1%*	-	-	3	3.0%	3	50.0%	2	4.0%	10	4.6%

Case Characteristics	Main Typology (2021/2022)											
	Adult Family		Child Death		Intimate Partner		Other		Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Incidents	**59**	***24.5%***	**10**	***4.1%***	**103**	***42.7%***	**5**	***2.1%***	**64**	***26.6%***	**241**	***100.0%***
Sub-Typology												
Familicide	-	-	-	-	2	*1.9%*	-	-	-	-	2	*0.8%*
Filicide / Child	3	*5.1%*	9	*90.0%*	-	-	-	-	-	-	12	*5.0%*
Fratricide/Sororicide / Sibling	9	*15.3%*	1	*10.0%*	-	-	-	-	-	-	10	*4.1%*
Intimate Partner	-	-	-	-	101	*98.1%*	-	-	-	-	101	*41.9%*
Other	6	*10.2%*	-	-	-	-	4	*80.0%*	-	-	10	*4.1%*
Other - Family	-	-	-	-	-	-	1	*20.0%*	-	-	1	*0.4%*
Parricide / Parents	41	*69.5%*	-	-	-	-	-	-	-	-	41	*17.0%*
Suicide - Family	-	-	-	-	-	-	-	-	3	*4.7%*	3	*1.2%*
Suicide - Intimate Partner	-	-	-	-	-	-	-	-	61	*95.3%*	61	*25.3%*
Suicide - No Suspect	-	-	-	-	-	-	-	-	-	-	-	-
Location of Incident												
Urban	54	*91.5%*	10	*100.0%*	95	*92.2%*	4	*80.0%*	55	*85.9%*	218	*90.5%*
Rural	5	*8.5%*	-	-	7	*6.8%*	1	*20.0%*	9	*14.1%*	22	*9.1%*
Not Known/ Not Recorded	-	-	-	-	1	*1.0%*	-	-	-	-	1	*0.4%*
Location of Death												
Victim's Home	41	*69.5%*	7	70.0%	72	69.9%	5	100.0%	38	59.4%	163	67.6%
Suspect's Home	5	*8.5%*	-	-	8	7.8%	-	-	-	-	13	5.4%
Other Residential Building	3	*5.1%*	1	10.0%	4	3.9%	-	-	9	14.1%	17	7.1%
Business Premises	-	-	1	10.0%	-	-	-	-	-	-	1	0.4%
Hospital	7	*11.9%*	1	10.0%	6	5.8%	-	-	4	6.3%	18	7.5%
Outside	3	*5.1%*	-	-	10	9.7%	-	-	12	18.8%	25	10.4%
Not Known	-	-	-	-	3	2.9%	-	-	1	1.6%	4	1.7%
Method of Death												
Blunt Instrument	7	*11.9%*	-	-	6	5.8%	1	20.0%	-	-	14	5.8%
Burning or scalding (Incl. Arson)	2	*3.4%*	-	-	1	1.0%	-	-	-	-	3	1.2%
Drowning	1	*1.7%*	1	10.0%	1	1.0%	-	-	4	6.3%	7	2.9%
Kicking or hitting	5	*8.5%*	3	30.0%	-	-	-	-	-	-	8	3.3%
Other	8	*13.6%*	2	20.0%	14	13.6%	1	20.0%	3	4.7%	28	11.6%
Poison or Drugs	1	*1.7%*	-	-	5	4.9%	-	-	15	23.4%	21	8.7%
Sharp instrument	26	*44.1%*	-	-	41	39.8%	2	40.0%	1	1.6%	70	29.0%
Shooting	1	*1.7%*	-	-	3	2.9%	-	-	-	-	4	1.7%
Strangulation (Incl. Hanging)	-	-	2	20.0%	15	14.6%	-	-	40	62.5%	57	23.7%
Suffocation	2	*3.4%*	1	10.0%	4	3.9%	-	-	-	-	7	2.9%
Not Known	6	*10.2%*	1	10.0%	13	12.6%	1	20.0%	1	1.6%	22	9.1%
Suspect Relationship to Victim												
Current Partner/Spouse	-	-	-	-	83	80.6%	-	-	43	67.2%	126	52.3%
Ex-Partner/Spouse	-	-	-	-	20	19.4%	-	-	18	28.1%	38	15.8%
Child	41	*69.5%*	-	-	-	-	-	-	-	-	41	17.0%
Parent	3	*5.1%*	8	80.0%	-	-	-	-	2	3.1%	13	5.4%
Sibling	9	*15.3%*	1	10.0%	-	-	-	-	1	1.6%	11	4.6%
Other Family	6	*10.2%*	1	10.0%	-	-	1	20.0%	-	-	8	3.3%
Other	-	-	-	-	-	-	3	60.0%	-	-	3	1.2%
Not Known/ Not Recorded	-	-	-	-	-	-	1	20.0%	-	-	1	0.4%
Living Together												
Yes	38	*64.4%*	10	100.0%	68	66.0%	3	60.0%	33	51.6%	152	63.1%
No	20	*33.9%*	-	-	30	29.1%	2	40.0%	28	43.8%	80	33.2%
Not Known/ Not Recorded	1	*1.7%*	-	-	5	4.9%	-	-	3	4.7%	9	3.7%
Suspect Charged												
Yes	40	*67.8%*	5	50.0%	54	52.4%	3	-	2	3.1%	104	43.2%
No	17	*28.8%*	5	50.0%	35	34.0%	-	-	61	95.3%	118	49.0%
No - Suspect Suicide	1	*1.7%*	-	-	14	13.6%	-	-	1	1.6%	16	6.6%
Not Known or N/R	1	*1.7%*	-	-	-	-	2	40.0%	-	-	3	1.2%

Risk Factor	Main Typology (2020/2021)											
	Adult Family		Child Death		Intimate Partner		Other		Suspected Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**45**	**18.9%**	**29**	**12.2%**	**107**	**45.0%**	**7**	**2.9%**	**50**	**21.0%**	**238**	**100.0%**
Alcohol use	9	20.0%	-	-	33	30.8%	3	42.9%	16	32.0%	**61**	**25.6%**
Drug misuse	12	26.7%	3	10.3%	22	20.6%	1	14.3%	13	26.0%	**51**	**21.4%**
Previously suicidal	6	13.3%	4	13.8%	18	16.8%	1	14.3%	8	16.0%	**37**	**15.5%**
Mental il health	23	51.1%	7	24.1%	32	29.9%	2	28.6%	13	26.0%	**77**	**32.4%**
Depression and anxiety	8	17.8%	2	6.9%	15	14.0%	-	-	8	16.0%	**33**	**13.9%**
Psychotic disorder	8	17.8%	4	13.8%	5	4.7%	-	-	1	2.0%	**18**	**7.6%**
Other mental health	14	31.1%	2	6.9%	15	14.0%	2	28.6%	5	10.0%	**38**	**16.0%**
Recent economic distress	3	6.7%	1	3.4%	8	7.5%	-	-	1	2.0%	**13**	**5.5%**
Suspect previously missing	4	8.9%	-	-	5	4.7%	-	-	-	-	**9**	**3.8%**
Housing insecurity/Homeless	2	4.4%	-	-	7	6.5%	1	14.3%	3	6.0%	**13**	**5.5%**
Honour based violence or abuse	-	-	-	-	-	-	-	-	-	-	**-**	**-**
Relationship ending	4	8.9%	1	3.4%	18	16.8%	-	-	13	26.0%	**36**	**15.1%**
Child custody dispute	2	4.4%	2	6.9%	2	1.9%	-	-	3	6.0%	**9**	**3.8%**
Previous DA perpetrator	19	42.2%	3	10.3%	47	43.9%	2	28.6%	37	74.0%	**108**	**45.4%**
Previous attempt/threat to kill	3	6.7%	1	3.4%	7	6.5%	1	14.3%	4	8.0%	**16**	**6.7%**
Previous use of weapon	1	2.2%	-	-	7	6.5%	-	-	5	10.0%	**13**	**5.5%**
Previous non-fatal strangulation	-	-	-	-	10	9.3%	-	-	16	32.0%	**26**	**10.9%**
Previous stalking/surveillance	1	2.2%	1	3.4%	8	7.5%	-	-	4	8.0%	**14**	**5.9%**
Previously raped/sexually assaulted victim	3	6.7%	2	6.9%	9	8.4%	1	14.3%	3	6.0%	**18**	**7.6%**
Protective orders	4	8.9%	1	3.4%	8	7.5%	-	-	4	8.0%	**17**	**7.1%**
Previous breaches of order	3	6.7%	-	-	9	8.4%	-	-	3	6.0%	**15**	**6.3%**
Suspect a previous DA victim	6	13.3%	5	17.2%	17	15.9%	-	-	8	16.0%	**36**	**15.1%**
Suspect carer for the victim	4	8.9%	26	89.7%	17	15.9%	1	14.3%	2	4.0%	**49**	**20.6%**
Victim carer for the suspect	2	4.4%	1	3.4%	4	3.7%	-	-	1	2.0%	**8**	**3.4%**
Coercive or controlling behaviour	6	13.3%	3	10.3%	33	30.8%	-	-	30	60.0%	**72**	**30.3%**

Risk Factor	Main Typology (2021/2022)											
	Adult Family		Child Death		Intimate Partner		Other		Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**62**	**24.4%**	**14**	**5.5%**	**104**	**40.9%**	**6**	**2.4%**	**68**	**26.8%**	**254**	**100.0%**
Alcohol use	20	32.3%	1	7.1%	35	33.7%	4	66.7%	30	44.1%	**90**	**35.4%**
Drug misuse	20	32.3%	4	28.6%	33	31.7%	4	66.7%	23	33.8%	**84**	**33.1%**
Previously suicidal	4	6.5%	-	-	16	15.4%	1	16.7%	17	25.0%	**38**	**15.0%**
Mental ill health	35	56.5%	6	42.9%	39	37.5%	1	16.7%	27	39.7%	**108**	**42.5%**
Depression and anxiety	10	16.1%	3	21.4%	21	20.2%	-	-	17	25.0%	**51**	**20.1%**
Psychotic disorder	12	19.4%	1	7.1%	5	4.8%	-	-	3	4.4%	**21**	**8.3%**
Other mental health	25	40.3%	5	35.7%	24	23.1%	-	-	10	14.7%	**64**	**25.2%**
Recent economic distress	6	9.7%	1	7.1%	5	4.8%	-	-	6	8.8%	**18**	**7.1%**
Suspect previously missing	1	1.6%	1	7.1%	6	5.8%	-	-	-	-	**8**	**3.1%**
Housing insecurity/Homeless	5	8.1%	1	7.1%	10	9.6%	3	50.0%	12	17.6%	**31**	**12.2%**
Honour based violence or abuse	-	-	-	-	2	1.9%	-	-	-	-	**2**	**0.8%**
Relationship ending	1	1.6%	-	-	20	19.2%	-	-	26	38.2%	**47**	**18.5%**
Child custody dispute	-	-	3	21.4%	2	1.9%	1	16.7%	8	11.8%	**14**	**5.5%**
Previous DA perpetrator	27	43.5%	6	42.9%	60	57.7%	2	33.3%	62	91.2%	**157**	**61.8%**
Previous attempt/threat to kill	1	1.6%	-	-	11	10.6%	-	-	9	13.2%	**21**	**8.3%**
Previous use of weapon	6	9.7%	-	-	14	13.5%	-	-	7	10.3%	**27**	**10.6%**
Previous non-fatal strangulation	3	4.8%	-	-	12	11.5%	-	-	4	5.9%	**19**	**7.5%**
Previous stalking/surveillance	-	-	-	-	10	9.6%	-	-	13	19.1%	**23**	**9.1%**
Previously raped/sexually assaulted victim	1	1.6%	-	-	8	7.7%	1	16.7%	10	14.7%	**20**	**7.9%**
Protective orders	4	6.5%	-	-	11	10.6%	-	-	13	19.1%	**28**	**11.0%**
Previous breaches of order	2	3.2%	-	-	10	9.6%	-	-	14	20.6%	**26**	**10.2%**
Suspect a previous DA victim	3	4.8%	4	28.6%	19	18.3%	1	16.7%	18	26.5%	**45**	**17.7%**
Suspect carer for the victim	22	35.5%	12	85.7%	8	7.7%	1	16.7%	4	5.9%	**47**	**18.5%**
Victim carer for the suspect	4	6.5%	-	-	-	-	-	-	3	4.4%	**7**	**2.8%**
Coercive or controlling behaviour	8	12.9%	-	-	39	37.5%	3	50.0%	41	60.3%	**91**	**35.8%**

Previous Police Contact	Main Typology (2020/2021)											
	Adult Family		Child Death		Intimate Partner		Other		Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**45**	***18.9%***	**29**	***12.2%***	**107**	***45.0%***	**7**	***2.9%***	**50**	***21.0%***	**238**	***100.0%***
Previous Police Contact - DA												
Yes	23	*51.1%*	10	*34.5%*	55	*51.4%*	2	*28.6%*	41	*82.0%*	131	*55.0%*
No	16	*35.6%*	17	*58.6%*	42	*39.3%*	3	*42.9%*	6	*12.0%*	84	*35.3%*
Not Known	6	*13.3%*	2	*6.9%*	10	*9.3%*	2	*28.6%*	3	*6.0%*	23	*9.7%*
Any Previous Police Contact												
Yes (to one or more)	35	*77.8%*	14	*48.3%*	78	*72.9%*	3	*42.9%*	43	*86.0%*	173	72.7%
Victim	7	*15.6%*	9	*31.0%*	30	*28.0%*	-	-	18	*36.0%*	64	26.9%
Suspect	26	*57.8%*	9	*31.0%*	70	*65.4%*	3	*42.9%*	38	*76.0%*	146	61.3%
Vulnerable	10	*22.2%*	5	*17.2%*	8	*7.5%*	1	*14.3%*	3	*6.0%*	27	11.3%
Other	2	*4.4%*	1	*3.4%*	9	*8.4%*	1	*14.3%*	1	*2.0%*	14	5.9%
Managed by Police/Probation												
Yes -Total	**5**	***11.1%***	**1**	***3.4%***	**16**	***15.0%***	**3**	***42.9%***	**1**	***2.0%***	**26**	***10.9%***
Yes - Unknown	3	*6.7%*	2	*6.9%*	11	*10.3%*	3	*42.9%*	1	*2.0%*	20	*8.4%*
Yes-Currently	2	*4.4%*	-	-	1	*0.9%*	-	-	-	-	3	*1.3%*
Yes - Previously	-	-	1	*3.4%*	4	*3.7%*	-	-	-	-	5	*2.1%*
No	35	*77.8%*	25	*86.2%*	80	*74.8%*	1	*14.3%*	33	*66.0%*	174	*73.1%*
Not Known/Recorded	5	*11.1%*	3	*10.3%*	11	*10.3%*	3	*42.9%*	16	*32.0%*	38	*16.0%*

Previous Police Contact	Main Typology (2021/2022)											
	Adult Family		Child Death		Intimate Partner		Other		Victim Suicide		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Total Number of Suspects	**62**	***24.4%***	**14**	***5.5%***	**104**	***40.9%***	**6**	***2.4%***	**68**	***26.8%***	**254**	***100.0%***
Previous Police Contact - DA												
Yes	29	*46.8%*	6	*42.9%*	65	*62.5%*	3	*50.0%*	64	*94.1%*	167	*65.7%*
No	33	*53.2%*	5	*35.7%*	38	*36.5%*	3	*50.0%*	4	*5.9%*	83	*32.7%*
Not Known	-	-	3	*21.4%*	1	*1.0%*	-	-	-	-	4	*1.6%*
Any Previous Police Contact												
Yes (to one or more)	48	*77.4%*	10	*71.4%*	79	*76.0%*	4	*66.7%*	64	*94.1%*	201	79.1%
Victim	16	*25.8%*	5	*35.7%*	33	*31.7%*	3	*50.0%*	36	*52.9%*	93	36.6%
Suspect	37	*59.7%*	7	*50.4%*	72	*69.2.0%*	4	*66.7%*	63	*92.6%*	183	72.0%
Vulnerable	13	*21.0%*	2	*14.3%*	14	*13.5%*	2	*33.3%*	10	*14.7%*	41	16.1%
Other	6	*9.7%*	-	*35.7%*	3	*2.9%*	-	-	4	*5.9%*	13	5.1%
Managed by Police/Probation												
Yes -Total	**3**	***4.8%***	**1**	***7.1%***	**12**	***11.5%***	**0**	**-**	**7**	***10.3%***	**23**	***9.1%***
Yes - Unknown	2	*3.2%*	1	*7.1%*	7	*6.7%*	-	-	4	*5.9%*	14	*5.5%*
Yes-Currently	1	*1.6%*	-	-	1	*1.0%*	-	-	1	*1.5%*	3	*1.2%*
Yes - Previously	-	-	-	-	4	*3.8%*	-	-	2	*2.9%*	6	*2.4%*
No	57	*91.9%*	8	*57.1%*	80	*76.9%*	5	*83.3%*	0	-	150	*59.1%*
Not Known/Recorded	2	*3.2%*	5	*35.7%*	12	*11.5%*	1	*16.7%*	61	*89.7%*	81	*31.9%*