

# DOMESTIC HOMICIDE PROJECT

## SPOTLIGHT BRIEFING #4: CARERS

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### BACKGROUND

The Domestic Homicide Project (the Project), based in the Vulnerability Knowledge and Practice Programme (VKPP), was established by National Police Chiefs' Council and the College of Policing. The Project was created in May 2020 through Home Office funding to collect, review, and share quick-time learning from all police-recorded domestic homicides and suspected suicides of individuals with a known history of domestic abuse victimisation. All police forces in England and Wales submit notice of relevant deaths to the Project shortly after the death occurs. The research is the first police-led work of its kind systematically collecting and analysing domestic homicides and suspected victim suicides following domestic abuse across England and Wales, aiming to learn lessons from every tragic death to seek to prevent future deaths. More detail, including key findings and recommendations, can be found in our first report, '[Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021](#)' and our forthcoming second year report (both available via [www.vkpp.org.uk](http://www.vkpp.org.uk)).

This briefing examines the role of the carer in more depth. It considers both where the victim was carer to the suspect and where the suspect was carer to the victim. For the purpose of this briefing, a carer has been defined as: anyone who is living with (or specifically mentioned as caring for) a victim/suspect with a disability or severe or long-term illness, whether physical or mental/neurological. This has been established from contextual information provided by the police forces and therefore is dependent on the information provided and the judgement of the Project Team. The subset of data includes domestic homicides and suspected victim suicides following domestic abuse where the victim and suspect are aged 16 and over. This briefing addresses an evidence gap identified by Bracewell et al. (2022) on domestic homicides involving carers.<sup>1</sup>

### CARERS – KEY FINDINGS

#### Case types and carer relationships

Between 1<sup>st</sup> April 2020 and 31<sup>st</sup> March 2022, the Project recorded a total of 470 domestic-abuse related deaths. Of these, 79 victims (17%, over one in six) were either cared-for by the suspect or were the carer of the suspect. The data presented in this briefing relates to this sub-set of victims.



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<sup>1</sup> Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J. and Chantler, K. (2022) 'Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic homicide', *Journal of Gender-Based Violence*, pp. 1–16. doi: 10.1332/239868021X16316184865237.

Table 1. Number of domestic abuse related deaths by year and case type

	Adult Family	Child Death	Intimate Partner	Other	Suspected Victim Suicide	Total
April 2020-March 2021	6	3	20	0	4	33
April 2021-March 2022	27	0	9	1	9	46
<b>Total</b>	<b>33</b>	<b>3</b>	<b>29</b>	<b>1</b>	<b>13</b>	<b>79</b>

Overall, there was a greater number (n = +13) of domestic abuse related deaths in which a caring relationship was identified in Year 2 (April 2021 - March 2022, n = 46) compared with Year 1 (April 2020 – March 2021, n = 33). Table 1 shows that, in terms of case type, overall, 42% (n = 33) of cases with caring relationships were adult family homicides (AFHs), with an increase of 21 between Year 1 (n = 6) and Year 2 (n = 27). The next largest category was Intimate Partner Homicide (IPH) accounting for 37% (n = 29). In contrast to AFH, there was a decrease in IPH from 20 in Year 1 to nine in Year 2. The next largest type of death was suspected victim suicide following domestic abuse at 16% (n = 13), which also increased between Year 1 (n = 4) and Year 2 (n = 9). There were also three child deaths where the victim was aged 16 or 17 years old, and one ‘Other’ where the relationship between victim and suspect was unclear but they had been living together. In the remainder of this briefing, deaths classified as Child Deaths and ‘Other’ are included in the total figures but, due to small numbers, have been removed from the presented analysis by case typology.



Figure 1. Nature of the caring relationship by year

Overall, in one-third of cases (n = 26) the victim was the carer to the suspect and in the remaining two-thirds of cases (n = 53) the suspect was carer to the victim (Figure 1). The proportion of victims as carers increased slightly in Year 2, predominantly driven by an increase in adult family homicides (AFH) (as discussed later).

**Key Point:** Cases involving a caring relationship increased overall from Year 1 to Year 2 as we emerged from the pandemic (by 39%); but this comprised a dual picture in which AFH deaths increased but IPH deaths decreased. It is possible that Covid-related restrictions put intimate partner cared-for victims at more risk; whereas emergence from the pandemic exposed victims of familial domestic abuse to more risk – especially where the suspect was cared-for by the victim

### Victim and suspect characteristics

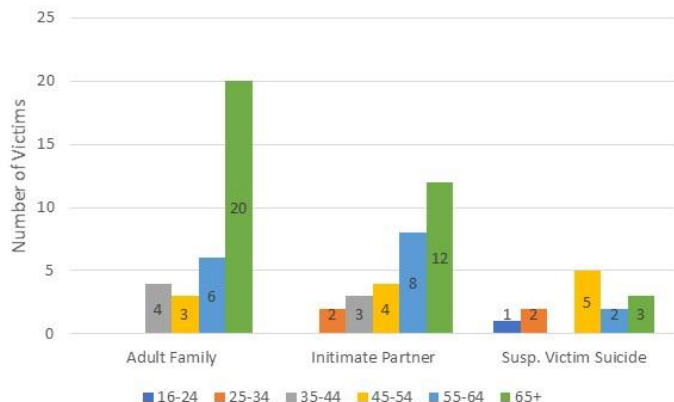


Figure 3. Number of victims by age group and case type

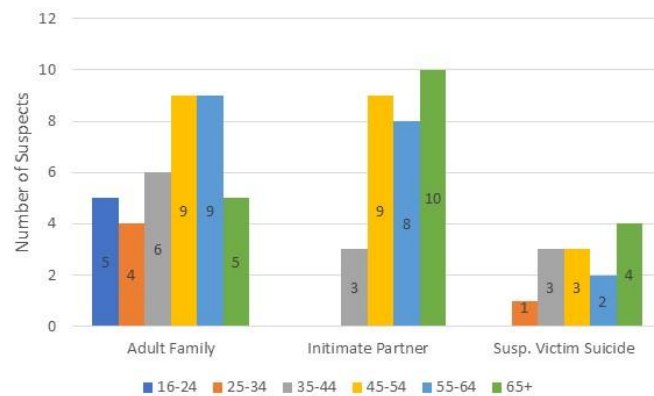


Figure 2. Number of suspects by age group and case type

Of the 79 victims with carer relationships, nearly three quarters (73%, n = 58) of victims were female and one quarter (27%, n = 21) were male.

Victims of adult family homicides (AFH) tended to be older than victims in other case types, with 79% (n = 26) aged 55 and over compared with 67% (n = 20) for Intimate Partner Homicides (IPH) (Figure 2). This finding is also consistently supported by prior research (Bows and Davies, 2019; Holt, 2017; Montique, 2019).<sup>2</sup>

Overall, there were 88 suspects associated with the 79 victims (in eight deaths there were two suspects). Of the 88 suspects, 78% (n = 69) were male and 22% (n = 19) were female.

Suspects of AFHs tended to be younger than those of IPH, with nearly two-fifths (n = 15) of AFH suspects aged under 45 compared with just a tenth (n=3) of IPH suspects (Figure 3). Conversely, IPH contained the greatest proportion of suspects aged 55 and over with 60% (n = 18).

**Key point:** Adult family homicide (AFH) victims tended to be older than intimate partner homicide victims. Conversely, AFH suspects tended to be younger than IPH suspects. This is in keeping with the profile of AFH which often involved (adult) children or grandchildren killing older relatives.

<sup>2</sup> Bows, H., & Davies P. (2019) Elder Homicide in the UK (2010–2015): A Gendered Examination. In: Bows H (eds.) Violence Against Older Women, Volume 1. Palgrave Studies in Victims and Victimology. Palgrave MacMillan; Holt, A. (2017) 'Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents and outcomes', *Criminology and Criminal Justice*, 17(5), pp. 568-587; Montique, B. (2019) *London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*. London: Standing Together Against Domestic Abuse. Available at: <https://www.standingtogether.org.uk/blog-3/london-dhr-case-analysis-and-review-launch-2020>.

### Detailed relationship of suspect to victim

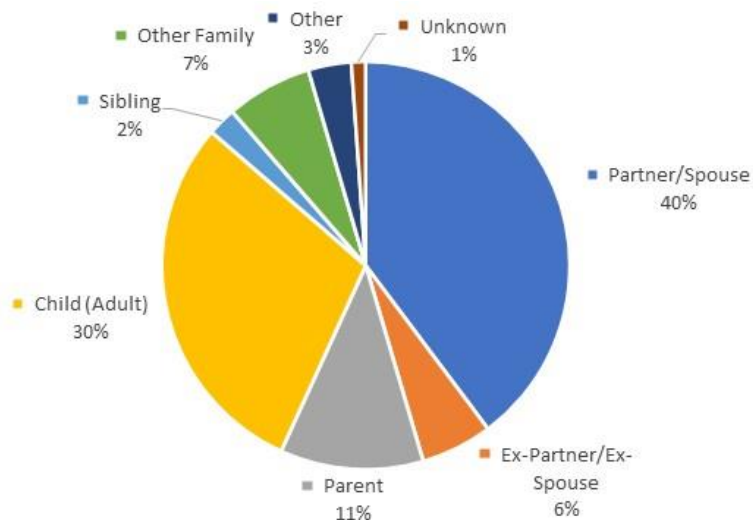


Figure 4. Proportional breakdown of the relationship between the suspect to the victim

The most common relationship between suspect and victim was current spouse or partner with 40% (n = 35) (Figure 4). Only 6% (n = 5) were an ex-spouse or partner. The next largest category of relationship was where the suspect was the victim’s (adult) child (30%, n = 26), and in all but two cases this was their son (and the daughter in the other two cases). It is of particular note that the number of suspects who were the (adult) child of the victim increased from five in Year 1 to 21 in Year 2. This is examined more closely in the next section.

Ten of the suspects were the parent of the victim (aged 16 and over) and six of the suspects were recorded as Other Family, which included two grandsons, a nephew and niece-in-law and a niece and nephew-in-law. Two suspects were the sibling of the victim and three were recorded as ‘Other’ and were privately organised carers who resided with the victim. There was one suspect where, although previously living with the victim, the police had not been able to establish the relationship between the suspect and victim at the time of submission.

### Direction of caring relationship (by case type)

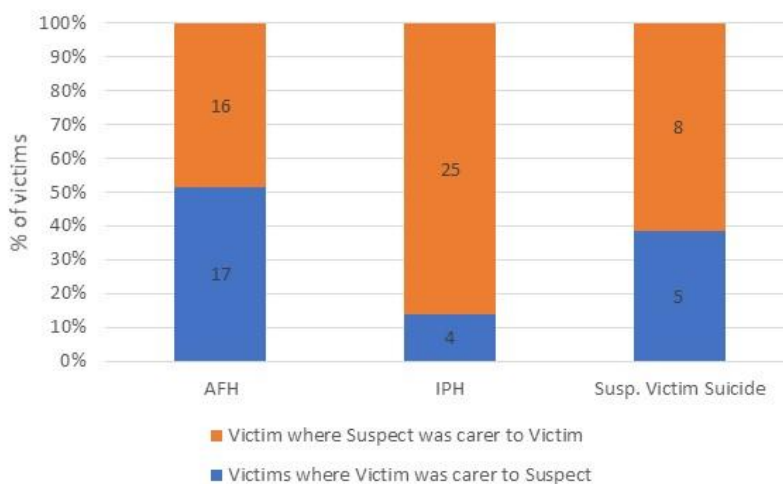


Figure 5. Nature of the caring relationship by case type

Overall, in two-thirds of cases the suspect was carer to the victim; however, whether the suspect or victim was the carer notably varied by case type (Figure 5). In the intimate partner homicide (IPH) cases it was far more common for

the suspect to have cared for the victim (86%, n = 25); only 4 cases involved the victim as carer for the suspect. By contrast, both the adult family homicide (AFH) and suspected victim suicide cases had a much more even split between suspect as carer (48%, n = 16 for AFH; 62%, n = 8 for suicides), and victim as carer (52%, n = 17 for AFH; 38%, n = 5 for suicides).

**Key Point:** The direction of caring relationship varied by case type, with IPH strongly involving a cared-for victim (86%, n = 25) whereas AFH and suspected victim suicides had an even split of cared-for victim and cared-for suspect.

### Type of care need

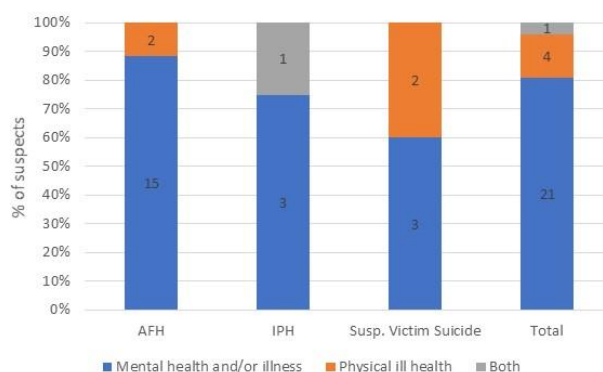
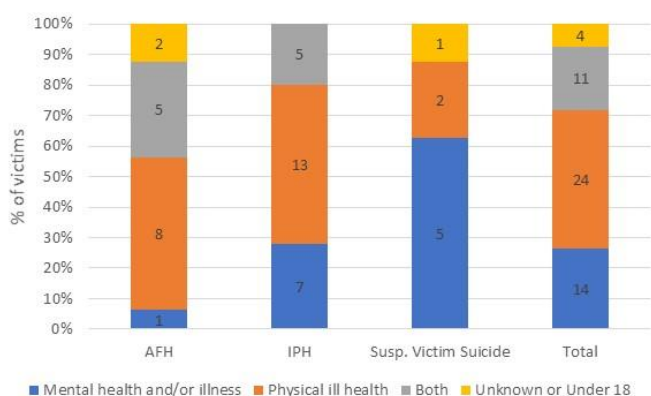


Figure 6. Proportion of victims by case type and care need

Figure 7. Proportion of suspects by case type and care need

Figures 6 and 7 show the difference in care need between cared-for victims and cared-for suspects. Overall, 45% (n = 24) of cared-for victims had physical health needs, 26% (n = 14) had mental health needs or illnesses (including dementia) and 21% (n = 11) had both. In contrast, 81% (n = 21) of cared-for suspects had mental health needs or illnesses, 15% (n = 4) had physical needs and just one had both.

Looking at AFH cases in particular, in all but two cases where the victim was the carer (15 out of 17) the suspect was recorded as having mental health issues or a mental health disorder. In the majority of cases (n = 12) the suspect was the son of the victim and in one case the daughter, as well as two cases where the suspect was the grandson. Where the suspect was recorded as having mental health issues/disorder, six (40%) were already known to mental health services. In one case the suspect had been released into the care of the victim just two days prior to the incident after being detained under the Mental Health Act 1983; and in another the suspect had been released from the hospital following a mental health assessment the morning of the incident. This ties in with the findings in the Adult Family Homicides Spotlight Briefing #1 which highlight that AFH suspects were most commonly characterised by mental ill health, caring responsibilities, and a lack of previous police and agency contact.

**Key point:** There was a different care needs profile between cared-for victims and cared-for suspects: the former having mainly physical health needs (45%) and the latter overwhelmingly mental health needs (89%).

### Previous contact with police and other agencies

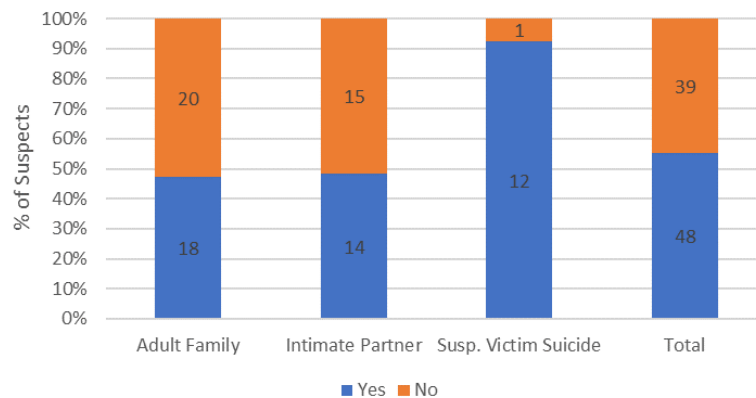


Figure 8. Proportion of suspects by case type and previous contact with police for domestic abuse

Overall, Figure 8 shows that just over half of suspects (55%, n = 48) had previous contact with the police for domestic abuse prior to the victim’s death. This was a similar picture for both AFH (47%, n = 18) and IPH (47%, n = 14). However, likely due to the way in which suspected victim suicides have been identified for this Project, all but one of the suspects in suspected suicide cases were previously known for domestic abuse.

Twelve victims (15%) were known to the police already as high-risk domestic abuse victims. Of these, five died by suspected suicide following domestic abuse and six were recorded as unexplained deaths.

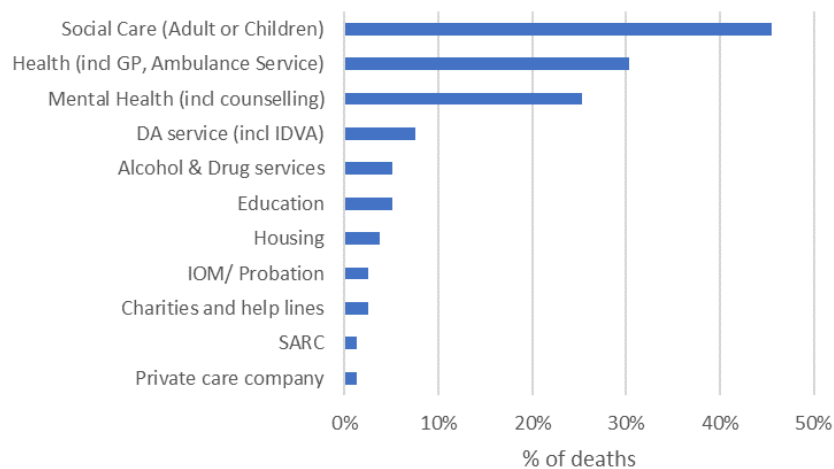


Figure 9. Proportion of deaths where the victim and/or suspect was known to other agencies other than the Police

Victims and/or suspects may have been known to more than one agency. Where it was recorded, the victim and/or suspect was known to non-police agencies in 71% of cases (n = 51/72). Overall, 46% (n = 36) of victims and/or suspects were known either to adult or children’s social services, health was involved in 30% (n = 24) of cases and mental health services in 25% (n = 20) (Figure 9). In addition, multi-agency groups were noted as being involved in 13 cases (MARAC = 9, MASH = 4, both MARAC and MASH = 1). Victims and/or suspects were known to specialist domestic abuse services in six cases, and alcohol and drug treatment services in four cases.

**Key point:** At least half of victims/suspects were previously known to the police. In addition, 71% were known to another agency – most commonly social care, health or mental health services.

## Features of the death

### Completed or attempted homicide-suicide

In just over one-fifth ( $n = 6$ ) of the intimate partner homicides (IPH) the suspect either died or attempted to die by suicide following the murder. This was more common in Year 1 (five cases) than Year 2 (one case). In all six cases the victims were female, cared-for by the suspect and five of the six victims were aged 65 and over. None of the victims were previously known to police. The details of these cases suggest that the victims were suffering with terminal illnesses such as dementia, cancer and organ failure. As part of the Project, police were asked to comment on the possible impact of the Covid-19 pandemic or associated restrictions on the incident. Although Covid related insight was only explicitly recorded for two of the cases, the Project's Year 1 report more broadly identified that the pandemic and lockdowns had affected the ability of several older couples to access care and health support.

### Neglect

The issue of neglect (as identified by police as a feature of the death) was present in a number of intimate partner (IPH) and adult family homicides (AFH) where the suspect cared for the victim. Overall, there were five IPHs where neglect was recorded, four in Year 1 and one in Year 2. In all cases the victim had physical ill health, and in all but one case the victim was female. In four of the five cases there had been no previous contact with police and the main agency to have prior knowledge of victim and/or suspect was health. There were eight AFHs (two in Year 1 and six in Year 2) where neglect was recorded by the police. The relationship of the suspects to the victims in these eight cases included nephew and niece-in-law, niece and nephew-in-law, step-son, brother, son, one case where the suspects were the son and two carers and two cases where the suspects were both parents. In these cases, there was a mixture of physical and mental health needs, including dementia and learning difficulties. As with the IPH cases, only a small number ( $n = 2$ ) of the eight AFH victims had previous contact with the police. However, five victims were known to other agencies, mainly Adult Social Care and health. Police suggested that there was an impact from Covid restrictions in one IPH and two AFH deaths. Information from the IPH case submission suggested that the victim and suspect had been shielding and had felt unable to seek medical assistance. On the other hand, in three AFH deaths it was recorded that the carers/suspects declined appointments and/or not accessed appropriate care for the victim. Moreover, in one of these cases police noted that "professionals felt that parents were obstructive to care and support".

**Key point:** In cases where police reported neglect as a feature of the death, or the suspect-carer died (or attempted to die) by suicide following the homicide, victims and suspects were less likely to be known to the police.



## KEY LEARNING AND PRACTICE IMPLICATIONS FOR AGENCIES



**Key message #1** – One in six domestic abuse related deaths involved a caring relationship. This was most pronounced in adult family homicides (AFH).



**Key message #2** – The direction of caring relationship varied by case type, with most intimate partner homicide (IPH) involving a cared-for victim (86%); by contrast AFH and suspected victim suicides had an even split of cared-for victim and cared-for suspect.



**Key message #3** – There was a different care needs profile between cared-for victims and cared-for suspects: the former having mainly physical health needs (45%) and the latter mental health needs (89%).



**Key message #4** – Where neglect was present, most victims/suspects had no previous contact with police, but most had previous involvement from health agencies and/or Adult Social Care.



**Key message #5** – The pandemic seems to have made it harder for vulnerable carers and those being cared-for to access outside support and help, for both physical and mental needs and for care support. When support is withdrawn, scarce or more difficult to access, risks increase.



**Practice point #1** – Police should be aware that where domestic abuse and caring relationships overlap this may increase the risk to the victim, especially in adult family homicides. In completing DASH/DARA risk assessments, police should establish the nature of the caring relationship and ask how that might impact the DA risk. Police should consider referring to MARAC and/or making an adult safeguarding referral in such cases.



**Practice point #2** – Front line officers should use professional curiosity where they suspect that carers are preventing those they are caring for from accessing health and support services, and ensure this information is shared appropriately with other agencies through local safeguarding processes.



**Practice point #3** – In carrying out Care Act Assessments and reviews of Care Plans, relevant (non-police) agencies should look beyond care needs and carer stress, and always consider vulnerability and domestic abuse. They should always consider a referral in these cases into multi-agency forms such as MARAC and MASH.



**Practice point #4** – Where policing comes into contact with an individual experiencing mental ill health and there is a caring dynamic within the home setting, this should be included in risk assessments and shared with mental health services.