DOMESTIC HOMICIDE PROJECT
SPOTLIGHT BRIEFING #5
SUSPECTED VICTIM SUICIDE FOLLOWING DOMESTIC ABUSE

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1. INTRODUCTION

The Domestic Homicide Project (the Project), based in the Vulnerability Knowledge and Practice Programme (VKPP), was established by National Police Chiefs' Council, the College of Policing and the Home Office in May 2020. The Project aims to collect, review, and share quick-time learning from all police-recorded domestic homicides and suspected suicides of individuals in England and Wales with a known history of domestic abuse victimisation (hereafter 'suspected victim suicide') to learn lessons from every tragic death to seek to prevent future deaths.[1] All police forces in England and Wales submit notice of relevant deaths to the Project shortly after the death occurs.

The Project's definition of suspected victim suicides is: *"apparent suicides and unexplained or suspicious deaths that appear to be as a result of / following domestic abuse victimisation (e.g., non homicide cases with long-term missing person, deaths from drug overdoses in suspicious circumstances)".* 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.

The Project's Year 2 Report (December 2022)[2] for the first time presented detailed analysis of suspected victim suicides submitted to the Project over a 24-month period between 1st April 2020 and 31st March 2022. This included profiling suspected victim suicide cases, including potential risk factors and emerging themes from qualitative analysis of individual cases. It also presented learning from 'deep dives' conducted with five police forces in England and Wales and a short survey of forces, which received responses from 13 forces.

This briefing summarises key findings for police on suspected victim suicide from the Year 2 Report and highlights key practical learning and practice recommendations. It covers:

- Scale and nature of suspected victim suicides following domestic abuse
- Risk factors, prior agency contact and Domestic Homicide Reviews (DHRs)
- Investigating suspected victim suicides following domestic abuse
- Promising practice to identify and prevent victim suicide
- Key findings and practice recommendations for police

[1] Please note that the Project does not collect data on suspected suicides involving suspects of domestic abuse, as this is outside the remit.

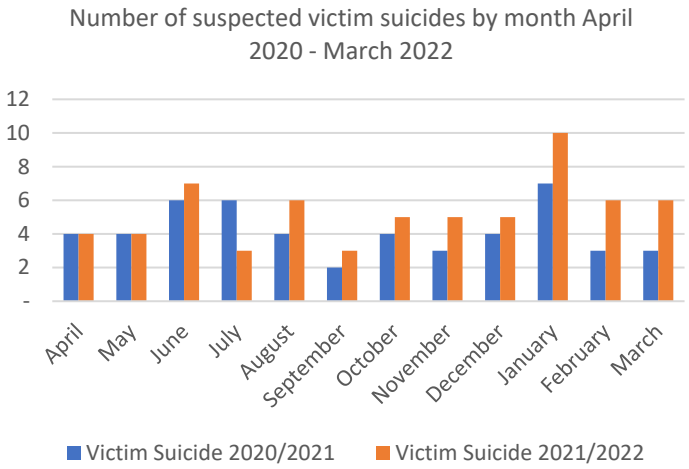
[2] Bates, L. et al. (2022) Domestic Homicides and Suspected Victim Suicides 2021-2022 Year 2 Report. Vulnerability Knowledge and Practice Programme (VKPP). Available at: https://www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf.

2. SCALE AND NATURE OF SUSPECTED VICTIM SUICIDE FOLLOWING DOMESTIC ABUSE

Number of deaths

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% between years. This is likely as a result of police getting better at identifying and submitting relevant deaths.

In all, 95% (n = 107) of the preceding domestic abuse was from an intimate partner, with 5% (n = 6) from a family member. This shows that the abuse profile of the suspected victim suicide cases is closest to that of intimate partner homicides.

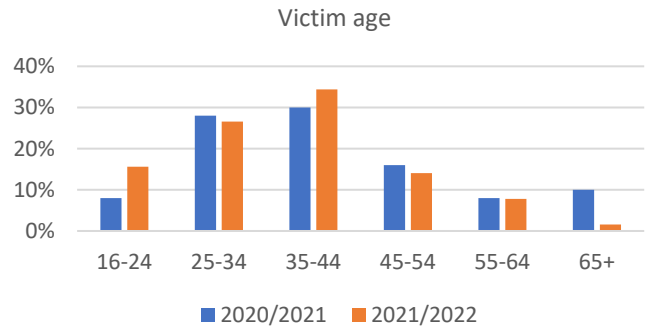


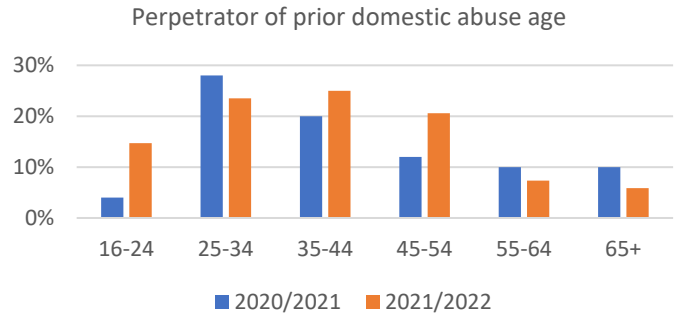
Victim and perpetrator of prior domestic abuse characteristics

Victim and perpetrator of prior domestic abuse sex

Female victims were by far the most common across both years, at 85% (n = 97), with male victims accounting for 15% (n = 17). Closer analysis in year two of the 10 intimate partner cases involving male victims found that one-fifth (n =2) involved LGBTQ+ relationships in which both the victim and perpetrator of the prior domestic abuse were male; the other cases involved female perpetrators with male victims. Notably, in all these suspected victim suicide cases involving a male victim and female intimate partner perpetrator, the male victim also had a record of perpetrating domestic abuse against either this or against a previous partner.

Victim and perpetrator of prior domestic abuse age





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)). The proportion of older victims aged 65 years and over went down in Year 2 (from 10% (n = 5) to 2% (n = 1)).

A number of younger victims were university students. In several cases, the victim had significant contact with their university, either with 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 one 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 from the victim's family as part of the investigation after the death.

Victim and perpetrator of prior domestic abuse ethnicity

Victims were mainly of white ethnicities across both years (88%, n = 100). 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. As with victims, whilst the majority of perpetrators were of white ethnicities (87% across both years, n = 103), the proportion of perpetrators of black ethnicities went up from 2% (n = 1) in Year 1 to 9% (n = 6) in Year 2.

LGBTQ+ victims and perpetrators of prior domestic abuse

Whilst most victims were not identified as LGBTQ+ across both years (82%, n = 93), there was a rise in LGBTQ+ victims in Year 2 (13% (n = 8) compared with 4% (n = 2) in Year 1). Of these eight LGBTQ+ victims in Year 2, five were female and three male and they were in both female and male same-sex partnerships.

Victim 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).

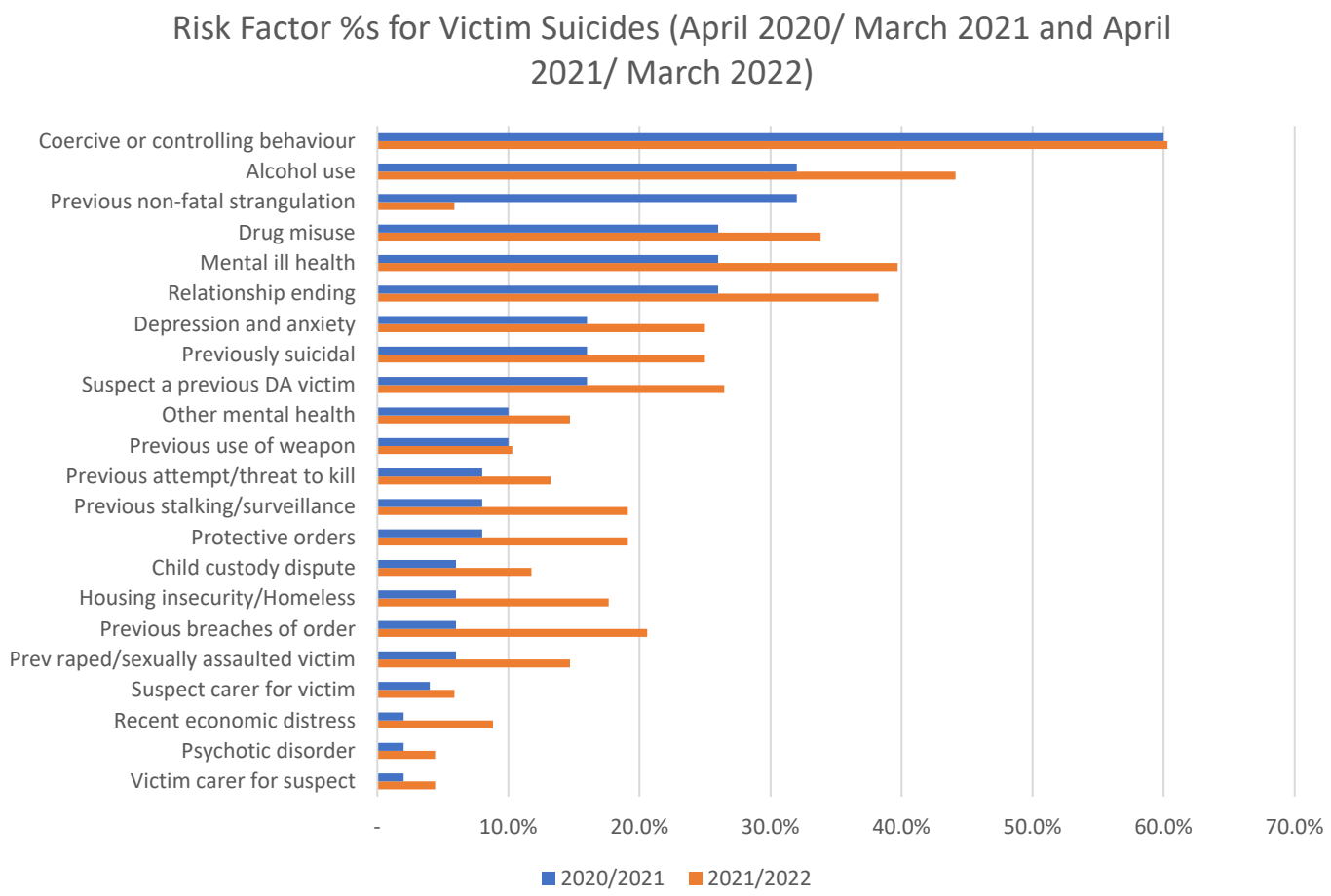
Method of death

The method of death was most commonly hanging, accounting for 55% (n = 63) of cases across both years; followed by poison or drugs (26%, n = 30). There was a rise in deaths by hanging in Year 2 compared with Year 1 (from 46% (n = 23) to 63% (n = 40)).

Key Learning Points:

- Suspected victim suicide is strongly characterised by intimate partner domestic abuse, it is heavily gendered, and victims are most commonly in their mid 20s to mid 40s.
- Universities need to work to and be cognisant of local partnership safeguarding requirements and referral processes, to help safeguard young domestic abuse victims.
- Most commonly deaths occurred by hanging, poison or drugs.

3. RISK FACTORS RELATED TO THE PERPETRATOR



A history of coercive control in suspected suicide cases remained high in both years (at 60%). Previous non-fatal strangulation was significantly ($p<0.05$) associated with suspected victim suicide (as opposed to other case types). Drug and alcohol misuse and mental ill health by the perpetrator were common antecedent risk factors, as was the relationship ending and perpetrator prior threats of suicide. Stalking, surveillance, and sexual violence were also risk factors identified in the history of these cases. Additionally, across both years, one-third (n = 36) of the perpetrators of the prior domestic abuse in suspected victim suicides were known to police already as high-risk or serial domestic abuse perpetrators. Furthermore, across both years, over two-thirds (n = 47) of perpetrators in these cases were known to MARAC (multi-agency risk assessment conferences).

Key Learning Points:

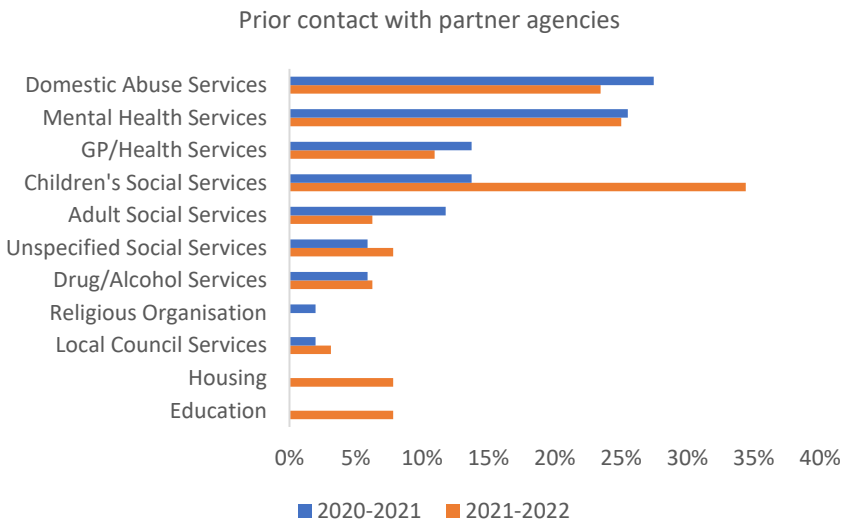
- Controlling and coercive abuse is highly present in the history of suspected victim suicides.
- Perpetrators of the prior abuse are often high risk or serial perpetrators, with two-thirds known to MARAC.

4. Prior Agency Contact

Other than the police, victims and domestic abuse perpetrators in suspected victim suicides were most commonly known to domestic abuse services, mental health services, GP/health services, children's social care and adult social services.

Key Learning Point:

Victims are frequently known to domestic abuse and mental health services – they are not hidden.



5. Domestic Homicide Reviews (DHRs)

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)[3]. 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).[4] 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 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, 2022, p. 67).[5]

In our dataset, where known, 96% of victim suicide cases were confirmed by police as having been referred to a CSP for a DHR. This rose from 90% in Year 1 to 100% in Year 2). Additionally, 91% were accepted (rose from 87% in Year 1 to 94% in Year 2). Police forces reported 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 have driven a rise in referral and acceptance rates year-on-year. However, limited resources in some CSPs to fund reviews meant some forces experienced a lower acceptance rate in proportion to their referrals. Bereaved families reported mixed experiences of reviews including DHRs. Some felt they had experienced attitudes which they described as dismissive, victim-blaming or careless.

[3] 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.
[4] 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
[5] Home Office (2022) Tackling Domestic Abuse Plan. Available at: https://www.gov.uk/government/publications/tackling-domestic-abuse-plan.

Key Learning Points:

- As with domestic homicides, the proportion of suspected victim suicides referred and accepted for DHRs is increasing year on year: in the last year, where the referral and acceptance outcomes were known, 100% were referred and 94% accepted for a DHR.
- There remains a need for revised Home Office guidance giving clarity to Community Safety Partnerships (CSPs) on commissioning DHRs for suspected suicides.
- Specific recommendations relating to DHRs in suspected victim suicide cases are made in our Year 2 Report, page 13-14 (Recommendation 5 and Recommendation 6).

POLICE PRACTICE FINDINGS & RECOMMENDATIONS

6. INVESTIGATING SUSPECTED SUICIDES FOLLOWING DOMESTIC ABUSE

Context

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)[6]:

- 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).[7] 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, *forthcoming*).[8]

[6] 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.pd

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

[8] College of Policing (*forthcoming)* Categories for unexpected death investigations. College of Policing.

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).[9] 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).[10] Following the publication of this 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.

Our findings

Sudden and unexpected death policies

We found that individual forces differ considerably in their policies and treatment of suspected suicides, including use of terminology. For instance, one force's Standard Operating Procedures (SOP) on Investigating Deaths distinguishes between 'Sudden' and 'Suspicious' Deaths and stipulates that suspected suicides should always be treated as Suspicious Deaths; whilst the Death Investigation Policy in another force refers to a suspected suicide as an example of 'non-suspicious sudden death'. Individual force policies also vary on how to account for domestic abuse as part of the evidence-gathering process in a suspected suicide. Some have specific guidelines on dealing with suspected suicides which include a requirement to 'identify whether there is any history of domestic violence' or to carry out 'intelligence checks on the deceased and other subjects, particularly important where any domestic violence issues are present and may inform decisions as to any suspicion'.

Checks on the scene

We found that the initial police response to a report of a sudden or unexpected 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. Responding officers will conduct an initial check on the victim (and the address) via the Police National Computer (PNC) and the force's own crime recording system, but how and when these checks are completed differs. For instance, some forces complete checks before attending the scene (e.g., en-route), or while on the scene; whereas others conduct these checks after leaving the scene, during the completion of their initial report. Overall, there is varied practice among forces in terms of when checks are completed, which individual checks are completed, whether checks encompass both crime and non-crime incidents, and on which national and force databases checks are run.

Death report to coroner

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. We found that 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

[9] 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/.

[10] 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.

requested contents. In this way, local coroners may differ in what they request officers to complete. We did not find any Sudden Death forms which ask specifically about a history of domestic abuse, but most forms do request some level of the PNC and force level system checks described above.

Listing household members and next of kin

We found that attending officers may not be routinely recording all individuals present in the household at the time of a death. This could prevent the identification of domestic abuse, appropriate enquiries being made relating to that individual, and evidence-gathering in relation to later coronial inquest investigations. Additionally, one 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. This risks the domestic abuse perpetrator being able to control the narrative.

Early, proactive intelligence gathering

We found that gathering of relevant information from family and friends is particularly important to the process of identifying a history of domestic abuse. Whilst there are pockets of individual good practice, this is currently not carried out in a systematic way. As shown by several cases in the Project dataset, family and friends may have crucial information about the abuse which was not previously disclosed or known to police or other partner

Supervisory review

Most forces have a policy for a supervisory officer to review the responding officer's actions in sudden or unexpected deaths. However, we found a lack of clarity across forces about whether this supervisory requirement is for supervision in-person on the scene, or for a desk-based review of the initial case file. Which approach is taken by forces is seemingly dependent on the circumstances of the death and resource availability.

In practice, and in line with College of Policing guidance, if the circumstances at the scene are not perceived to be suspicious, the initial investigation would be paused at that point when all initial investigative avenues are exhausted at the scene. Therefore, if a history of abuse is 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 does come to light after the initial response, including when officers complete an investigation on behalf of the Coroner, and where this happens, the police may re-examine the case. Police suggested the need for a shift in investigative mindset, to emphasise professional curiosity amongst all officers attending and reviewing such deaths.

7. Promising Practice to Identify and Prevent Victim Suicides

Promising Practice #1: Real Time Suicide Surveillance Systems (RTSSS)

RTSSS bring together reports of suicides in a local area with information held by partner agencies in police, health, social services, and sometimes domestic abuse services. RTSSS track the number of completed and attempted suicides locally, but also capture information such as the location and method to help identify patterns for preventive interventions. We heard several examples of applied use of RTSSS to identify suicide cases involving domestic abuse. For instance, one force added questions to its RTSSS to capture the victim's history of domestic abuse. Where a suicide occurred, the RTSSS could be consulted to see if there was knowledge of prior domestic abuse unknown to police. Moving towards prevention, another force has implemented a process whereby an attempted suicide of a domestic abuse victim is reported to the local Independent Domestic Violence Advocate (IDVA) service, who contacts that individual to provide additional support.

Promising Practice #2: Posthumous Prosecutions

Several forces have attempted to prosecute the domestic abuse perpetrator after the victim's suicide for the prior controlling or coercive behaviour (CCB) or another domestic abuse-related offence including manslaughter. Some forces pursued a posthumous charge straightaway; others re-opened the investigation when new information came to light (e.g., during an inquest). In only one or two cases have posthumous prosecutions for the preceding abuse been successful, with CPS evidential thresholds cited as a particular challenge; but our Year 2 report contains two case studies of attempted prosecutions. Early consultation with family and friends, and proactive use of existing evidence (digital, BWV) seems to be key to success.

Promising Practice #3: Dedicated suicide prevention posts and partnerships

Several forces described investing strategically in posts and multi-agency partnerships to prevent suicide related to domestic abuse. One force implemented a Suicide Prevention and Vulnerability Officer post. As well as monitoring and identifying relevant deaths, this person runs safeguarding events for police and partners, and established training as part of police officer continued professional development. Another force enshrined domestic abuse as a priority within their local Suicide Prevention Strategy, whilst another established a dedicated multi-agency Domestic Abuse Suicide Prevention Working Group; another conducts a weekly review of all suspected suicides to learn lessons about prevention, trends and support needs.

Promising Practice #4: Early information sharing with coroners

Some forces have established local practices with the coroner to identify relevant deaths. In one force, the Suicide Prevention Officer cultivated strong lines of communication with the coroner, which meant that relevant information could be shared early. For instance, he lets the coroner know if the deceased's family mentioned past domestic abuse; the coroner in turn alerts him of overnight deaths in hospital where the police might not otherwise have known about the death (but they might have information on domestic abuse history. Another force described proactively reviewing and identifying previously unknown domestic abuse from family and friends' witness statements to the coroner for inquest.

8. Key Findings and Practice Points for Police

Key Finding #1 – There is variation in how and when police conduct system checks for prior domestic abuse when attending an unexpected death or suspected suicide. Some response officers complete checks before attending, or when at the initial scene, others after leaving the scene and during the write up of the initial report.

Practice Point #1 – Reasonable and prompt system checks should be made for any known history of domestic abuse crimes and non-crime incidents. 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 (e.g., on call-handling, intelligence, and public protection systems) – this should involve consulting local partners for intelligence of any history of domestic abuse undisclosed to police.

Key Finding #2 – Most force policies require a supervisory officer to review the attending officer's actions, but it is inconsistent whether this result in supervision in-person on the scene, or a desk-based review of the initial case file, with the approach taken seemingly dependent on the circumstances of the death and resource availability.

Practice Point #2 – In line with forthcoming guidance from the College of Policing on unexpected deaths, a PIP 3 Senior Investigating Officer (SIO) should be appointed to provide oversight of all unexpected death investigations. Oversight review should consider any evidence of domestic abuse history.

Key Finding #3 – If a history of abuse is not identified in the early stages of the investigative response, future opportunities to hold the perpetrator to account could be limited. 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 the police reviewed the case.

Practice Point #3 - When attending the scene of an unexpected death, police must always apply professional curiosity and an investigative mindset to test the obvious explanation. Attending officers should be alert to signs or disclosures of a history of domestic abuse, especially coercive control.

Key Finding #4 – Following a sudden or unexpected death, officers notify the 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: whilst they ask for information of the circumstances of the death, there is no routine prompt about domestic abuse history.

Practice Point #4 – The NPCC should explore with coroners whether there is scope for standardising police unexpected death investigations. This might include whether unexpected death reports could be standardised across forces.

Key Finding #5 – Attending officers might not routinely record all individuals present in the household at the time of the death. Not doing so can prevent the identification of domestic abuse and of evidence-gathering in relation to later coronial inquest investigations.

Practice Point #5 – Initial police enquiries in unexpected deaths 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 in the household; and (3) contact close associates and others who may have information about a history of domestic abuse, including family, friends and neighbours. Any relevant information uncovered could be included in the 'circumstances of death' section in the death report to Coroners.