Domestic Homicides and Suspected Victim Suicides 2020-2025

Year 5 Report

National Centre for Violence Against Women and Girls (VAWG) and Public Protection

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'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, CEO Advocacy After Fatal Domestic Abuse (AAFDA)

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Foreword – Police Chiefs and the College of Policing

The response to and prevention of Violence Against Women and Girls (VAWG) is a priority within policing. Police chiefs have described VAWG as a national emergency and have called for a whole system approach that brings criminal justice and multi-agency partners, government bodies and industry together to tackle the threat through prevention, pursuit of perpetrators and support for victims and their families. To match our commitment and ambition we launched our National Centre for Violence Against Women and Girls and Public Protection (NCVPP) in 2025 to ensure we coordinate our national response.

The Domestic Homicide Project is in its fifth year, and the collective number of domestic homicides, unexpected deaths and suspected victim suicides following domestic abuse is stark. This highlights the extent of our challenge. The devastating impact of such crimes on victims and their families is not lost on policing, and we need to do more alongside other agencies to protect victims from such horrendous crimes.

The Domestic Homicide Project's work has helped to raise the profile of the impact of domestic abuse on victims, including its link to suicide. In 2025, the Project's research informed updated guidance about the response to unexpected deaths, highlighting the importance of identifying any history of domestic abuse and the implications of this for investigation and potential to pursue a prosecution. It is encouraging to see that this work is part of the Government's VAWG strategy 2025-2030.

As always, our work has been greatly supported by numerous stakeholders, charities and academics who are experts in this field. This work would not be possible without their contribution. We would also like to take the opportunity to remember the many victims and their families who have lost loved ones, many of whom have continued to help guide our work over the past five years. We are thankful for your support and contribution.

AC Louisa Rolfe OBE
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Policing Reform Lead,
NPCC Crime Coordinating Committee Chair, NPCC Lead Domestic Abuse

T/DCC Rob Griffin
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Director NCVPP

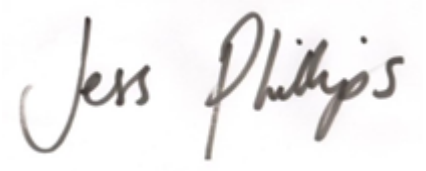
Foreword – Minister for Safeguarding and Violence Against Women and Girls

In the fight to protect women and girls in our society, the human cost of domestic abuse cannot be overlooked. On average, police in England and Wales record a domestic abuse related crime every 40 seconds. The Domestic Homicide Project has demonstrated the scale and nature of domestic abuse related deaths, of which more than two thirds involve female victims. This research has also shown that overall, there are increasing numbers of reported cases where a victim of domestic abuse has taken their own life. This is a national emergency, and we must treat it as such.

As Minister for Safeguarding and Violence Against Women and Girls (VAWG), I am absolutely committed to tackling all domestic abuse related deaths. We must continue building our understanding and embed the learning gathered from all sectors to protect victims and, ultimately, prevent future deaths.

Freedom from Violence and Abuse: a cross-government strategy, was published in December 2025 and sets out the Government's plans to halve VAWG over the next decade. The work of the Domestic Homicide Project is a crucial part of this. We have committed to exploring the possibility of expanding the project's scope in future years to capture all deaths that occur in the context of VAWG. This will enable a more comprehensive understanding of every death resulting from these forms of violence and abuse, to improve our response and take decisive action to prevent further loss of life. The Domestic Homicide Project has reached a significant milestone this year, with five years of data on domestic abuse related deaths which is not captured elsewhere. With such a solid foundation, the insights from the project can now be applied to wider policy development to confront the most severe and heartbreaking outcomes of violence and abuse.

I want to extend my sincere thanks to the National Centre for VAWG and Public Protection, the National Police Chiefs' Council and the College of Policing, and all those who have contributed to this project. I look forward to the next five years, as we continue to work together to drive meaningful changes to support victims and survivors of domestic abuse.



Jess Phillips MP

Minister for Safeguarding and Violence Against Women and Girls

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Summary of Findings and Recommendations

In 2020 the Domestic Homicide Project was established by police and government[7] in England and Wales to collect, review, and share quick-time learning from all police-recorded domestic homicides, unexpected deaths[8] and suspected suicides of individuals with a history of domestic abuse (DA) victimisation. In the wake of the Covid-19 pandemic, the project aimed to establish the impact of the pandemic and associated restrictions on domestic homicides and learn lessons from every tragic death to seek to prevent future deaths. Based on its unique contribution, the project has been embedded and expanded to fill a gap in information not available elsewhere or within the same timescales.[9]

In this year's report the project team has included figures for six typologies: intimate partner homicide (IPH); adult family homicide (AFH); unexpected death; suspected victim suicide following domestic abuse (SVSDA); child death; and deaths classified as 'other' (those who live together but are not intimate partners or family members). In some cases, the report presents data within the combined category of domestic homicides, which includes both IPH and AFH.

Chapter 2: Domestic Homicides, Unexpected Deaths and Suspected Victim Suicides Following Domestic Abuse, April 2020 - March 2025

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Findings

Finding 1: Across the full five-year dataset (1st April 2020 – 31st March 2025) the project recorded 1452 deaths in 1410 incidents. These deaths were spread across the following typologies: 641 domestic homicides (including 414 IPH + 227 AFH), 553 SVSDA, 131 unexpected deaths, 86 child deaths and 41 deaths classified as 'other'.

In Year 5 (1st April 2024 – 31st March 2025), there were a total of 347 deaths, which is an increase of 33 deaths as compared to the updated figure of 314 reported to have occurred in Year 4 (1st April 2023 – 31st March 2024). The 347 deaths reported in Year 5 included

[7] The Project is funded by the Home Office, with strategic leadership from the NPCC and College of Policing and is housed within the National Centre for Violence Against Women and Girls and Public Protection (NCVPP).

[8] 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.

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

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

Finding 2: SVSDA remains the most recorded typology across the full five-year dataset (38%, n=553).

The number of IPH deaths has remained relatively stable over the five years of data collection. This continues to highlight the enduring issue of abuse by an intimate partner, its consequences and the need to work towards prevention.

The relatively small proportion of child deaths reported in Year 5 (5%, n=17) indicates that they are still likely to be underreported by police forces. The reported data appears to reflect child deaths with a perceived link to DA or associated with a familicide and may be impacted by the statutory definition of domestic abuse including those aged 16 and older which is discussed further in Section 3.2.

Recommendations

Recommendation 1 – To the NCVPP and College of Policing [PREVENTION]: For the NCVPP to work with the College of Policing to consider how the key findings and recommendations can be shared within domestic abuse training for all officers.

Recommendation 2 – To the Government, NCVPP, Department for Education, National Child Mortality Database, police and partners [PREVENTION]: To work in partnership to ensure the identification, recording and submission of cases involving individuals under 16. To consolidate data from sources such as the National Child Mortality Database and police systems to ensure the scale and prevalence captures all domestic abuse-related child deaths, including unexpected deaths, suspected suicides and deaths related to teenage relationship abuse.

Recommendation 3 - To the College of Policing and NCVPP [PREVENTION]: To work with partners and relevant stakeholders to update guidance for police practice, safeguarding and referrals for support in response to domestic abuse experienced by children and young people, including teenage relationship abuse.

Recommendation 4 - To the NCVPP and Domestic Homicide Project [PREVENTION]: Further to the Government's Violence Against Women and Girls (VAWG) Strategy commitment, the NCVPP and Domestic Homicide Project should consider scoping the expansion of this research to wider fatal VAWG, subject to agreement on definition and inclusion criteria as well as appropriate resourcing.

Chapter 3: Typologies and characteristics of victims and suspects

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Findings

Finding 3: Across the five-year dataset, the most common method of death was by hanging (23%, n=330/1452), accounting for 59% (n=326/553) of SVSDA deaths. Sharp instrument was the second most common method of death overall (22%, n=323/1452), and the most common in cases of IPH (40%, n=166/414) and AFH (49%, n=111/227), accounting for 43% (n=227/641) of domestic homicides.

Additional analysis showed that of the 323 sharp instrument-related deaths, 93% (n=299) occurred in private spaces, reflecting how readily available knifes are, particularly within domestic settings.

Finding 4: In Year 5 alone (April 2024 – March 2025), 18 cases involving a fall from height were reported by forces to the project, increasing the total to 39 deaths involving this method of death across the five years of data collection. The 18 cases reported in Year 5 cases represent a threefold increase from the six cases reported in Year 4. This may be evidence of an increased understanding and awareness of such cases involving a history of domestic abuse rather than an empirical rise in this type of death.

Finding 5: Across the five years of data collection, 69% (n=1069/1554) of suspects were the current (46%, n=714) or ex-partner/spouse (23%, n=355) of the victim. Suspects of IPHs were most commonly recorded as the victim's current partner/spouse (83%, n=351/423), whilst SVSDA cases represented the highest proportion of suspects recorded as the victim's ex-partner/ex-spouse (43%, n=266/622). This is also reflected in the prevalence of recent separation or threat of relationship ending as a risk factor within SVSDA cases (see Chapter 4 for further discussion). Additionally, the suspect was the child of the victim in 11% (n=165) of cases across all five years, primarily in cases of AFH (53%, n=128/240).

Finding 6: Across the five-year dataset, victims were predominantly female (73%, n=1058/1452), and suspects predominantly male (79%, n = 1229/1554). In domestic homicide cases (AFH & IPH) and SVSDA cases (n=1187), most incidents involved one victim and one suspect (92%, n=1091), most frequently with a female victim and male suspect (72% of n=1091, n = 785). This pattern was particularly pronounced in IPH cases, where the majority involved a female victim and male suspect (84%, n=324/386), compared to 46% (n=92/200) in AFH cases. Within same-sex cases, 10% (n=107) involved one male victim and one male suspect, whilst 3% (n=38) involved one female victim and one female suspect.

Finding 7: Across all five years, 60% (n=875/1452) of victims were between 25 and 54 years old, with 26% (n=371) being 55 years or older. Turning to suspects, 69% (n=1078/1554) were aged 25 to 54 years old, with 18% (n=285) being 55 years or older.

Thus, a higher proportion of victims (+8%) were aged 55 years and older as compared to suspects, and a higher proportion of suspects were aged 25 to 54 years old (+9%) as compared to victims.

Whilst 8% (n=111/1452) of victims were reported as aged 16 to 24 years old and 6% (n=94/1452) of victims being under 16 years of age, the challenges surrounding the reporting of child deaths and associated identification of teenage relationship abuse are discussed with further information provided in Section 3.2.3.

Finding 8:

In the vast majority of cases, ethnicity was recorded for the victim (96%) and suspect (95%). Across the five-year dataset, most victims were recorded as White (79%, n=1146/1452), with around one in five identified as belonging to minoritised ethnic groups (18%, n=255). Similarly, most suspects were also recorded as White (78%, n=1210/1554), with 17% (n=259) identified as belonging to minoritised ethnic groups. Overall, proportions of minoritised ethnic groups among both victim and suspect were broadly in line with the 2021 Census; however, analysis of disaggregated data in the main body of the report suggests potential disproportionality within specific ethnic groups, such as the Black, Black British, Caribbean or African ethnic group.

This chapter also details data on victim and suspect nationality (see Section 3.2.4) and additional analyses of victims from minoritised ethnic groups in cases of domestic homicide and SVSDA that are disaggregated by sex, ethnic group and typology (see Section 3.3).

Additionally, whilst the figures may be influenced by barriers to data recording within the policing context, 3% of victims (n=48/1452) and 3% of suspects (n=44/1554) were recorded as being LGBTQ+. The majority of LGBTQ+ victims (65%, n=31/48) and suspects (61%, n=27/44) were recorded within SVSDA cases, suggesting the importance of considering suicide prevention opportunities for victims of DA within this population.

The analysis of protected characteristics can help to identify communities who may be over-represented or under-served, facilitating partnership working and targeted engagement programmes.

Recommendation

Recommendation 5 – To the police, NPCC, NCVPP and Domestic Homicide Project [PREVENTION]: To continue collecting data and improve data quality in relation to protected characteristics, as well as areas of interest such as deaths involving a fall from height, to build an evidence base for targeted intervention and prevention activity.

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

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Findings

Finding 9: Across the five-year dataset, of 1,554 suspects, the most commonly identified antecedent risk factors were:

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

Notably, for 20% (n=304/1554) of suspects, alcohol and drug use were recorded as co-occurring risk factors. Furthermore, these risk factors varied by typology, such as the predominance of mental ill health within cases of AFH (62%, n=149/240). Similarly, CCB was highly prevalent in cases of IPH (42%, n=176/423), SVSDA (56%, n=349/622) and unexpected deaths (45%, n=64/142).

Additional analyses indicated that the presence of CCB was statistically associated with the presence of other recorded risk factors within the cases, although these relationships were generally weak. The strongest associations for CCB were observed with harassment and Image-Based Sexual Abuse (IBSA), indicating that these forms of abuse were more likely to be identified in cases where CCB was present than would be expected by chance.

Moreover, previous non-fatal strangulation (NFS) was strongly, and statistically significantly, associated with the presence of all other recorded risk factors. Most notably, NFS was associated with ‘threats to kill’, suggesting that these factors were identified together more frequently than would be expected by chance.

Lastly, proportion testing indicated that NFS was proportionally more prevalent in cases of SVSDA compared to cases of domestic homicide (IPH and AFH).

Recommendation

Recommendation 6 – To the NCVPP and NPCC [PREVENTION/PERPETRATORS]: The prevalence of coercive and controlling behaviour (CCB) alongside related risk factors (e.g., separation, non-fatal strangulation) is evident within the five-year dataset, particularly within cases of IPH, SVSDA and unexpected deaths. Therefore, the NCVPP should consider how the understanding of CCB, as a criminal offence and wider pattern of abusive behaviour, can facilitate a step change in the use of the legislation to support prevention and the pursuit of perpetrators.

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

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Findings

Finding 10: Across the five-year dataset, excluding cases of SVSDA, 57% (n=530/932) of suspects were known to the police for DA perpetration prior to the victim's death.

Within cases of SVSDA, 88% (n=550/622) involve a history of DA perpetration known to the police prior to the victim's death. This would be expected given the need for the police to know about the abuse to submit the case to this project, but it also suggests that some cases are being identified posthumously through information from family, friends or other agencies. This finding also indicates that SVSDA victims were often 'visible' to the police, which indicates opportunities for intervention or prevention.

Finding 11: 36% (n=386/1080) of the suspects who were known to the police for DA prior to the victim's death were also known as high-risk and/or serial perpetrators. This was most common within IPH suspects (41%, n=97/234) and SVSDA prior DA perpetrators (39%, n=213/550), typologies that demonstrate similar risk profiles overall.

Finding 12: Of the suspects who were known to the police for DA, 41% (n=438/1080) were also involved in cases which were referred to a Multi-Agency Risk Assessment Conference (MARAC), although this varied by typology. Prior DA perpetrators in SVSDA cases (46%, n=252/550) and suspects in IPH cases (38%, n=90/236) are referred to MARAC at a higher rate compared to suspects in AFH cases (24%, n=30/127). Additionally, suspects in unexpected deaths had the highest proportion of MARAC referrals (50%, n=53/107).

Finding 13: Of the suspects known to the police for DA, 16% (n=175/1080) were recorded as having been previously managed by police or probation (e.g., under MAPPA, IOM, or DRIVE).

Finding 14: In 70% of incidents (n=982/1410) across the five-year dataset the victim and/or suspect was known to a partner agency, most commonly in cases of SVSDA (80%, n=441/553), again demonstrating the visibility of these cases to services. Mental health services were the single most recorded agency (25%, n=355). When combining all cases known to social services (including adult, children, and unspecified services), this accounted for 43% of victims and/or suspects (n=600).

For those cases in which the suspect was not previously known to the police for any reason (n=214), 38% (n=81) involved a suspect and/or victim that were known to a partner agency, continuing to highlight the importance of multi-agency collaboration and information sharing.

Recommendations

Recommendation 7 – To the Government, Department for Health and Social Care and NPCC [PREVENTION]: To work in partnership to improve cross-government working in relation to suicide prevention, ensuring learning regarding suicide following domestic abuse are captured within resources such as NHS England's Staying Safe from Suicide: Best practice guidance e-learning session described in the Government's VAWG Strategy.

Recommendation 8 – To the NPCC, NCVPP and Domestic Homicide Project [PERPETRATORS]: To scope the possibility of conducting in-depth case analysis to gather information regarding the history and trajectory of police and partner agency contact of domestic abuse perpetrators who go on to commit domestic homicide.

Chapter 6: Domestic Homicide Reviews

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Findings

Finding 15: Of those cases that were referred for a Domestic Homicide Review (DHR) or other type of review, 65% (n=763/1180) were accepted, which rises to 84% (n=763/903) when considering only those cases that were referred, and the referral outcome was known (see Section 6.1 for additional detail and breakdowns by typology).

Recommendation

Recommendation 9 – To the Government [PREVENTION]: The following recommendation is rolled over from the Year 4 report due to timelines for enacting legislative changes regarding Domestic Homicide Reviews (DHRs) - To monitor and evaluate changes influenced by the updated definition and forthcoming statutory guidance relating to DHRs (to be re-named Domestic Abuse Related Death Reviews) once these changes have been enacted.

Chapter 7: Spotlight on Suspected Victim Suicide Following Domestic Abuse – Investigation of unexpected deaths and posthumous prosecution efforts

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Findings

Finding 16: Following the project's 'deep dive' work on the police response to unexpected deaths involving a history of domestic abuse, case studies of three unexpected deaths, including two classified as SVSDA, are provided in this chapter. Themes arising from this work include the continued importance of gathering information from family members and friends, use of professional curiosity in relation to the investigation of any unexpected death and consideration of posthumous prosecution based on a previously recorded or

newly identified history domestic abuse. These themes highlight the relevance of updated APP guidance informed by the project's previous findings.

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

The project team believe there are at least two additional UAM charges proceeding to trial within the next year. With evidence of a small number of SVSDA cases receiving further investigation and attempts to pursue posthumous charges, this is an area of continuing development within the police and criminal justice response to suicide following domestic abuse.

Recommendations

Recommendation 10 – To the NPCC, NCVPP, College of Policing and Domestic Homicide Project [PREVENTION/PERPETRATORS]: To build upon learning from the Domestic Homicide Project's work on the police response to unexpected deaths, including SVSDA, regarding the translation of policy into practice. The findings from this research should inform consideration of options for future work including the strengthening of relevant guidance and training.

Recommendation 11 – To the police, NPCC, NCVPP and CPS [PERPETRATORS]: To engage in joint working across the police, CPS and relevant stakeholders to share learning and emerging practice in relation to the response to unexpected deaths and posthumous prosecution of Unlawful Act Manslaughter and domestic abuse related offending to inform future guidance and policy developments.

Recommendation 12 – To the NCVPP and Domestic Homicide Project [PREVENTION]: For the Domestic Homicide Project to share relevant research findings regarding unexpected deaths and SVSDA with coroners, such as to inform the training programme for coroners described within the Government's VAWG Strategy.

Recommendation 13 – To the police, NPCC and Coroners [SUPPORT FOR VICTIMS]: To apply findings from this research to ensure consistency and standardisation of policy and practice surrounding coronial processes. To ensure police forces liaise with the Coroner and identify and report any history of domestic abuse that may be relevant to the inquest.

Chapter 8: Fourth Consultation with Bereaved Family Members

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Findings

Finding 17: During the fourth consultation with family members bereaved by fatal domestic abuse, their perspectives and experiences helped inform the findings and recommendations presented in this report.

Regarding potential barriers to the response to unexpected deaths, family members described challenges to information sharing when multiple force areas and/or agencies are involved, limitations to the use of body worn camera footage, narrow remit for coronial conclusions, the ripple effect on and responsibilities of families, perceptions of vulnerability as the cause of death rather than considering links to abuse, victim blaming attitudes and unconscious bias. In contrast, themes for potential solutions included the collection of relevant data, adapting learning from this research to other sectors, consistency of investigations, and providing support for bereaved family members.

Recommendation

Recommendation 14 – To the NCVPP and Domestic Homicide Project [SUPPORT FOR VICTIMS]: To continue consultation with family members bereaved by fatal domestic abuse, Family Liaison and Coordination of Support Services (FLACSS) and the charities which represent bereaved families, to allow the voices of the victims to inform future work in this area.

MAIN REPORT

Chapter 1 – Introduction

1.1 Definitions and terminology

For the purposes of data collection, to capture an accurate picture of the scale of domestic abuse (DA) related deaths in quick time, the project adopted a wide definition for inclusion. The overall definition for this project is:

'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 died by suicide or there is an unexpected death as a result of or following DA.'

Therefore, in addition to domestic homicide by a (current or ex) partner or family member, the project also collects data on suspected suicides of individuals with a known history of DA victimisation. The inclusion of suspected victim suicides following domestic abuse (SVSDA) does not require a causal link between the death and prior DA, nor does it specify a time frame for the abuse. This affords police forces flexibility in interpreting which cases to submit to the project, with emphasis on including cases when in doubt.

Throughout the analysis cases are divided into six typologies, primarily based on victim-perpetrator relationship:

Adult Family Homicide (AFH)

Homicide of an individual aged 18 or over by an adult family member.

Intimate Partner Homicide (IPH)

Homicide of an individual (any age) by a current or former intimate partner.

Suspected Victim Suicide Following Domestic Abuse (SVSDA)

Suspected suicide of a person (any age) following known DA against them.

Where we present analysis of the whole dataset in this report and use the umbrella term 'suspect', in cases of SVSDA this refers to the perpetrator of the prior DA. Where we only discuss SVSDA, we use the term 'prior DA perpetrator'. The known history of DA may be police recorded or be brought to the attention of the police after the victim's death by another agency, family or friends.

Unexpected Death

Within this dataset, unexpected deaths include the death of an individual (any age) with a history of domestic abuse that is under investigation but not (yet) deemed a homicide, suspected suicide or non-suspicious death.[10]

Child Death

Homicide of a child aged under 18 by a family member or family member's partner.

Other

Where the relationship is not intimate partner or familial but the victim and suspect live together, e.g., lodger or flatmate (individuals over the age of 18)

Currently, the statutory definition of DA does not consider children under the age of 16 experiencing abuse in their intimate relationships as victims of DA. This gap poses a challenge as it makes it difficult to identify these cases and offer appropriate support (Weir & Barrow-Grint, 2024). Consequently, although the DH project collects data on victims of all ages, IPH and SVSDA cases whereby the victim and/or suspect are under 16 would not routinely be identified as a domestic abuse related death and would therefore not typically be submitted to the project (see also Section 3.2.3). The project team's updates to, and in some cases removal of, age-related definitions for analysis allow the inclusion of IPH, SVSDA and unexpected deaths for individuals of any age with classification based on the relationship between the victim and suspect and circumstances of the death. Following last year's recommendations, the DH project team continue to encourage the identification and submission of such cases by the police. Additionally, the project team are working with the Home Office to help ensure that data on teenage relationship abuse related deaths are consistently collected.

In addition to this project's inclusion of SVSDA, the counting of deaths in this report will differ from Home Office Homicide Index (HOHI) figures on domestic homicides, based on differences in definition, inclusion criteria and data collection:

1. The DH Project definition includes children aged 0-15 (suspected to have been) killed by a family member or intimate partner, but these cases would not be included within the HOHI definition of domestic homicide (16 years or older).

2. Furthermore, in contrast to the HOHI definition of domestic homicide, the DH Project includes the category of 'other' deaths - individuals that are living together but are not family members or in an intimate relationship.

[10] Please note that it is the purview of the Coroner to investigate deaths which are deemed to be unnatural, violent, where the cause is unknown or the deceased died while in custody or in a state of detention (*Coroners and Justice Act 2009, c.25*). Verdicts possible during an inquest include natural causes; accident or misadventure; neglect; alcohol or drug related; road traffic collision; suicide; lawful or unlawful killing; industrial disease; and open verdicts, where there is insufficient evidence for any other verdict (Courts and Tribunals Judiciary, 2025).

3. Because this project gathers information on deaths in quick-time, suspects are initially counted pre-charge though the data is regularly updated. This differs from the HOHI, which captures homicide suspects at a later point, once charged.

4. Similarly, by capturing deaths pre-charge and pre-inquest, this project includes deaths that are, at the time of initial reporting, unexpected. Unexpected deaths may not yet have been formally deemed a homicide or suicide. If, following further investigation, the police deem these cases to be non-suspicious deaths by natural causes without third party involvement, they are excluded from the project's dataset.

5. This project conducts data reconciliation with other public data sources and relevant charities that are checked against police force records, such as Counting Dead Women and the ManKind Initiative.

In some cases, we present data with combined figures for IPH and AFH and term these 'domestic homicides'. These figures are most similar to the HOHI definition of domestic homicide, with remaining differences based on data collection methods noted above.

1.2 About the data

This report marks a significant milestone for the Domestic Homicide Project as it provides five years of data from 1st April 2020 to 31st March 2025, containing the analysis of 1,452 domestic abuse related deaths associated with 1,410 incidents.

Forty two out of 43 (98%) territorial police forces in England and Wales submitted data for Year 5. Only one force did not submit any deaths themselves, however they confirmed that due to their size they have an established arrangement whereby relevant deaths are submitted by a neighbouring force. Ninety initial submissions across the five-year dataset were excluded from the analysis due to subsequent information provided indicating the incidents were not crimes or not domestic-related. Seven of these were exclusions of deaths occurring in Year 5. This also includes unexpected deaths that, upon further investigation, no longer met the project's definition.

As in previous reports, the project team coded the data quality and completeness of each submission (n=1410), using a three-point grading system. Overall, 81% (n=1136) of submissions were initially assessed as being complete and 86% (n=1214) of good or excellent quality. The project team also conducts immediate follow ups to capture any missing/incomplete data. Longer-term follow-ups are also carried out for all new cases submitted within the reporting year, typically around six months after the initial submission. All cases are revisited to capture any additional information that may emerge over time. This primarily includes updated demographic information, investigation and criminal justice outcomes (if available), and further insights relating to partner agency involvement and indicators of coercive and controlling behaviour (CCB).

As above, the project team also completed data reconciliation exercises with the cases collected by Counting Dead Women and the ManKind Initiative. Data reconciliation with the Counting Dead Women X account identified a further 36 submissions that were

checked against relevant police force records. Of these, four cases met the project criteria and were subsequently added to the database as new submissions. Reconciliation reviewing ManKind's records did not identify any new cases to be added to the database. We are grateful to these organisations for their work to identify and collate this information, as well as their generosity and co-operation in helping to triangulate the cases.

In addition, the project team engaged with a number of stakeholders to discuss the project's use of data and associated language related to protected characteristics (e.g., sex, ethnicity and sexual orientation) in the context of their work. As part of this exercise, the team met with individuals representing Killed Women, Southall Black Sisters, Imkaan, ManKind, Galop, and Men Reaching Out, as well as academics and consultants associated with these organisations. Once again, we would like to extend our thanks to these individuals for their time, and their dedication to understanding, responding to and preventing domestic abuse, domestic homicide and suicide following domestic abuse. We are very grateful for their cooperation, insight, and expertise.

Appendix A of this report (separate document, see project page) includes responses to the recommendations made in the Year 4 report directed towards policing, government, the College of Policing, and this project, along with relevant updates on progress.

The glossary of acronyms and terms used throughout this report, as well as Appendix B containing all datasets used for analysis, can be found on the project page.

All content presented in the report is the exclusive work product of the Domestic Homicide Project. Should any individual or organisation wish to use the Domestic Homicide Project's data in their own outputs, please contact the authors via dhproject.vkpp@college.police.uk to ensure clarity regarding the meaning and interpretation of the presented findings. Any use of this information must include proper citation of the Domestic Homicide Project and presenting the data as one's own without prior consent is strictly prohibited.

Chapter 2 - Domestic Homicides, Unexpected Deaths and Suspected Victim Suicides Following Domestic Abuse: April 2020 - March 2025

2.1 Overall deaths April 2020 - March 2025

This report marks five years of data collection and analysis. Across the five-year dataset, this project has counted 1452 deaths in 1410 incidents. These deaths were spread across the following typologies: 641 domestic homicides (414 IPH and 227 AFH), 553 SVSDA, 131 unexpected deaths, 86 child deaths and 41 deaths classified as 'other' (see Figure 1**Error! Reference source not found.**).

Figure 1 Number and proportion of deaths by typology (April 2020 – March 2025)

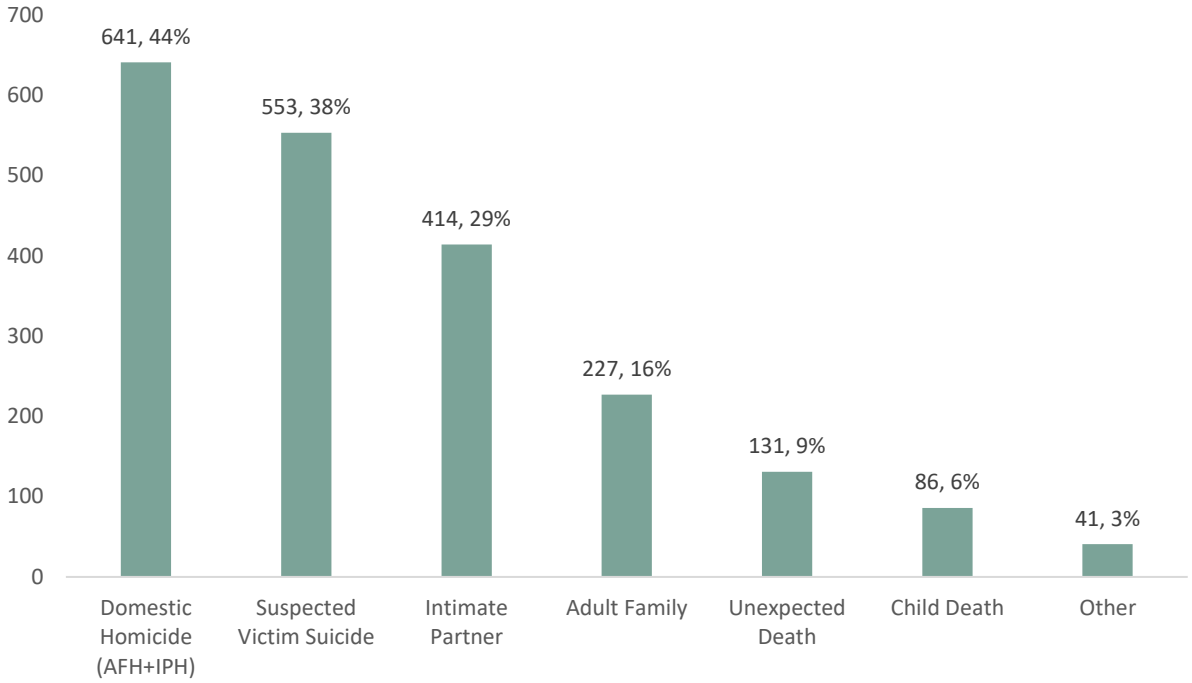
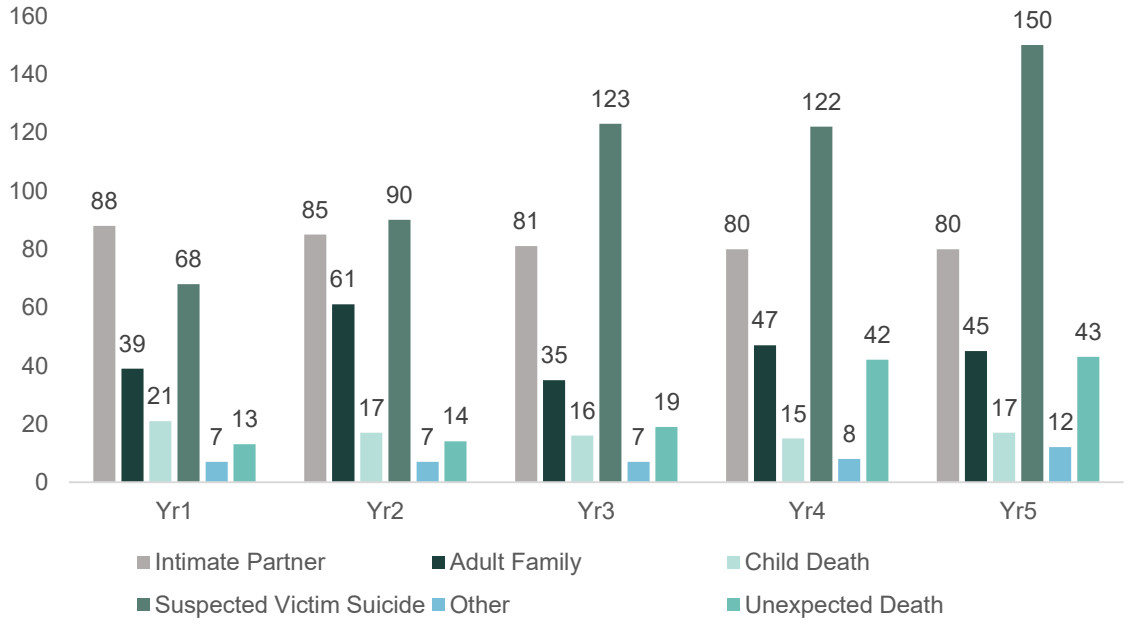


Figure 2 Number of deaths per year by typology (April 2020 – March 2025)



Year-to-year changes may reflect general fluctuations in the number of domestic abuse related deaths and/or changes to reporting and identification of cases particularly in relation to SVSDA and unexpected deaths (see Table 1, below).

The project team also examined whether incidents were reclassified as unexpected deaths from other typologies as the investigation progressed. Of the 131 unexpected deaths across the five-year dataset, seven (5%) were previously considered homicide, two (2%) were previously considered suicide, and one (1%) was previously classified as ‘other’.

The team also coded for cases that were reclassified from unexpected deaths to other typologies as the investigation progressed. Across the five-year dataset, 15 unexpected deaths were reclassified as homicides (seven IPHs, six AFHs and two child deaths), whilst 27 were reclassified as suspected victim suicides.

Suspected victim suicide following domestic abuse (SVSDA) remains the most recorded typology across the full five-year dataset (38%, n=553). As highlighted in previous reports, the rise in reported SVSDA likely reflects better case identification and reporting, rather than an empirical increase in cases. This may be due to greater awareness of the suicide-DA link through this project, increasing research efforts (e.g., Rowlands and Dangar, 2024; Munro, Bettinson and Burton, 2024) as well as extensive media coverage of cases involving the pursuit of criminal charges of domestic abuse perpetrators or coronial rulings of 'unlawful killings', such as the deaths of Kiena Dawes and Georgia Barter.

The number of IPH deaths has remained relatively stable over the five years of data collection (see Table 1Error! Reference source not found.). Alongside the overall scale of deaths recorded over the past five years (n=1452), this highlights the enduring nature of this issue and need to work towards prevention.

The relatively low submission of child deaths in Year 5 (5%, n=17/347), alongside records from other sources such as the National Child Mortality Database (2025), and the annual Child Safeguarding Practice Review Panel report (CSPRP, 2024), indicate they are likely underreported by police forces. The cases submitted to this project primarily represent child deaths linked to child abuse or familicide. Consequently, the following chapters primarily focus on analysing AFH, IPH, unexpected deaths, and SVSDA.

There is additional detail on the analysis presented throughout this report in the data tables in Appendix B (separate document).

Table 1 Number and proportion of deaths by typology – changes between Years 1, 2, 3, 4 and 5 (April 2020 – March 2025).

	2020/2021 (Year 1)		2021/2022 (Year 2)		2022/2023 (Year 3)		2023/2024 (Year 4)		2024/2025 (Year 5)		Overall	
	N	%	N (and n= change vs previous year)	Yearly % (and % point change vs previous year)	N (and n= change vs previous year)	Yearly % (and % point change vs previous year)	N (and n= change vs previous year)	Yearly % (and % point change vs previous year)	N (and n= change vs previous year)	Yearly % (and % point change vs previous year)	N	%
Domestic Homicides (AFH & IPH)	127	54%	146 (+19)	53% (-1%)	116 (-30)	41% (-12%)	127 (+11)	40% (-1%)	**125 (-2)**	**36% (-4%)**	**641**	**44%**
Intimate Partner Homicide	88	37%	85 (-3)	31% (-6%)	81 (-4)	29% (-2%)	80 (-1)	25% (-4%)	**80 (0)**	**23% (-2%)**	**414**	**29%**
Adult Family Homicide	39	17%	61 (+22)	22% (+5%)	35 (-26)	12% (-10%)	47 (+12)	15% (+3%)	**45 (-2)**	**13% (-2%)**	**227**	**16%**
Suspected Victim Suicide	68	29%	90 (+22)	33% (+4%)	123 (+33)	44% (+11%)	122 (-1)	39% (-5%)	**150 (+28)**	**43% (+4%)**	**553**	**38%**
Unexpected Death	13	6%	14 (+1)	5% (-1%)	19 (+5)	7% (+2%)	42 (+23)	13% (+6%)	**43 (+1)**	**12% (-1%)**	**131**	**9%**
Child Death	21	9%	17 (-4)	6% (-3%)	16 (-1)	6% (0%)	15 (-1)	5% (-1%)	**17 (+2)**	**5% (0%)**	**86**	**6%**
Other	7	3%	7 (0)	3% (0%)	7 (0)	2% (-1%)	8 (+1)	3% (+1%)	**12 (+4)**	**3% (0%)**	**41**	**3%**
Total per year	236	100%	274 (+38)	100%	281 (+7)	100%	314 (+33)	100%	**347 (+33)**	100%	**1452**	100%

2.2 Overall deaths April 2024 - March 2025

In Year 5 (1st April 2024 to 31st March 2025), the project counted a total of 347 deaths in 337 incidents. These deaths included 150 (43%) SVSDA, 125 (36%) domestic homicides, (80 (23%) IPH and 45 (13%) AFH), 43 (12%) unexpected deaths, 17 (5%) child deaths and 12 (3%) deaths classified as 'other'.

When comparing Year 5 to Year 4, there was a notable increase in the number of reported SVSDA cases (from 122 to 150), representing an increase of four percentage points. As above, highlighting the entrenched nature of this issue, the number of IPH recorded in Year 5 remained the same as in Year 4, although representing a slightly lower proportion of all cases (a decrease of two percentage points) likely due to the increased reporting of SVSDA cases.

Importantly, the number of cases by typology for Year 4 shown in Table 1 refer to updated figures, not to those presented in our Year 4 report (Hoeger et al., 2025). The increase in the number of deaths by typology compared to our previous report, reflects retroactive reporting by police forces to the project after the commencement of the annual analysis. This means that forces are actively reviewing their domestic abuse related deaths, continuing to identify and submit cases to the project when appropriate. For instance, the figures published for Year 4 in the previous report included 262 deaths (now 314), with 98 SVSDA (now 122) and 28 unexpected deaths (now 42).

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

Chapter 3 – Typologies and characteristics of victims and suspects

3.1 Case characteristics

3.1.1 Method of death

The most common method of death across the five years of data collection was hanging (23%, n=330/1452). Hanging as a method of death accounts for 59% (n=326/553) of SVSDA cases.

The second most common method of death overall, and the most common for AFH and IPH cases, was by sharp instrument (22%, n=323/1452), accounting for 43% (n=277/641) of domestic homicides (49%, n=111/227 of AFH and 40%, n=166/414 of IPH; see Table 2). This supports wider domestic homicide and femicide data which indicate that sharp instruments remain the most common method of killing (Femicide Census, 2020; Home Office, 2023).

Additional analysis showed that of all sharp instrument-related deaths across the five-year dataset, only 7% (n=24/323, 15 IPH and 9 AFH) occurred in public spaces. This indicates that domestic abuse-related knife killings occur overwhelmingly in private spaces, distinguishing these from "street" knife crime.

Legal reforms have been introduced to address wider knife availability (e.g., Criminal Justice Bill on Knife Crime and Ronan's Law), however reducing domestic-abuse-related knife violence remains difficult as most incidents involve household kitchen knives. Recent years have seen campaigns such as Let's Be Blunt, alongside a UK Parliament's Early Day Motion, which focus on promoting blunt-tip kitchen knives. Research on this topic (Nichols-Drew et al., 2020; Nichols-Drew, 2023) has suggested that the use of blunt-tipped knives has the potential to reduce the occurrence of serious injury. However, more research would be needed in relation to the efficacy of this strategy in the context of domestic homicide.

In cases of sharp-instrument related deaths, the sentencing guidelines starting point when a knife has been taken to the scene with intent to harm is a 25-year sentence. In contrast, where the knife is already available at the scene, which appears common in cases of domestic homicide, the sentencing starting point decreases to 15 years. In 2024, the Ministry of Justice asked the Law Commission to conduct a comprehensive review of homicide law, for which public consultation is ongoing. The review will consider murder across all contexts, including the framework for offences, defences, and sentencing. It will also take into account relevant recommendations from Clare Wade KC's 2023 Independent Domestic Homicide Sentencing Review, which could inform how domestic homicides involving sharp instruments are addressed under the statutory sentencing framework.

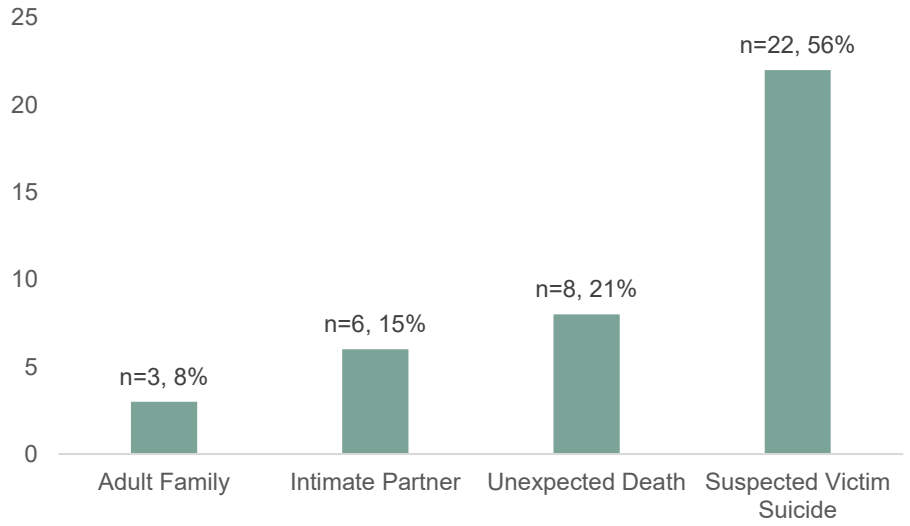
Table 2 Number and proportion of victims by method of death by typology – April 2020 to March 2025

	Adult Family		Intimate Partner		Suspected Victim Suicide		Unexpected Death		Child Death		Other		Overall	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Hanging	-	-	-	-	326	59%	4	3%	-	-	-	-	**330**	**23%**
Sharp instrument	111	49%	166	40%	8	1%	3	2%	16	19%	19	46%	**323**	**22%**
Poison or Drugs	3	1%	11	3%	146	26%	32	24%	3	3%	-	-	**195**	**13%**
Not Known	10	4%	39	9%	8	1%	47	36%	9	10%	2	5%	**115**	**8%**
Strangulation	8	4%	60	14%	1	<1%	1	1%	8	9%	3	7%	**81**	**6%**
Kicking or hitting	32	14%	30	7%	-	-	5	4%	10	12%	3	7%	**80**	**6%**
Blunt Instrument	28	12%	31	7%	-	-	2	2%	2	2%	4	10%	**67**	**5%**
Other	7	3%	16	4%	1	<1%	11	8%	6	7%	3	7%	**44**	**3%**
Fall from Height	3	1%	6	1%	22	4%	8	6%	1	1%	-	-	**40**	**3%**
Suffocation	4	2%	14	3%	9	2%	1	1%	4	5%	2	5%	**34**	**2%**
Suspected Neglect	11	5%	7	2%	-	-	10	8%	6	7%	-	-	**34**	**2%**
Burning or scalding (incl. arson)	4	2%	8	2%	6	1%	2	2%	10	12%	1	2%	**31**	**2%**
Shooting	3	1%	17	4%	-	-	-	-	6	7%	4	10%	**30**	**2%**
Drowning	1	<1%	2	<1%	15	3%	2	2%	4	5%	-	-	**24**	**2%**
Road Traffic/Railway Collision	2	1%	7	2%	11	2%	3	2%	1	1%	-	-	**24**	**2%**
Total	227	100%	414	100%	553	100%	131	100%	86	100%	41	100%	**1452**	**100%**

3.1.1.1 Deaths Involving a Fall from Height

In Year 5 (April 2024 – March 2025) there were 18 reported cases of deaths involving a fall from height, compared to 21 victims (associated with 22 suspects) reported in updated figures covering the previous four-year period (April 2020 to March 2024, excluding one case of child death). Therefore, across all five years there were 39 victims reported to have died following a fall from height, accounting for approximately 3% of deaths overall (n=1452). These 39 cases were associated with 49 suspects. One case of unexpected death had two suspects; all the remainder additional suspects were recorded in cases of SVSDA. The number of victims by typology is presented in Figure 3.

Figure 3 Number and proportion of deaths following a fall from height (April 2020 – March 2025)



It is important to note that the coding and recording of this method of death was introduced within the project's analysis in Year 4. Following conversations with the Killed Women Network in relation to their campaign, "Fallen Women", last year's report included a chapter analysing relevant cases. The 18 cases involving a fall from height reported in Year 5 represent a threefold increase from the six cases reported in Year 4. The analytical focus on this method of death and requests to forces to submit these cases are likely to have improved understanding and awareness of such cases involving a history of domestic abuse. This will therefore influence the number and proportion of deaths reported to involve a fall from height, rather than necessarily representing an empirical rise in cases.

Of the 39 victims recorded across the five-year dataset, 31 (79%) were female and 8 (21%) were male. In contrast, most suspects were male (n=44/49, 90%). Across all five years, three of the 31 female victims (10%) of a fall from height were pregnant at the time of their death.

In relation to the victim's ethnicity in deaths involving a fall from height, the majority were recorded as being from the White ethnic group (n=32, 82%), followed by the Asian or Asian British ethnic group (n=4, 10%), the Black, Black British, Caribbean or African ethnic group (n=2, 5%), and Mixed or Multiple ethnic groups (n=1, 3%).

Similarly, the majority of the suspects were recorded as being from the White ethnic group (n=41, 84%), followed by the Asian or Asian British ethnic group (n=5, 10%), the Black, Black British, Caribbean or African ethnic group (n=2, 4%), and Mixed or Multiple ethnic groups (n=1, 2%).

Of the 49 suspects associated with deaths involving a fall from height, 10 had a familial relationship to the victim, whereby the suspects were the child of the victim (n=3; 1 unexpected death, 2 AFH), the parent of the victim (n=3, all SVSDA), siblings of the victim (n=2, both SVSDA) or 'other family member' (n=2; 1 AFH and 1 SVSDA).

On the remaining cases where the victim was or had been in an intimate relationship with the suspect, 17 suspects were the victim's ex-partner (35%; 12 SVSDA, 3 unexpected deaths and 2 IPH), 16 of them were the victim's current partner (33%; 11 SVSDA, 3 unexpected deaths and 2 IPH) and six were the victim's spouse (12%; 2 SVSDA and 2 IPH and 2 unexpected deaths, see Table 3).

Table 3 Number and proportion of suspects in cases of falls from height according to their relationship to the victim (April 2020 - March 2025)

	Adult Family		Intimate Partner		Unexpected Death		Suspected Victim Suicide		Total	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Child	2	67%	-	-	1	11%	-	-	3	6%
Ex-partner	-	-	2	33%	3	33%	12	39%	17	35%
Other Family	1	33%	-	-	-	-	1	3%	2	4%
Parent	-	-	-	-	-	-	3	10%	3	6%
Partner	-	-	2	33%	3	33%	11	35%	16	33%
Sibling	-	-	-	-	-	-	2	6%	2	4%
Spouse	-	-	2	33%	2	22%	2	6%	6	12%
Total	**3**	**100%**	**6**	**100%**	**9**	**100%**	**31**	**100%**	**49**	**100%**

In terms of their previous contact with the police, 42 out of the 49 (86%) suspects were known to the police for domestic abuse. When excluding cases of SVSDA, the proportion of suspects previously known to the police for DA decreases to 72% (n=13/18). For 23 (47%) suspects, there was a recorded risk factor for a history of coercive and controlling behaviour (CCB). Additionally, 20 (41%) of the suspects were known as high-risk DA perpetrators and 21 (43%) were perpetrators in cases that had been heard at MARAC.

Last year's qualitative analysis of deaths involving a fall from height is cited in the updated College of Policing APP regarding the response to unexpected deaths. This guidance references the need for professional curiosity and advises officers to 'contact close associates and others who may have information relevant to a history of domestic abuse,

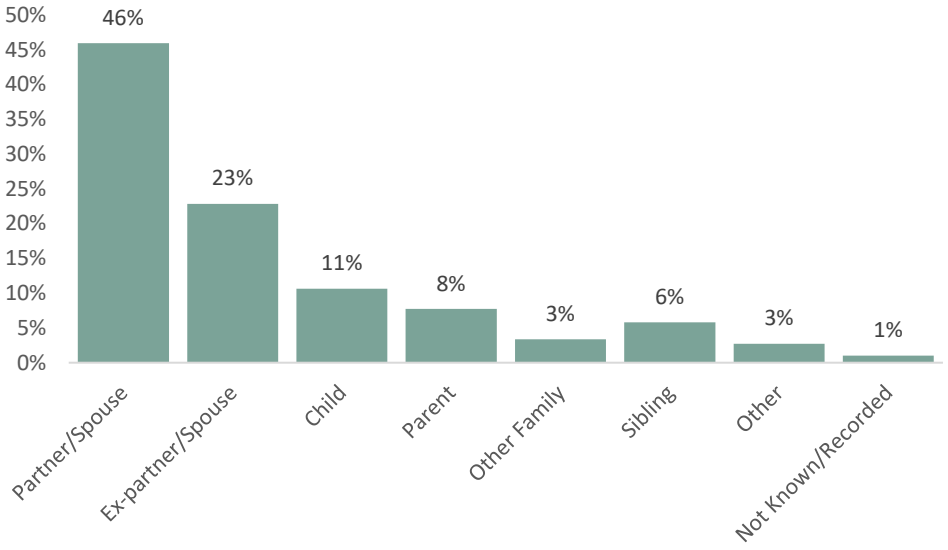
including family, friends and neighbours.' The guidance also refers to last year's finding that two thirds of fall from height cases involved suspects that were present at the scene of the death, in several cases being the individual who called emergency services and claimed that the victim had fallen or jumped (Hoeger et al., 2025).

3.1.2 Suspect's relationship to the victim

Across the full five year data and including all typologies there were 1554 suspects, 69% (n=1069) of whom were the current (46%, n=714) or ex-partner/spouse (23%, n=355) of the victim (see Figure 4). It was common for suspects of IPHs to be recorded as the victim's current partner/spouse (83%, n=351/423). SVSDA cases had the highest proportion of suspects recorded as the victim's ex-partner/spouse (43%, n=266/622), compared to 15%, (n=65/423) for IPH, and 17%, (n=24/142) for unexpected deaths.

The suspect was the child of the victim in 11% (n=165/1554) of cases across all five years, primarily represented within AFH cases (53%, n=128/240). Within this typology, suspects also included the victims' parent (5%, n=12), sibling (15%, n=35), as well as suspects classified as 'other family' members (27%, n=65)[11].

Figure 4 Proportion of suspects by relationship to victim, n = 1,554 (April 2020 - March 2025)



Based on the nature of the submissions to this project, whilst some cases involved one victim and multiple suspects, some cases also involved one suspect and multiple victims to whom the suspect was related in different ways. For example, there were three IPH cases which also had additional victims classified as 'other'. These cases primarily reflect

[11] 'Other family' referred to suspects who were identified as a victim's stepparent/child/sibling, grandparent/child, or in-law, and on some occasions a partner/ex-partner to a relative of the victim.

what the project team describes as homicide by proximity, which is the homicide of individuals in the immediate vicinity of the victim with a domestic link to the suspect.[12]

Across the five-year dataset, there were at least three identified cases involving homicides by proximity:

- A quadruple murder where a male suspect murdered his female partner, her mother, her grandmother, and her grandmother's male partner.
- A triple murder where a male suspect murdered his female partner, her mother and her sister.
- A double murder where a male suspect murdered his female ex-partner and her new male partner.

Homicides by proximity are distinct from familicides. The term familicide typically refers to cases whereby the suspect kills their (ex-)intimate partner/spouse and one or more children (Frei & Illic, 2023; Wilson et al., 1995). In familicide cases, the suspect has a domestic link to the child victims as their (step-)father or primary carer. In homicides by proximity, individuals who are killed in addition to the victim with a domestic link to the suspect do not have direct familial or intimate ties to the suspect and are targeted because of their physical and/or relational proximity to the 'domestic victim' at the time of their murder.

Whilst in the three cases described above the additional victims had an intimate or familial relationship to the 'domestic victim', this is not always the case. For example, within our dataset we identified an adult family homicide in which a son murdered his father in the home before fatally attacking a passer-by outside the residence who had no domestic connection to either the victim or suspect. At the time of the analysis, this second victim was classified as an 'other involved' person and excluded from the domestic homicide victim sample. Viewed through another lens, however, this victim could be classified within the 'other' typology of domestic abuse-related deaths.

3.2 Demographics

3.2.1 Victim sex

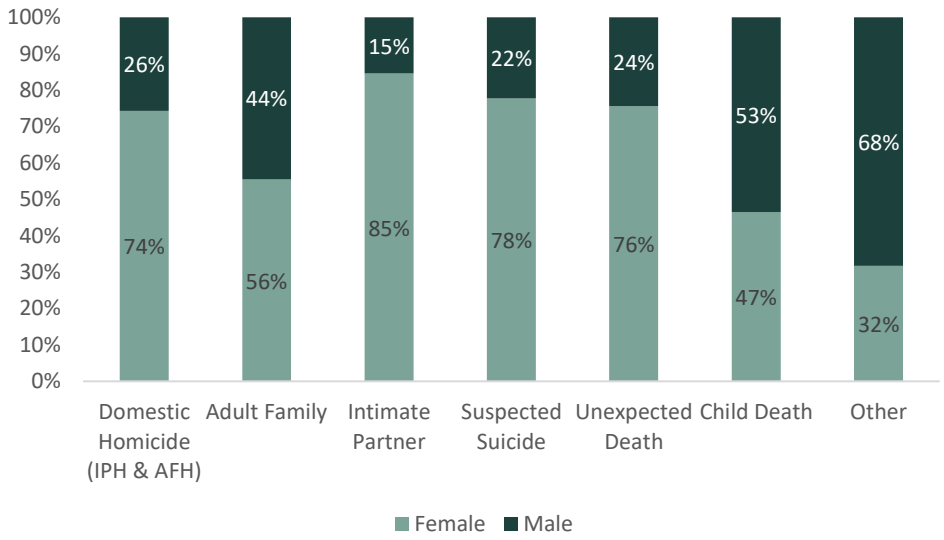
Across all five years, the majority (73%, n=1058) of the 1452 victims were recorded as female, whilst 27% (n=394) were recorded as male (see Figure 5). This difference by sex was particularly notable for victims of IPH (85%, n=350/414 female compared to 15%, n=64/414 male), SVSDA (78%, n=430/553 female, 22%, n=123/553 male) and unexpected deaths (76%, n=99/131 female, 24%, n=32/131 male). This difference was

[12] We deliberately avoid using the term 'collateral death' when referring to such incidents. The concept of 'collateral damage' is used in the context of military action, and it occurs when an intentional act of violence causes unintended harm as a side effect. The concept has been criticised as euphemistic and dehumanising, potentially minimising the gravity of harm (Rockel & Halpern, 2009; Perice, 2007; Schwenkenbecher, 2014). By using the term homicide by proximity, we aim to capture the spatial and/or relational proximity of such victims without indicating hierarchical status.

less prominent within AFH deaths (56%, n=126/227 female, 44%, n=101/227 male). Furthermore, over half of victims were recorded as male within child death cases (53%, n=46/86) and within most 'other' deaths (68%, n=28/41), although these sample sizes are small relative to the other typologies.

Important context is provided in Section 4.1 regarding suspects also known as victims of domestic abuse (and victims also known as suspects of domestic abuse), including specific data on the potential identification of a 'primary' perpetrator by sex in cases of SVSDA.

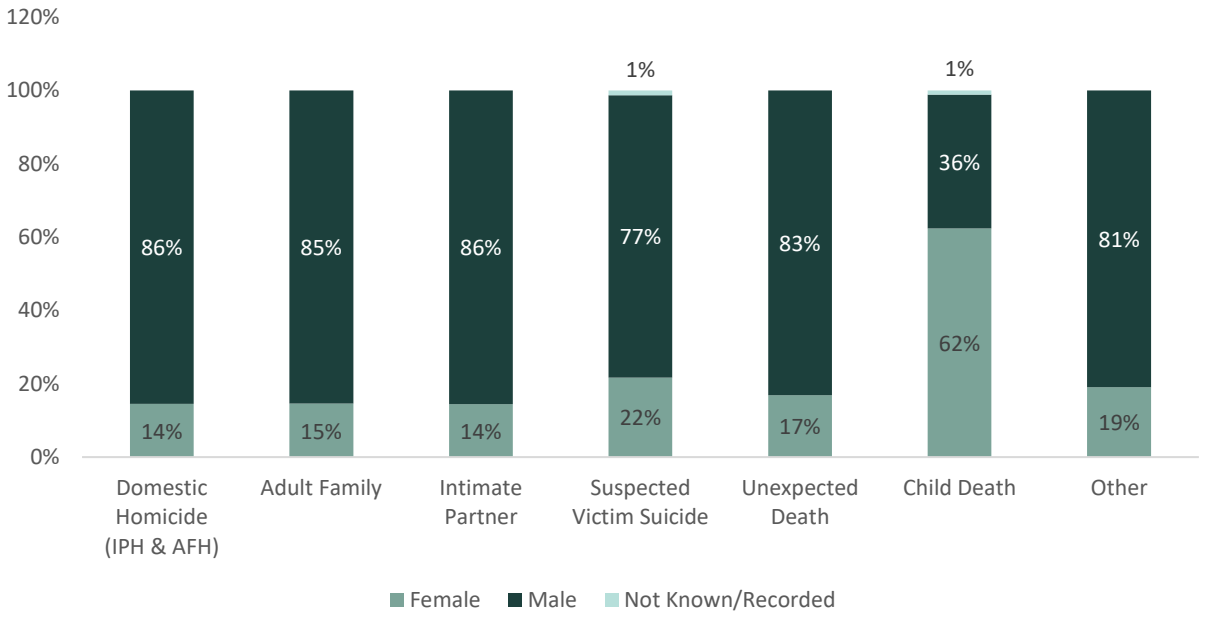
Figure 5 Proportion of victims by typology and sex (April 2020 - March 2025)



3.2.1 Suspect sex

In contrast to victims, across all five years, the majority of the 1,554 suspects were recorded as male (79%, n=1229 male, 20%, n=316 female, and 0.6%, n=9 not known/recorded). This difference by sex of the suspect was observed across all typologies apart from child deaths (see Figure 6).

Figure 6 Proportion of suspects by typology and sex (April 2020 - March 2024)



3.2.2 Victim-Suspect pairings by sex

3.2.2.1 Cases with one victim and one suspect

Analysis of victim-suspect pairings by sex and typology was conducted for domestic homicides (AFH & IPH, n=634) and SVSDA incidents (n=553), totalling 1187 cases. Across these typologies, most cases involved one victim and one suspect (92%, n=1091/1187). Within these 1091 cases, 72% (n=785) involved one female victim and one male suspect, whilst 14% (n=153) involved one male victim and one female suspect. Additionally, 10% (n=107) involved one male victim and one male suspect, whilst 3% (n=38) involved one female victim and one female suspect (see Table 4).

Table 4 Proportion and number of domestic homicide and SVSDA cases with one victim and one suspect, by sex (April 2020 – March 2025)

		Victim Sex					
		Female		Male		Total	
		N	% of total	N	% of total	N	%
Suspect Sex	Female	38	3%	153	14%	191	18%
	Male	785	72%	107	10%	892	82%
	N/R	3	<1%	5	<1%	8	1%
	Total	**826**	**76%**	**265**	**24%**	**1091**	**100%**

One victim-one suspect case pairings by sex present differently when comparing by typology. Whilst the vast majority of IPH cases involved one female victim and one male suspect (84%, n=324/386), this applied to just 46% of AFH cases (n=92/200), whereby

44% of cases involved one male victim and one male suspect (87/200). Within SVSDA, 73% (n=369/505) of cases involved a female victim and male prior DA perpetrator (see Table 5, Table 6, Table 7).

Table 5 Proportion and number of IPH cases with one victim and one suspect, by sex (April 2020 – March 2025)

		Victim Sex				TOTAL	
		IPH					
		Female		Male			
		N	% of total	N	% of total	N	%
Suspect Sex	Female	1	<1%	55	14%	56	15%
	Male	324	84%	6	2%	330	85%
	N/R	-	-	-	-	-	-
	Total	**325**	**84%**	**61**	**16%**	**386**	**100%**

Table 6 Proportion and number of AFH cases with one victim and one suspect, by sex (April 2020 – March 2025)

		Victim Sex				TOTAL	
		AFH					
		Female		Male			
		N	% of total	N	% of total	N	%
Suspect Sex	Female	16	8%	5	3%	21	11%
	Male	92	46%	87	44%	179	90%
	N/R	-	-	-	-		-
	Total	**108**	**54%**	**92**	**46%**	**200**	**100%**

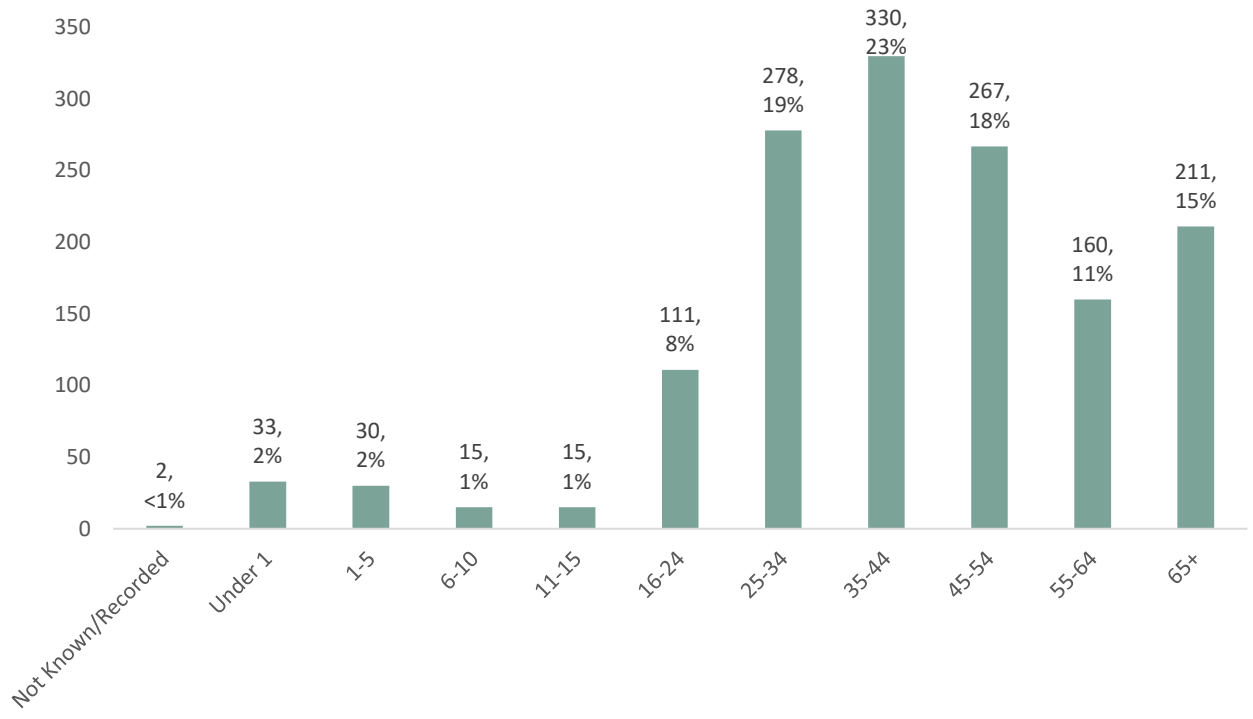
Table 7 Proportion and number of SVSDA cases with one victim and one suspect, by sex (April 2020 – March 2025)

		Victim Sex				TOTAL	
		SVSDA					
		Female		Male			
		N	% of total	N	% of total	N	%
Suspect Sex	Female	21	4%	93	18%	114	23%
	Male	369	73%	14	3%	383	76%
	N/R	3	1%	5	1%	8	2%
	Total	**393**	**78%**	**112**	**22%**	**505**	**100%**

3.2.3 Victim age

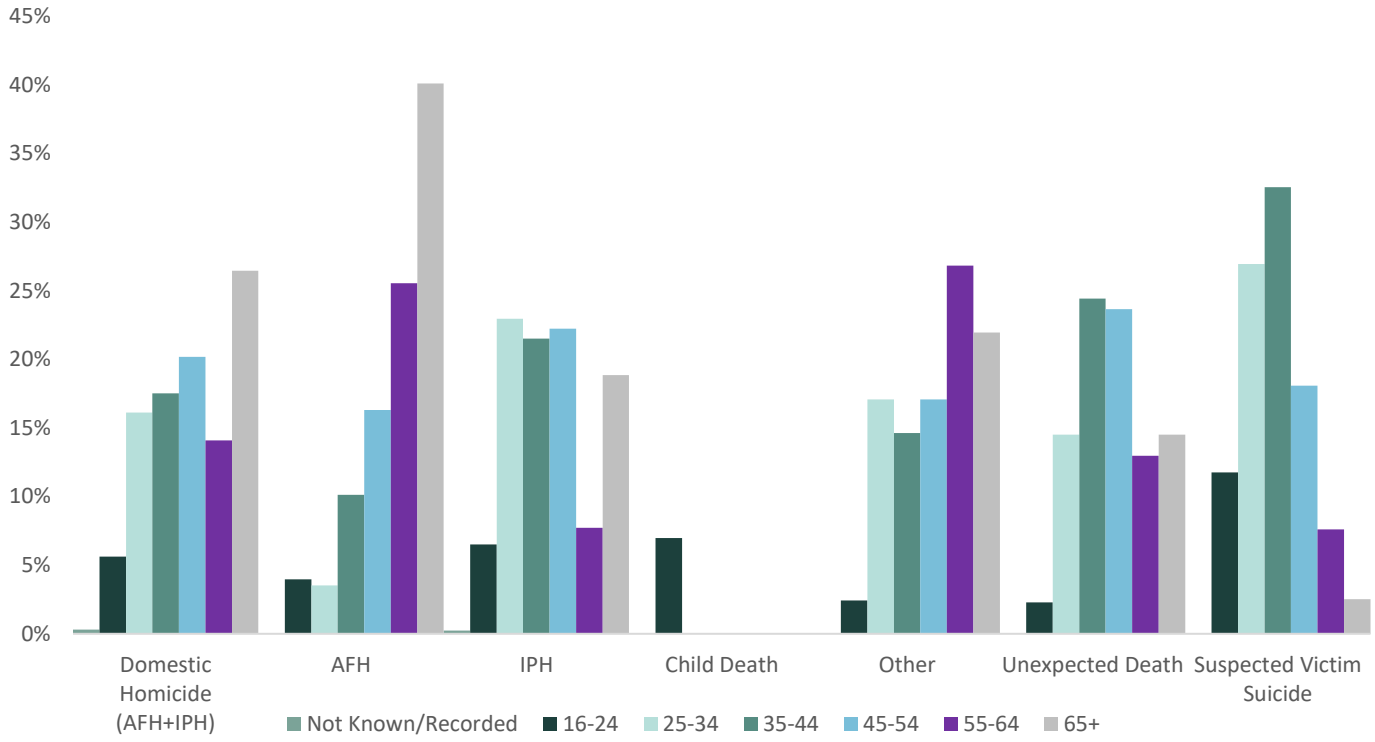
Across all five years, 60% (n=875/1452) of victims were aged 25 to 54 years old, with 26% (n=371) being 55 years or older, 8% (n =111) aged 16 to 24 as per Figure 7 below. Whilst aggregated data for victims under the age of 16 is not included in the graph, 6% (n =94) of the victims were under 16 years old.

Figure 7 Number and proportion of victims by age group (April 2020 – March 2025)



When comparing by typology across the five-year dataset (see Figure 8), AFH victims tended to be older than in other typologies. The majority of AFH victims were aged 45 years and older (82%, n=186/227), with 40% (n=91) being 65 years and older. In contrast, SVSDA victims were younger, most commonly aged 25 to 44 years old (59%, n=329/553). Within IPH deaths, there were similar proportions of victims aged 25 to 34 (23%, n=95/414), 35 to 44 (21%, n=89) and 45 to 54 (22%, n=92). In one case of IPH the victim's age was not recorded. In unexpected deaths, 48% (n=63/131) of victims were aged 35 to 54, whilst in deaths classified as 'other' nearly half of victims were aged 55 and older (49%, n=20/41). Most child death victims were aged between newborn and five years old (62%, n=53/86).

Figure 8 Proportion of victims by age group and typology, excluding victims under 16 (April 2020 – March 2025)



Domestic homicides and suspected suicides of younger victims aged 16-24 are discussed in depth within our Spotlight Briefing (Bates et al., 2024). Furthermore, wider data on all child deaths, not only those that are DA-related, is available from the National Child Mortality Database (2025), and the annual Child Safeguarding Practice Review Panel report includes analysis of serious child safeguarding incidents (CSPRP, 2024). Additionally, data from the Crime Survey of England and Wales (CSEW) for the year ending March 2025 showed that a significantly higher proportion of young people (16 to 19 years old, 18.2%; 20 to 24 years old, 12.9%) were victims of any DA compared to those aged 25 years and older (ONS, 2025).

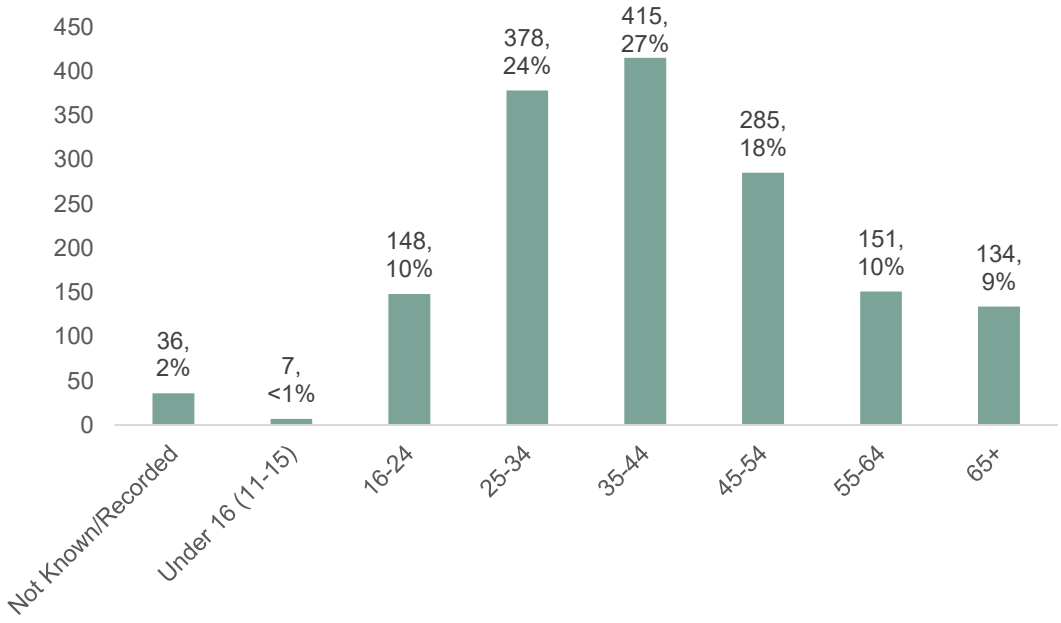
Whilst this project's overall definition includes 'any age', at the time of analysis the project had not yet received submissions from police forces involving the death of an individual under 16 years old who was suspected to have been killed by an intimate partner under 16 years old. However, there have been four reported cases of SVSDA involving victims under the age of 16 whereby the perpetrator was over the age of 18. Of these cases, three involved an adult family perpetrator and one involved an intimate partner perpetrator.

Furthermore, Year 5 marks the first case of suspected suicide following teenage relationship abuse (TRA) in the dataset, whereby both the victim and suspect were under the age of 18. For both IPH and SVSDA cases, this likely reflects ongoing underreporting. A notable barrier to case submission, particularly for cases involving individuals under 16 in intimate relationships, may be the statutory definition of domestic abuse, which applies only to individuals aged 16 and over (Home Office, 2024, Weir & Barrow-Grint, 2024). Consequently, incidents involving under-16s in intimate relationships may not be recorded as domestic abuse or domestic homicide, making them less identifiable to the police and other agencies.

3.2.3 Suspect age

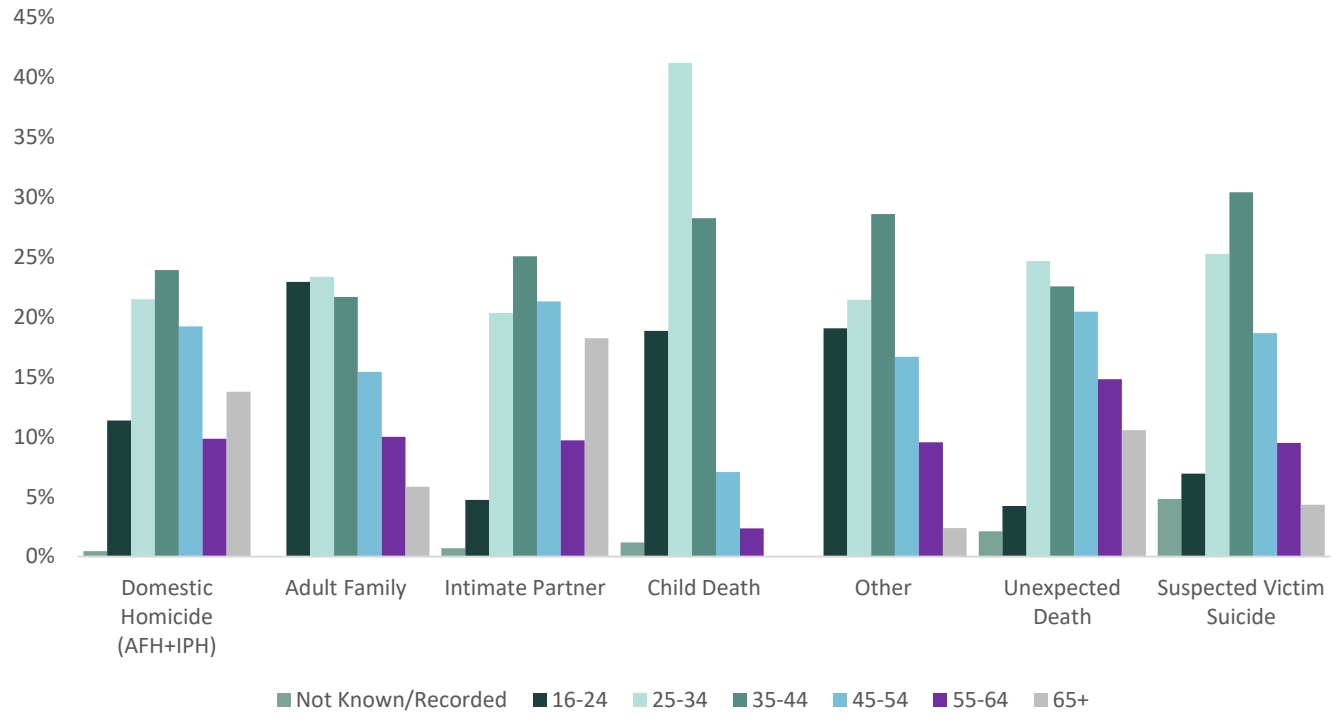
Across all five years, suspects had a slightly younger age profile than victims overall with 69% (n=1078/1554) aged 25 to 54 years old, 19% (n=285) being 55 years or older, 10% aged 16 to 24 years old (n=148) and 0.5% (n=7) under 16 years old (see Figure 9). For 2% of suspects (n=36), age was not known or not recorded.

Figure 9 Number and proportion of suspects by age group (April 2020 – March 2025)



When comparing typologies across the five-year dataset (see Figure 10), in contrast to AFH victims, suspects in AFH cases tended to be younger than in other typologies, with the majority of AFH suspects being between 16 and 44 years old (68%, n=163/240), primarily reflecting their relationship being the child or grandchild of the victim. In IPH (67%, n=282/423) and SVSDA (74%, n=462/622) cases, suspects were slightly older than in AFH cases, with most being between 25 and 54 years old. Approximately half of unexpected death suspects (47%, n=67/142) and suspects in deaths classified as 'other' (50%, n=21/42) were 25 to 44 years old. In child deaths, the majority of suspects were between 25 and 44 years old (69%, n=59/85), with 41% aged 25 to 34 (n=35).

Figure 10 Proportion of suspects by age group and typology (April 2020 – March 2025)



3.2.4 Victims ethnicity and nationality

Submitters were asked to record, where known, the ethnicity of the victim and suspect, using the Census ethnic group categories. In 96% (n=1401) of cases the victim's ethnicity was recorded.

Across the five-year dataset, a total of 79% (n=1146/1452) of victims were recorded by forces as being from the White ethnic group. Additionally, 7% (n=95) were recorded as being from the Black, Black British, Caribbean or African ethnic group, 7% (n=96) from the Asian or Asian British ethnic group, 2% (n=26) from Mixed or Multiple ethnic groups, and 3% (n=38) from the Other ethnic group. In 4% (n=51) of cases, the victim's ethnicity was not known or not recorded. Taken together, victims from minoritised ethnic groups (other than the White ethnic group) [13] comprised 18% (n=255) of the combined five-year dataset (see Figure 11). Further disaggregated analysis by typology and sex is available in Section 3.3.

Regarding nationality, the majority of victims were recorded as being British (72%, n=1052/1452), which was consistent across all typologies. The most common nationalities after British were Eastern European[14] (5%, n=73) and Indian (1%, n=17). In 15% (n=211)

[13] To note, where the term minoritised ethnic groups is used in this report it does not include White ethnic groups.

[14] According to the United Nations, 'Eastern European' primarily refers to individuals from: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Czech, Estonia, Georgia, Hungary, Latvia, Lithuanian, Polish, Republic of Moldova, Romania, Russian Federation, Serbia and Slovakia.

of cases, the victim's nationality was not known or had not been recorded, therefore the victim's nationality was recorded in 85% of cases.

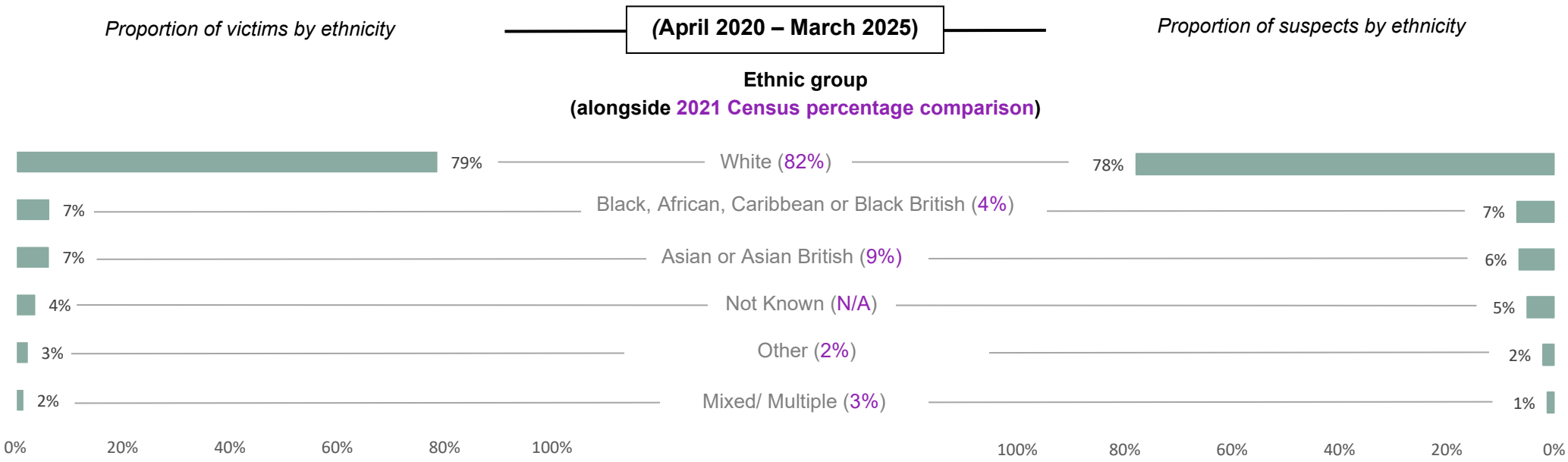
3.2.5 Suspects ethnicity and nationality

Across the five-year dataset, a total of 78% (n=1210/1554) of suspects were recorded by forces as being from the White ethnic group. Additionally, 7% (n=107) were recorded as being from the Black, Black British, Caribbean or African ethnic group, 6% (n=101) from the Asian or Asian British ethnic group, 1% (n=19) from Mixed or Multiple ethnic groups, and 2% (n=32) from the Other ethnic group. In 5% (n=85) of cases, the suspect's ethnicity was not known or not recorded. Taken together, those from minoritised ethnic groups therefore comprised 17% (n=259) of the combined five-year dataset (see Figure 11).

In terms of nationality, most suspects were recorded as being British (71%, n=1099), which was consistent across all typologies. As with victims, the most common nationalities after British were Eastern European (7%, n=109) and Indian (1%, n=13). In 14% (n=220) of cases, the suspect's nationality was not known or had not been recorded.

The project team also reviewed any changes to the recording of ethnicity and nationality within the Year 5 dataset as compared to previous years. Regarding the recording of South Asian ethnic groups and nationalities, across the full dataset, six of the seven Bangladeshi suspects and four of the five Bangladeshi victims were recorded within Year 5 (April 2024 – March 2025) and related to submissions from three separate forces. Whilst a small number of cases, when compared to previous years, this suggests that officers attending the scene may have carried out improved nationality data collection during this period, particularly for individuals of South Asian heritage. This is consistent with recent findings from HMICFRS (2025), that show that when recording crime, forces nearly always recorded the victim's race. This would be a positive development, as in previous years, HMICFRS (2023) made recommendations to forces in relation to the importance of recording protected characteristics, including race.

Figure 11 Victims and Suspects ethnicity compared to the 2021 census



The project dataset includes a slightly lower proportion of victims from the White ethnic group (79% compared to 82%) and an equal proportion of victims from minoritised ethnic groups (18%, n=255/1452), compared to the general population as measured by the 2021 Census. Within the 18% of victims from minoritised ethnic groups, there are slightly higher proportions of victims from the Black, Black British, Caribbean or African ethnic group (7% compared to 4%), and the Other ethnic group (3% compared to 2%) compared to the general population. In contrast, the project dataset includes slightly lower proportions of victims from the Asian or Asian British ethnic group (7% compared to 9%) and Mixed or Multiple ethnic groups (2% compared to 3%) compared to the general population.

The project dataset includes a slightly lower proportion of suspects from the White ethnic group (78% compared to 82%) compared to the general population as measured by the 2021 Census. The proportion of suspects recorded as being from minoritised ethnic groups is similar to that of the general population (17% compared to 18%, n=259/1554). The Project dataset includes a slightly higher proportion of suspects from the Black, Black British, Caribbean or African ethnic group (7% compared to 4%), and a slightly lower proportion of suspects from the Asian or Asian British ethnic group (6% compared to 9%) and Mixed or Multiple ethnic groups (1% compared to 3%) compared to the general population.

3.3 Analysis of victims from minoritised ethnic groups in cases of Domestic Homicides and SVSDA

The analysis below builds upon the above finding concerning the disproportionate number of victims from the Black, Black British, Caribbean or African ethnic group in comparison to their representation within the population according to the 2021 Census. It is also informed by a report by Imkaan and the Centre for Women's Justice (Ofer, 2023), which utilised analysis from 44 case studies of domestic homicides and SVSDA involving female victims from minoritised ethnic groups to develop 14 recommendations for the NPCC, College of Policing, Home Office and the Department of Health and Social Care.

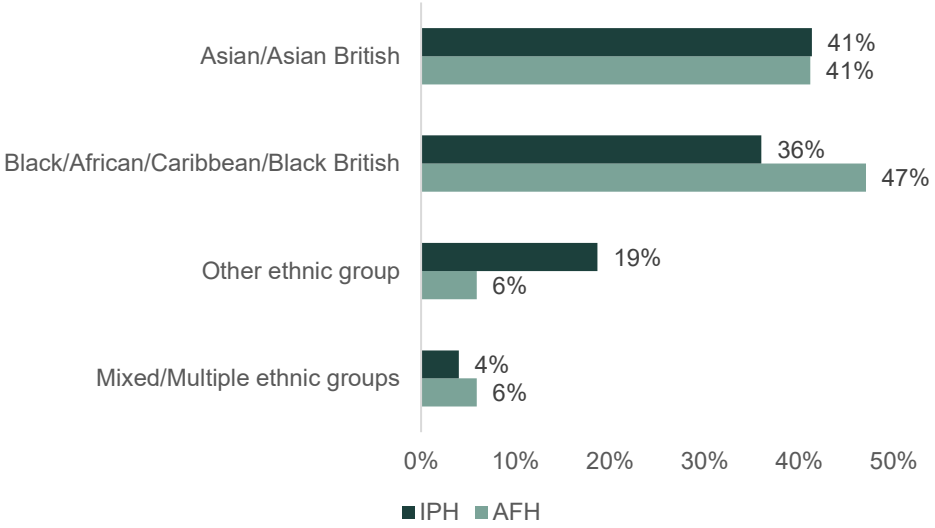
One of these recommendations related to the importance of disaggregating relevant data to ensure any potential disproportionality can be identified. Other recommendations focused on the inclusion of relevant data for domestic abuse related suicides, alongside domestic homicides. In last year's report, the project team conducted analysis of domestic homicides and SVSDA focusing on female and male victims from minoritised ethnic groups to illustrate any differences by sex of the victim and ethnicity by typology. The following is replication of that analysis with the five-year dataset.

3.3.1 Female victims from minoritised ethnic groups in cases of Domestic Homicide

Of the 641 domestic homicide victims (227 AFH and 414 IPH) recorded across the five-year dataset, 476 (74%) were female. Of these female victims, 23% (n=109/476) were from minoritised ethnic groups. Therefore, similar to the above analysis across all typologies, female victims from minoritised ethnic groups represent 17% of all 641 domestic homicide victims. For 2% of female victims (n=11/476), ethnicity was not known or recorded.

Of the 109 female victims from minoritised ethnic groups, 41% (n=45) were recorded as being from the Asian or Asian British ethnic group, 39% (n=43) from the Black, Black British, Caribbean or African ethnic group, and 5% (n=5) from Mixed or Multiple ethnic groups. A total of 16 (15%) female victims from minoritised ethnic groups were recorded as being from the Other ethnic group (see
Figure 12 for proportions disaggregated by typology).

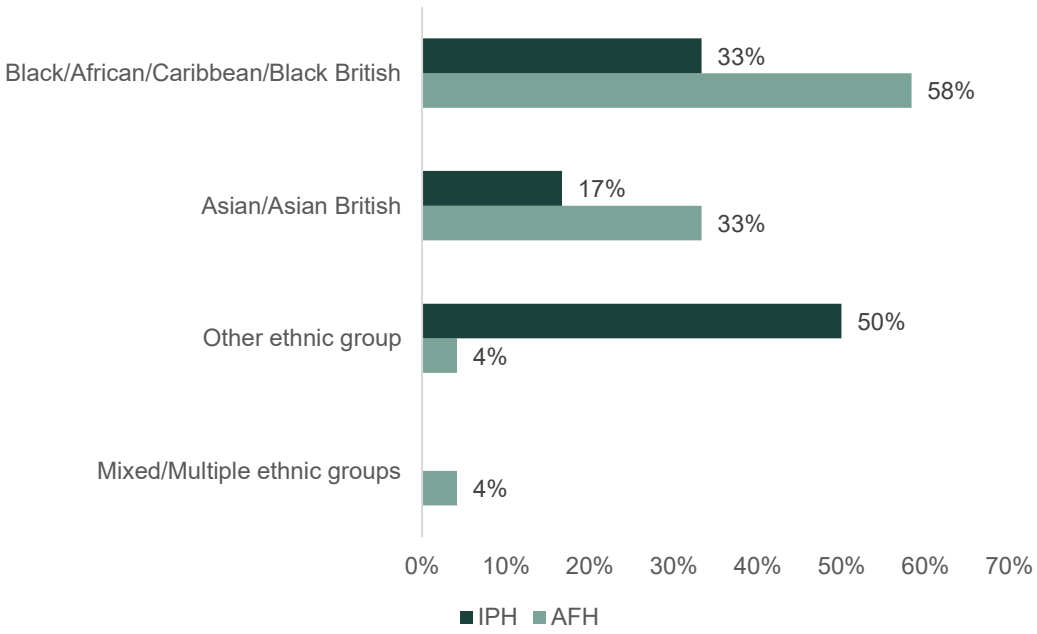
Figure 12 Proportion of Domestic Homicide cases with female victims from minoritised ethnic groups (April 2020 – March 2025, n=109)



3.3.2 Male victims from minoritised ethnic groups in cases of Domestic Homicide

Across the five-year dataset, 26% of domestic homicide victims were male (n=165/641). For 2% (n=3/165) of male victims, ethnicity was not known or not recorded. 18% (n=30/165) of male victims of domestic homicide were from minoritised ethnic groups. Of these 30 victims, 53% (n=16) were recorded as being from the Black, Black British, Caribbean or African ethnic group, 30% (n=9) from the Asian or Asian British ethnic group, 13% (n=4) from the Other ethnic group and one male victim (1%) was from Mixed or Multiple ethnic groups (see Figure 13).

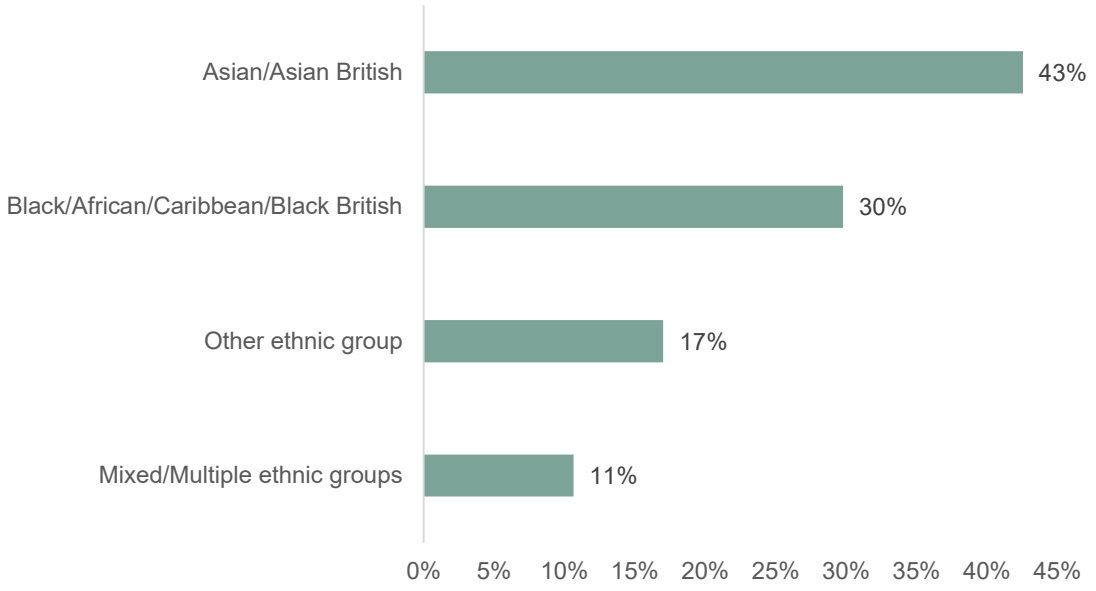
Figure 13 Proportion of Domestic Homicide cases with male victims from minoritised ethnic groups (April 2020 – March 2025, n=30)



3.3.3 Female victims from minoritised ethnic groups in cases of Suspected Suicide

Of the 553 victims of SVSDA recorded across the five-year dataset, 78% (n=430) were female. For 3% of female victims (12/430), ethnicity was not known or recorded. Among these female victims, 11% (n=47/430) were from minoritised ethnic groups. Of these 47 victims, 43% (n=20) were recorded as being from the Asian or Asian British ethnic group, 30% (n=14) from the Black, Black British, Caribbean or African ethnic group, 17% (n=8) from the Other ethnic group and 11% (n=5) from Mixed or Multiple ethnic groups (see Figure 14).

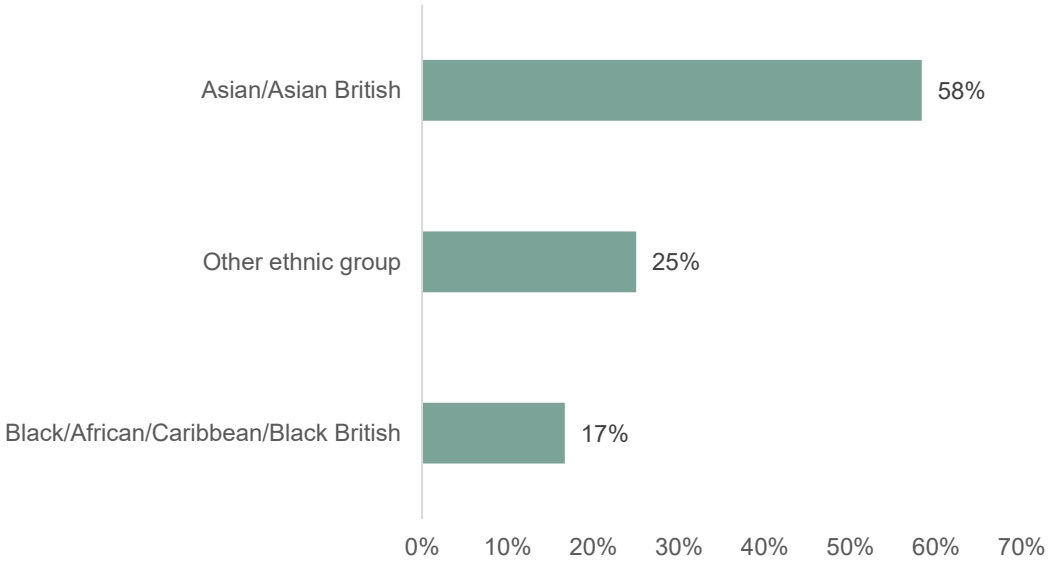
Figure 14 Proportion of SVSDA cases with female victims from minoritised ethnic groups (April 2020 – March 2025, n=47)



3.3.4 Male victims from minoritised ethnic groups in cases of Suspected Suicide

Across the five-year dataset, 22% of SVSDA victims were male (n=123/553). For 6% (n=7/123) of male victims, ethnicity was not known or recorded. Among these male victims of SVSDA, 10% (n=12/123) were from minoritised ethnic groups. Of these 12 victims, seven (58%) were recorded as being from the Asian or Asian British ethnic group, three (25%) from the Other ethnic group and two (17%) from the Black, Black British, Caribbean or African ethnic group (see Figure 15).

Figure 15 Proportion of cases of SVSDA with male victims from minoritised ethnic groups (April 2020 – March 2025, n=12)



3.4 Other protected characteristics and additional factors

3.4.1 Victims' sexual orientation, religion and pregnancy status

Across five years of data collection, 48 of the 1452 victims (3%) were recorded as being LGBTQ+. However, for 25% (n=363) of victims this characteristic was listed as 'not known' or not recorded. Findings from an HMICFRS (2025) report show that forces rarely recorded victims' sexual orientation. Four (0.3%) of the victims within the five-year dataset were recorded as having undergone gender reassignment although this characteristic was 'not known' or not recorded for 13% (n=192) of victims. Discussions with stakeholders raised that many trans, non-binary and intersex individuals do not seek to have gender reassignment surgery. Therefore, the variable 'gender reassignment' would not necessarily capture all individual's experiences.

There are several factors, including policing-specific challenges, that could affect the identification of LGBTQ+ victims. Research demonstrates that, despite LGBTQ+ individuals being disproportionately victimised, they are less likely to report these instances to the police (Grasso et al., 2024). For instance, this may be because they are concerned about discrimination based on their LGBTQ+ identity, fear that they would not be taken seriously, that the police would not be able to help and that services tend to perceive the LGBTQ+ community as one homogeneous group (Galop, 2022; Magić & Kelley, 2018). As such, these factors contribute to diminished trust and willingness to engage with the police and statutory agencies (Donovan & Barnes, 2020; Donovan & Hester, 2011; Donovan & Hester 2014), impacting the recording of this data across services.

Discussions with stakeholders also alluded to how patriarchal norms and constructs of masculinity, particularly hegemonic masculinity (which frames men as having to be strong

and dominant (Connell & Messerschmidt, 2005; McMahon, 2022)), can shape whether individuals recognise themselves as victims of DA - especially among gay and bisexual men (Maxwell et al., 2025). Research shows that the gendered perceptions of victimhood in the context of DA can also stigmatise male victims and limit their acknowledgement of their victimisation where they may struggle to relate their own experiences to what they perceived to be a "heavily feminised figure of [an] 'ideal victim'" (Goldenberg et al. 2016; Kim et al., 2024; Maxwell et al., 2025; McAulay, 2024, p. 282). Research on barriers to disclosure and help-seeking among gay and bisexual men show a perceived focus on physical forms of IPV, and that there was an expectation that they should have 'fought back', failing to acknowledge the experience of CCB and other forms of abuse (Maxwell et al., 2025).

Notably, 65% (n=31/48) of LGBTQ+ victims across the five-year dataset were recorded within SVSDA cases, of which 58% (n=18/31) were female and 42% (n=13/31) were male. Research shows that bisexual women are at a 6-fold increased risk of suicide attempts during their lifetime compared to heterosexual women, and that out of those who have previously attempted suicide, sexual minority women tended to have attempted from a younger age (Blosnich et al., 2017). These findings reinforce the importance of considering opportunities to support suicide prevention activities within the LGBTQ+ community.

Moreover, these findings also reflect the prevalence of mental health care needs among LGBTQ+ victims of DH, as well as victim/survivors of DA. Whilst LGBTQ+ individuals are at a higher risk of poor mental health (McDermott et al., 2024), research shows that they also experience stigma and discrimination within mental health services and have unique intersectional needs and challenges (Patten et al., 2022; Rees et al., 2020). However, there remains a dearth of specialist services to support LGBTQ+ individuals with mental health care needs (Education Policy Institute, 2024). These findings demonstrate the opportunity for targeted mental health support for those within the LGBTQ+ community, including in relation to DA.

Five percent (n=69) of the 1452 victims across the full dataset were recorded as having a known religion, with 2% (n=23) recorded as having no religious beliefs and the remaining 94% (n=1360) being 'not known' or not recorded. For the 69 victims where religion was known, the three most recorded religions were Christian (52%, n=36), Muslim (19%, n=13) and Sikh (14%, n=10).

Finally, six (<1%) of the victims were recorded as being pregnant at the time of their death and 13 (1%) as having given birth within the six months prior to their death. However, this was not confirmed or recorded for 13% (n=138/1058) of cases involving female victims. Whilst this is a relatively small number within the overall dataset, the project's Spotlight Briefing on Young Victims (Bates et al., 2024) and findings from deaths involving a fall from height demonstrate the importance of capturing this information.

3.4.2 Suspects' sexual orientation, religion and pregnancy status

In the five-year dataset, 44 (3%) of the 1554 suspects were recorded as being LGBTQ+. For 30% (n=462) of suspects, this characteristic was listed as 'not known' or not recorded.

As seen for victims, the majority of LGBTQ+ suspects were recorded in cases of SVSDA (61%, n=27/44), 52% (n=14/27) of which were female and 48% (n=13/27) male. Two suspects (<1%) within the five-year dataset were recorded as having undergone gender reassignment, although this characteristic remained 'not known' or not recorded for 17% (n=266) of suspects.

Around 3% (n=53) of the 1554 suspects were recorded as having a known religion, with 2% (n=27) recorded as having no religious beliefs and the remaining 95% (n=1474) being not known or not recorded. For the 53 suspects where religion was known, the three most recorded religions were Muslim (38%, n=20), Christian (34%, n=18) and Sikh (17%, n=9).

Similar to victims, 1% (n=23) of suspects were recorded as being pregnant or having given birth within the previous six months at the time of the victim's death. Suspect pregnancy was not known or not recorded in 28% (n=88/316) of cases involving female suspects.

3.4.3 Victims' and Suspects' care needs

Overall, mental health[15] was the most commonly record care need for victims (29%, n=425) and suspects (44%, n=687, see Table 8 for a breakdown of all care needs). In 32% (n=499/1554) of cases for suspects and in 26% (n=383/1452) of cases for victims, it was not known or not recorded whether the individual had any care needs. Similar to the recording of sexual orientation above, HMICFRS (2025) findings indicate that forces rarely recorded victims' disabilities. However, data from the CSEW shows that individuals aged 16 and over who have a disability are significantly more likely to have been a victim of domestic abuse than individuals without a disability (13.4% as compared to 6.7%; ONS, 2025).

Within this project's database, when comparing by typology for victims, mental health needs were most common in cases of SVSDA (55%, n=303/553). Victims of unexpected deaths were reported to have relatively similar rates of physical (28%, n=37/131) and mental health (31%, n=40/131) care needs.

For suspects, mental health care needs were highest in cases of AFH (62%, N=149/240). When considered in conjunction with the risk factors detailed in Chapter Four, these findings highlight the important role of mental health and other specialist support services in responding to domestic abuse.

[15] Any references to mental ill health are based on their recording by the police, and whilst some of these cases will be based on formal clinical diagnosis or evidence of treatment, others may be based on self, partner, family/friend, or police-reported mental illness or self-harm. For additional information about suspect mental ill health risk factors see Section 4.2.

Table 8 Number and proportion of victims and suspects with care needs (April 2020 – March 2025)

	Physical health care needs		Mental health care needs		Learning or developmental needs		Dementia	
	N	%	N	%	N	%	N	%
Victims (n=1452)	208	14%	425	29%	62	4%	31	2%
Suspects (n=1554)	95	6%	687	44%	57	4%	8	1%

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

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

4.1 Overall risk factors

Police forces are asked to identify the presence of 27 potential risk factors relating to the relationship and the suspect. Whilst not possible to claim that these factors lead to domestic homicide or SVSDA, these risk factors have been commonly identified in such cases. These risk factors were initially identified through a review of academic research, which is detailed in the Year 1 report (Bates et al., 2022).

The project team conducts follow ups and re-codes the risk factors where they can be identified within the free text on the submission form. However, the figures are likely to be underestimates because this information is captured early within the investigation and the police alone may not hold information about all potential risk factors unless directly reported to them. Moreover, this list of risk factors has been updated, such as the (non-retroactive) inclusion of 'image-based sexual abuse' and 'harassment / malicious communications' beginning in April 2024 which will affect their overall proportion across the dataset.

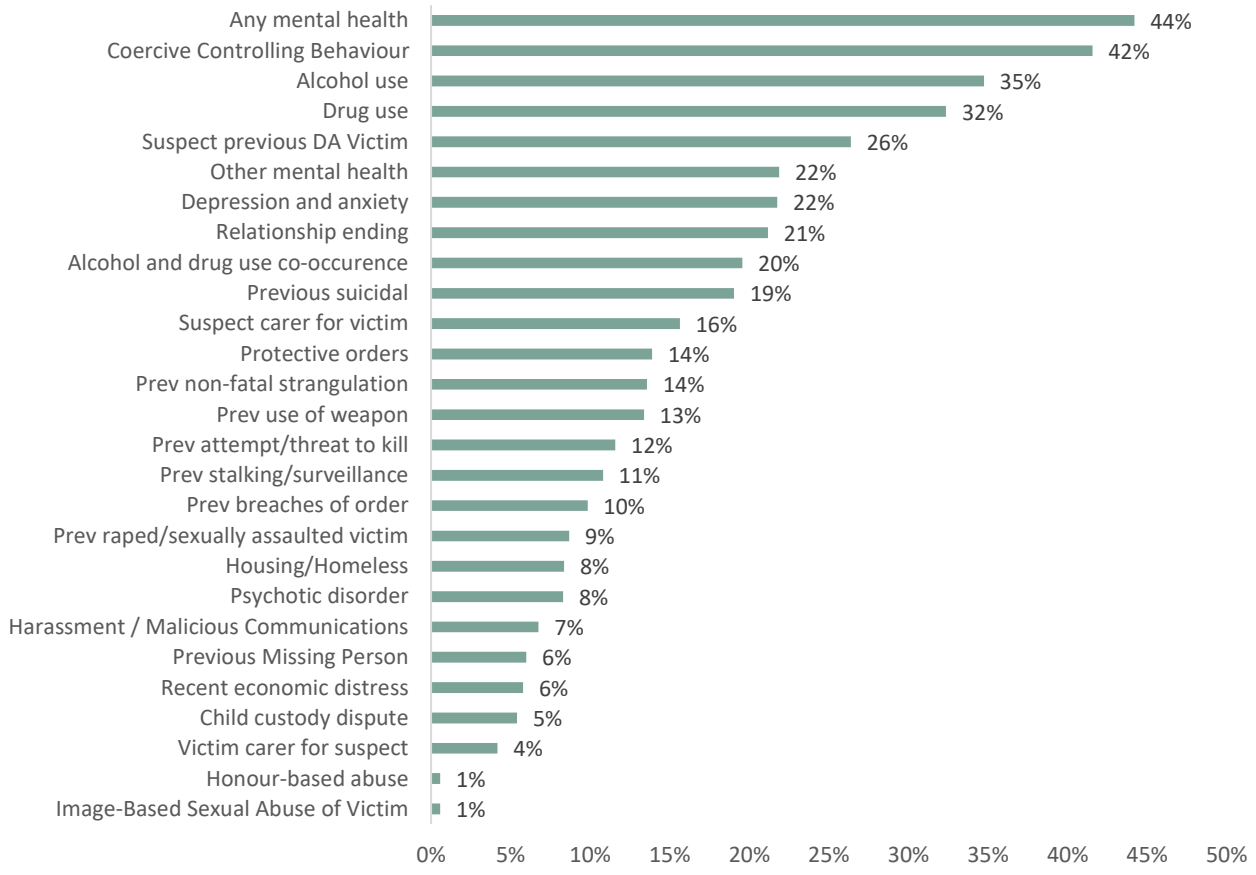
As shown in Figure 16 across the five-year dataset, the most commonly recorded risk factors in relation to the suspect (n=1554) were identified as:

1) Any mental ill health[16] (44%, n=687)
2) A history of CCB (42%, n=646)
3) Alcohol use (35%, n=540)
4) Drug use (32%, n=503)

Importantly, some of these risk factors may co-occur. For example, 20% (n=304) of suspects had *both* alcohol use and drug use as co-occurring risk factors.

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

Figure 16 Proportion of suspects with recorded risk factors (April 2020 – March 2025)



Another commonly recorded risk factor was the suspect being known to the police as a victim of domestic abuse (26%, n=410). The Year 3 report (Hoeger et al., 2024, Chapter 7) presented analysis regarding the potential identification of a 'primary' perpetrator in cases of SVSDA. This year's analysis reviewed cases of SVSDA whereby the suspect profile was coded as 'victim/vulnerable', including 24 cases. This coding was completed based on the police recorded history of the suspect, including consideration of any domestic abuse history raised by family or friends after the victim's death. Those suspects coded as 'victim/vulnerable' include those that are known primarily as victims of domestic abuse and/or demonstrate significant vulnerabilities.

Importantly, this analysis is based on information that has been reported to the police and could also involve counter and/or false allegations of abuse that would not be possible to identify without additional context. Overall, there are challenges to identifying a 'primary' perpetrator in cases of domestic abuse involving a history of offending recorded for all parties, particularly when a CCB perpetrator may attempt to manipulate the police and other agencies by portraying themselves as the primary victim (Barlow, 2023, Barlow and Walklate 2025).

With this context, upon reviewing the details within these case submissions, in 20 out of 24 of the cases the deceased (victim of the SVSDA) appeared to be the primary perpetrator

of the domestic abuse. In the four remaining cases additional information would be needed to identify the primary perpetrator of the abuse. Of the 20 cases in which the victim of the SVSDA appeared to be the primary perpetrator of the abuse, 16 were recorded as male and four as female. Regarding the 'suspects' who appeared to be the primary victim of the abuse, six were recorded as male and 14 as female.

Another risk factor that features prominently in the wider literature in relation to IPH is the actual, attempted, or perceived attempt of separation by the victim is (e.g. Campbell et al., 2007; Chopra et al., 2022; Femicide Census, 2020; Monckton-Smith, 2021). A threat of ending the relationship or a recent separation was identified within 21% (n=329) of cases across the project's five-year dataset. As demonstrated below in Section 4.2, separation is also a prominent risk factor in cases of SVDA (33%, n=207). As part of its efforts to halve violence against women and girls, the government has recognised the relevance of this risk factor for IPH and in December 2024 announced the addition of the attempt/intended attempt or the perceived attempt to end of relationship as a new statutory aggravating factor for sentencing in murder cases. These changes took effect in October 2025 (Sentencing Act, 2020).

Moreover, literature evidences the use of non-fatal strangulation (NFS) as a significant risk factor for, and potential predictor of, domestic homicide with more recent literature examining its link to suicide following domestic abuse (Christie et al., 2023; McGowan, 2024; Munro & Dangar, 2025; Pritchard et al., 2015). NFS also contributes to a range of adverse physical, neurological and psychological outcomes for its victims (Monahan et al., 2020). This highlights the need to understand NFS in the context of domestic abuse related deaths, to explore its occurrence across different typologies and the co-occurrence with other known risk factors.

Initially, chi-square analyses were conducted to explore the relationships between previous NFS and all other risk factors across the five-year dataset. Findings demonstrated that there were statistically significant strong associations between previous NFS and all other risk factors in the database (see Table 13 in Appendix B).

The strongest of these associations was with 'threats to kill': $\chi 2(16, 1554) = 4555.28$, $p < .001$, V = .856. This suggests that these factors were identified together more frequently than would be expected by chance. Wider research by Stansfield and Williams (2018) corroborates these findings, noting that "NFS between intimate partners represents an extreme controlling form of violent behaviour" (p.5105) and demonstrating a relationship between overt threats to a partner's life at incident arrest, and subsequent NFS post-arrest. These findings, alongside our analyses, suggest the role of NFS within CCB perpetration.

NFS was analysed further as a risk factor within domestic homicides (encompassing IPH and AFH cases), and SVSDA, to see if there was a difference in the presence of NFS across typologies using z-tests (See Table 9). Findings from these z proportion tests indicated that there was a statistically significant difference in the proportion of suspects

who had previously perpetrated NFS against the incident victim, and/or a previous victim(s), in domestic homicide (9%) as compared to SVSDA cases (21%): Z = -5.82, p < .001.

Specifically, these findings indicate that NFS as a risk factor was found to be more prevalent proportionally in cases of SVSDA as compared to domestic homicides. The aforementioned emerging academic research, alongside the analysis presented by this project team (Hoeger et al., 2025), demonstrate the potential links between NFS and suicidality, and suggest additional research should be conducted to improve understanding and inform awareness raising around this issue.

Table 9 Proportion test for NFS in Domestic Homicides and SVSDA

Risk Factor	Domestic Homicide (IPH & AFH)	DH Total	Suspected Victim Suicides	Suspected Victim Suicide Total	Z-Test
Presence of NFS as a Risk Factor	58 (9%)	641	116 (21%)	553	Z = -5.82, p < .001

Lastly, as the second most common risk factor across the full five-year dataset, chi-square analyses were conducted to explore the relationships between CCB and the other risk factors within the dataset. The analyses indicated that there were statistically significant weak associations between CCB and all risk factors in the dataset. The strongest of these associations were with harassment : $\chi^2(40, 1554) = 631.98$, $p < .001$, V = .285, Image Based Sexual Abuse [IBSA]: $\chi^2(40, 1554) = 573.49$, $p < .001$, V = .272, and Recent Threat/ Actual End to the Relationship: $\chi^2(32, 1554) = 284.61$, $p < .001$, V = .214.

These findings are consistent with the literature, which evidences IBSA and harassment as means of coercive control (Henry et al., 2022) and highlights that CCB is particularly prominent when victim/survivors try to end the relationship (Johnson et al. 2017; Myhill, 2018; Thomas et al., 2013). Risk factors and their associations with CCB can be seen in Table 15 within Appendix B.

4.2 Risk factors by case type

Across the five years of data collection, the top risk factors were relatively consistent though differed slightly by typology (see Table 10**Error! Reference source not found.**). For instance, CCB was not as prevalent in cases of AFH (16%, n=39/240) as compared to typologies such as IPH (42%, n=176/423) and SVSDA (56%, n=349/622), demonstrating their differing risk profiles. Additionally, alcohol use (47%, n=67/142), drug use (43%, n=61/142) and a co-occurrence between the two (27%, n=39/142), was most common in unexpected deaths.

Table 11 shows the prevalence of specific mental ill health risk factors[17] (i.e., within those included in the 'Any mental ill health' risk factor) by typology across the five-year dataset. Mental ill health classified as 'other'[18] (22%, n=340/1554) and depression and anxiety (22%, n=338/1554) were those most commonly recorded for suspects across all typologies.

[17] It is important to note that any references to mental ill health are based on their recording by the police, and whilst some of these cases will be based on formal clinical diagnosis or evidence of treatment, others may be based on self, partner, family/friend, or police-reported mental illness or self-harm.

[18] 'Other mental ill health' refers to any mental ill health risk factors identified without any official clinical diagnoses. This may include self-reported concerns from the suspect regarding their mental health, reported concerns from the suspect's family/friends/partners, and/or a history of self-harm.

Table 10 Most common suspect risk factors by typology (April 2020 – March 2025)

Adult Family (n=240)	Intimate Partner (n=423)	Suspected Suicide (n=622)	Unexpected Death (n=142)	Child Death (n=85)	Other (n=42)
Any mental ill health (62%, n=149)	Any mental ill health (43%, n=182)	Coercive and controlling behaviour (56%, n=349)	Alcohol use (47%, n=67)	Carer for the victim (86%, n=73)	Alcohol use (33%, n=14)
Drug use (35%, n=84)	Coercive and controlling behaviour (42%, n=176)	Any mental ill health (40%, n=248)	Coercive and controlling behaviour (45%, n=64)	Any mental ill health (47%, n=40)	Drug use (31%, n=13)
Alcohol use (34%, n=81)	Alcohol use (34%, n=142)	Alcohol use (36%, n=226)	Drug use (43%, n=61)	Suspect previously a DA victim (34%, n=29)	Any mental ill health (26%, n=11)
Carer for the victim (19%, n=46)	Drug use (27%, n=113)	Suspect previously a DA victim (34%, n=213)	Any mental ill health (40%, n=57)	Drug use (28%, n=24)	Suspect previously a DA victim (17%, n=7)
Coercive and controlling behaviour (16%, n=39)	Recent separation or threat of relationship ending (23%, n=98)	Drug use (33%, n=208)	Carer for the victim (28%, n=40)	Recent child custody dispute* (14%, n=12)	Coercive and controlling behaviour (17%, n=7)
Previous use of a weapon* (16%, n=39)		Recent separation or threat of relationship ending (33%, n=207)			

Alcohol use
Drug use
Suspect previously a DA victim
Carer for the victim
Recent separation or threat of relationship ending
Any mental ill health
Controlling or coercive behaviour

*Non-coloured risk factors represent those that were found to proportionately be one of the most common in just one typology.

Table 11 Most common risk factors related to 'any mental ill health' by typology (April 2020 – March 2025)

Adult Family (n=240)	Intimate Partner (n=423)	Suspected Suicide (n=622)	Unexpected Death (n=142)	Child Death (n=85)	Other (n=42)
Other mental ill health (37%, n=88)	Depression and anxiety (24%, n=101)	Depression and anxiety (22%, n=135)	Depression and anxiety (23%, n=32)	Other mental ill health (22%, n=19)	Depression and anxiety (12%, n=5)
Psychotic disorder (22%, n=53)	Previous suicidal thoughts/attempts (21%, n=90)	Previous suicidal thoughts/attempts (20%, n=126)	Other mental ill health (21%, n=30)	Previous suicidal thoughts/attempts (21%, n=18)	Other mental ill health (12%, n=5)
Depression and anxiety (20%, n=47)	Other mental ill health (20%, n=86)	Other mental ill health (18%, n=112)	Previous suicidal thoughts/attempts (14%, n=20)	Depression and anxiety (21%, n=18)	Previous suicidal thoughts/attempts (10%, n=4)
Previous suicidal thoughts/attempts (16%, n=38)	Psychotic disorder (6%, n=25)	Psychotic disorder (5%, n=28)	Psychotic disorder (8%, n=12)	Psychotic disorder (9%, n=8)	Psychotic disorder (7%, n=3)

- Depression and anxiety
- Previous suicidal thoughts/attempts
- Psychotic disorder
- Other mental ill health

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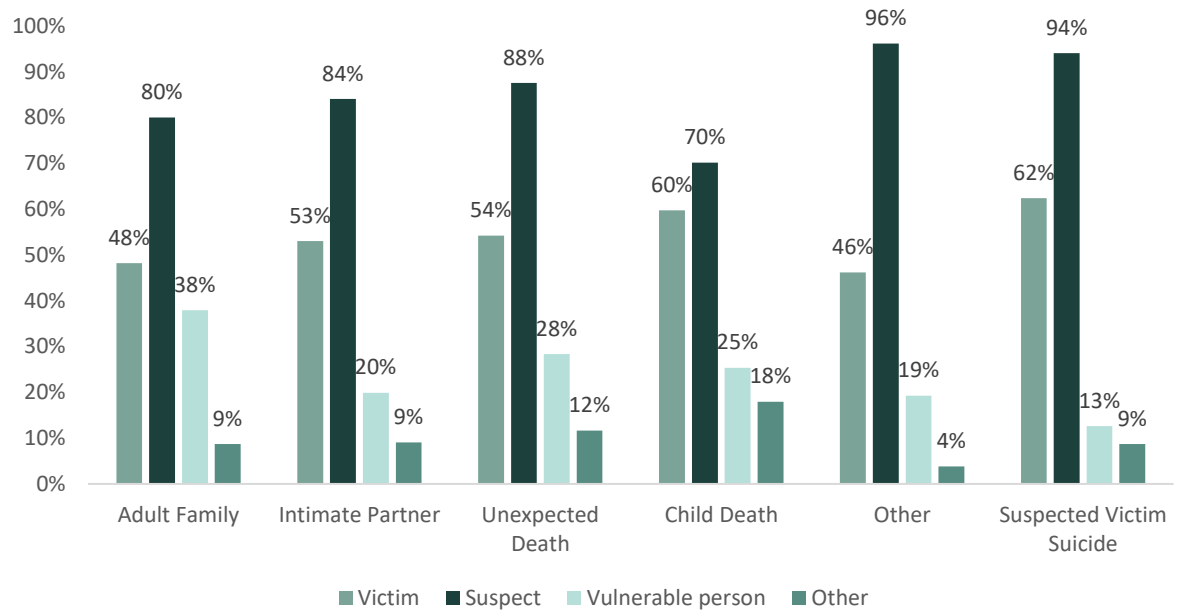
Chapter 5 – Prior suspect and victim contact with the police and other agencies

5.1 Suspect previously known to the police

Across the five-year dataset, 85% (n=1325/1554) of suspects were previously known to the police for any reason (i.e., as a victim, suspect, vulnerable person, witness, etc.). Within each typology, the proportion of suspects know to police for any reason were recorded as follows: 81% (n=195/240) in AFH cases, 78% (n=332/423) in IPH cases, 79% (n=67/85) in child deaths, 85% (n=120/142) in unexpected deaths, 94% (n= 585/622) in SVSDA and 62% (n=26/42) in cases recorded as other. The detail of how the suspects were known to the police are presented in Figure 17 below, whereby the proportions are calculated out of the total of those known to the police.

Figure 17 Proportion of suspects known to the police as a victim, suspect, vulnerable person or other circumstances by typology (April 2020 – March 2025)



5.2 Suspect previously known to the police for domestic abuse

Whilst a general history of police contact is relatively common for suspects, it is important to understand their contact with the police in relation to domestic abuse. The project team coded a separate variable to record whether the suspect was previously known to the police for DA-related offending (see Figure 18, below). Overall, 69% (n=1080/1554) of suspects were known to the police for DA, as a suspect or perpetrator prior to the victim's death.

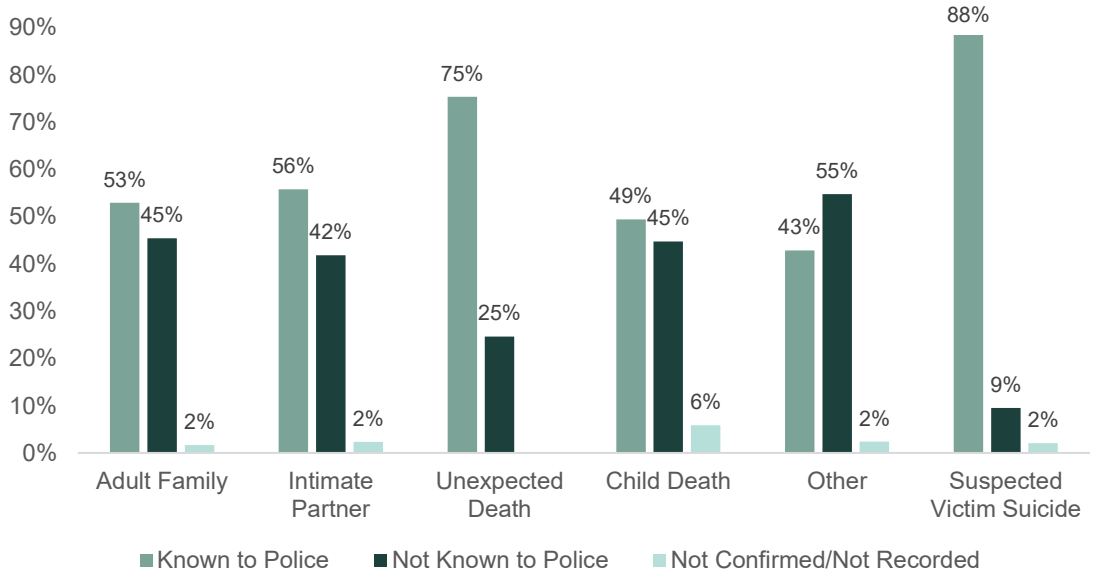
Notably, the inclusion of prior DA perpetrators in cases of SVSDA increases the proportion of suspects known to the police within the overall dataset. This occurs because most SVSDA cases involve a victim and perpetrator being known to the police for DA before the death for the case to be identified and reported to this project. Therefore, excluding cases

of SVSDA, 57% (n=530/932) of suspects were known to the police for DA perpetration prior to the victim's death across the five-year dataset.

As above, most prior domestic abuse perpetrators in SVSDA cases were known to the police for domestic abuse prior to the victim's death (88%, n=550/622). However, this would indicate that in some cases the information about the history of domestic abuse has been identified to the police after the victim's death by family members, friends or partner agencies.

Across the remaining typologies, unexpected deaths had the highest proportion of suspects known to the police for DA (75%, n=107/142). This is followed by suspects in IPHs (56%, n=236/423), AFHs (53%, n=127/240), child deaths (49%, n=42/85), and deaths classified as 'other' (43%, n=18/42).[19] As supported by the findings throughout this chapter, cases of SVSDA and unexpected death appear to be the most visible to the police (and other agencies) prior to the victim's death, indicating the potential for intervention.

Figure 18 Proportion of suspects known to the police for DA offending by typology (April 2020 – March 2025)



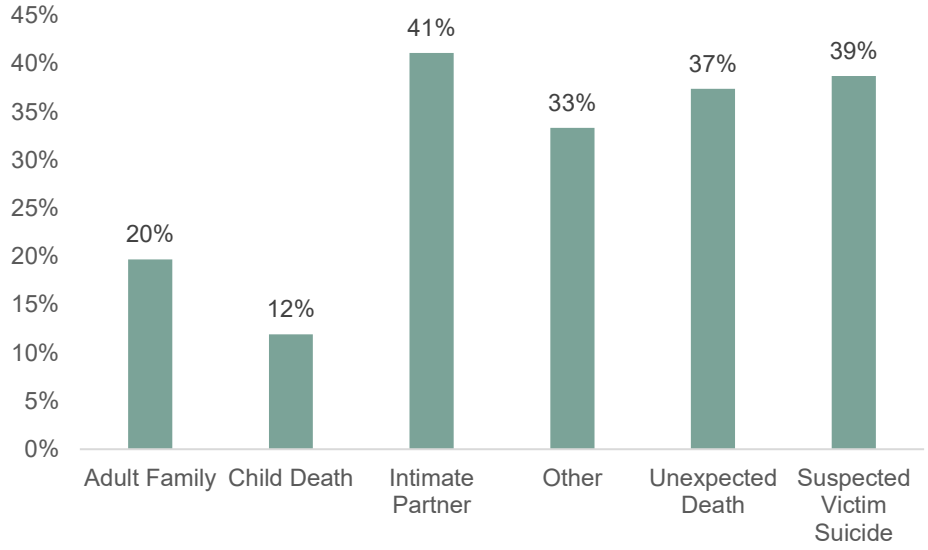
5.3 Suspect risk level and management

Data collection also included whether the suspect was previously known to the police as a high-risk or serial DA perpetrator, referred to MARAC, or managed by police or probation at the time of the victim's death.

Of the suspects who were known to the police for DA offending prior to the victim's death, 36% (n=386/1080) were known as high-risk and/or serial perpetrators. This primarily applied to suspects in IPH cases (41%, n=97/236), unexpected deaths (37%, n=40/107) and prior DA perpetrators in cases of SVSDA (39%, n=213/550; see Figure 19).

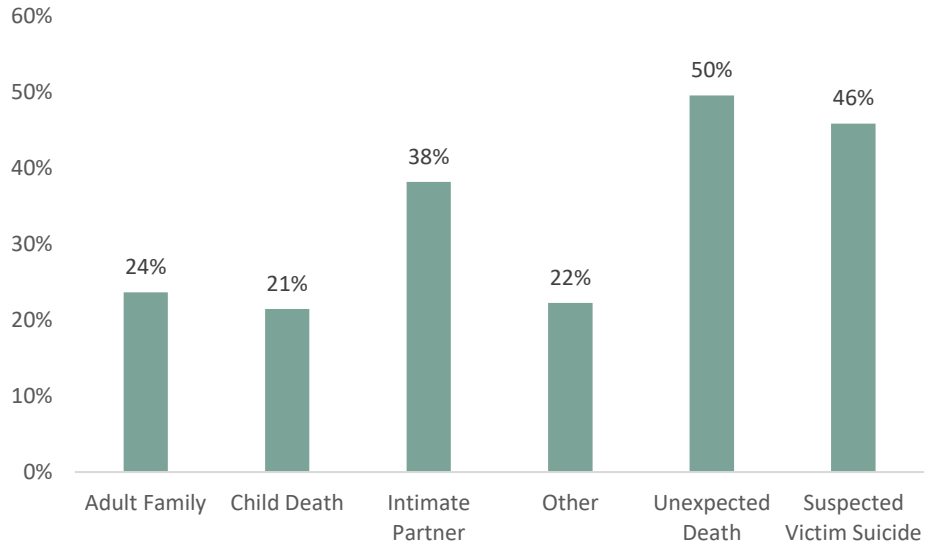
[19] Across all typologies, 33 suspects (2%) had not been confirmed to be known to the police for prior DA.

Figure 19 Proportion of suspects known to the police for DA offending and identified as high-risk or serial perpetrators by typology (April 2020 – March 2025)



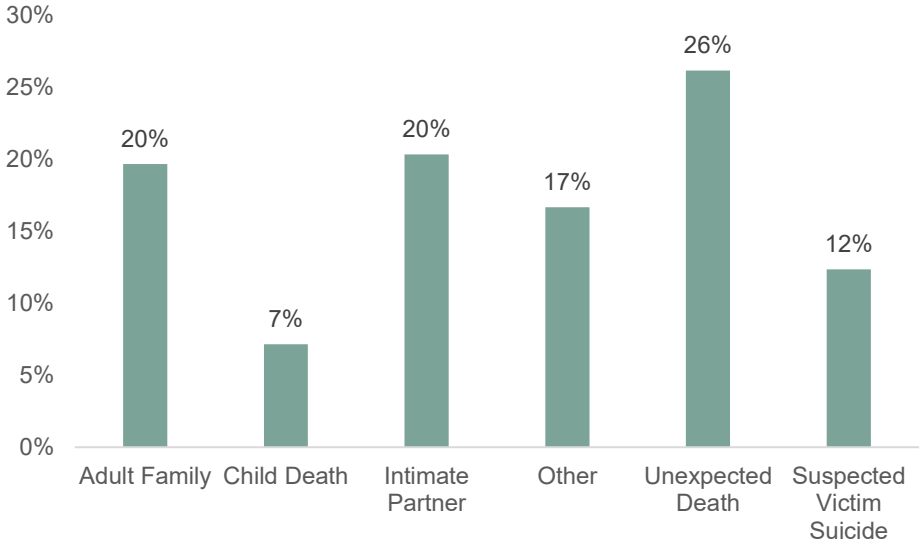
Additionally, of the suspects who were known to the police for DA, 41% (n=438/1080) were also involved in cases which were referred to MARAC, which varied by typology (see Figure 20). Findings continue to demonstrate that suspects in unexpected deaths (50%, n=53/107), prior DA perpetrators in SVSDA cases (46%, n=252/550) and suspects in IPH cases (38%, n=90/236) are referred to MARAC at a higher rate compared to suspects within AFH cases (24%, n=30/127).

Figure 20 Proportion of suspects known to the police for DA offending and referred to MARAC by typology (April 2020 – March 2025)



Across the five-year dataset, 16% (n=175/1080) of the suspects known to the police for DA, were recorded as having been (previously) managed by police or probation (e.g., under MAPPA, IOM, or DRIVE). When reviewed by typology, the highest proportion of these suspects were recorded in unexpected deaths (26%, n=28/107, see Figure 21).

Figure 21 Proportion of suspects known to the police for DA offending and managed by police or probation by typology (April 2020 – March 2025)

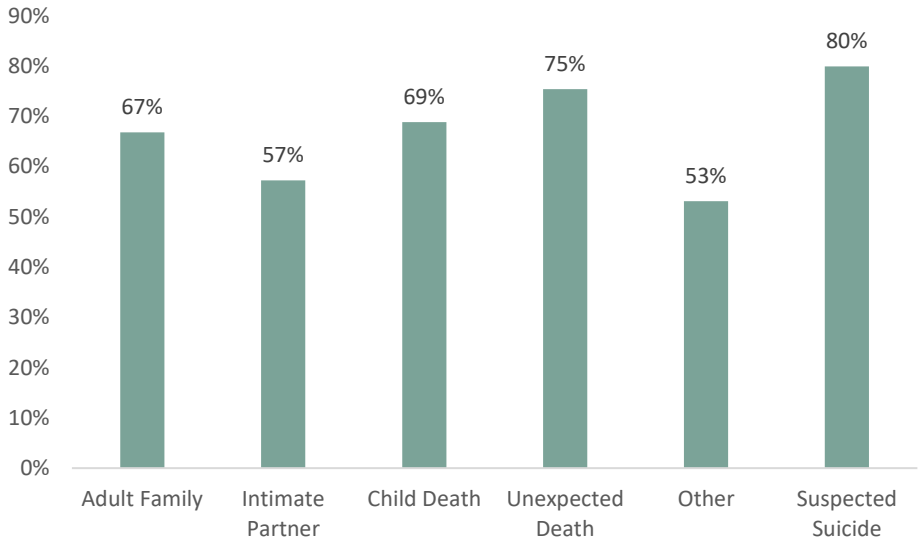


5.4 Suspect or victim previously known to other agencies

Across the five-year dataset, in 70% of incidents (n=982/1410) the suspect and/or victim was known to a partner agency, most commonly in cases of SVSDA (80%, n=441/553 – see Figure 22). Conversely, 30% (n=428) of suspects and/or victims were not recorded or not confirmed to be known to any partner agency.

Notably, in cases where the suspect was not previously known to the police for any reason (n=214), the suspect and/or victim was known to a partner agency in 38% (n=81) of cases. This continues to highlight the importance of multi-agency work to prevent domestic homicides and suicides following DA (Home Office, 2022; Hoeger et al., 2025).

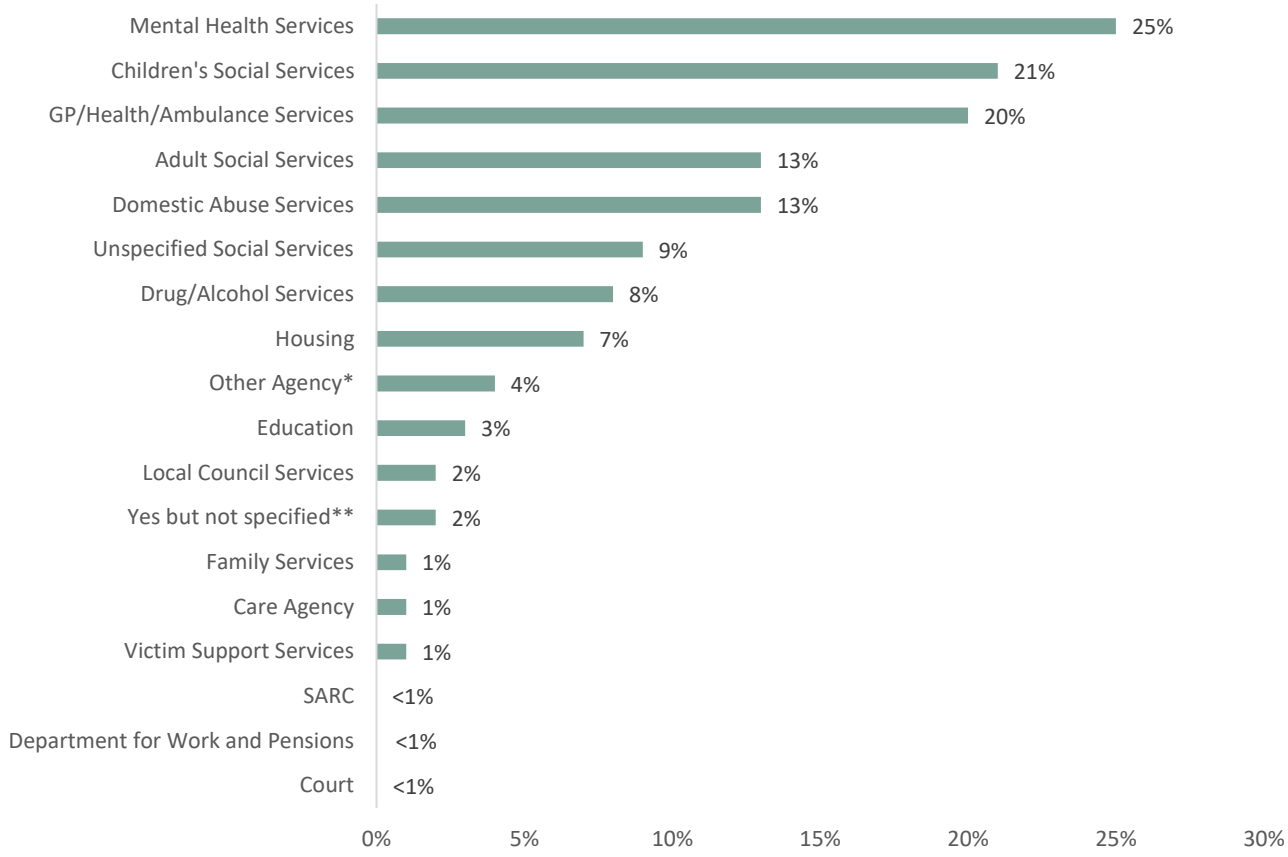
Figure 22 Proportion of victims and/or suspects known to other agencies by typology (April 2020 – March 2025)



Overall, the victim and/or suspect were most commonly known to mental health agencies (25%, n=355/1410), followed by children's social services (21%, n=290), health and

ambulance services (20%, n=287), adult social services (13%, n=189) and domestic abuse services (31%, n=180). When combining all cases known to social services (including adult, children, and unspecified services), this accounted for 43% of victims and/or suspects (n=600). Figure 23 shows the agencies that the victim and/or suspect were known to in Year 5, albeit this did vary according to typology (see Figure 24).[20]

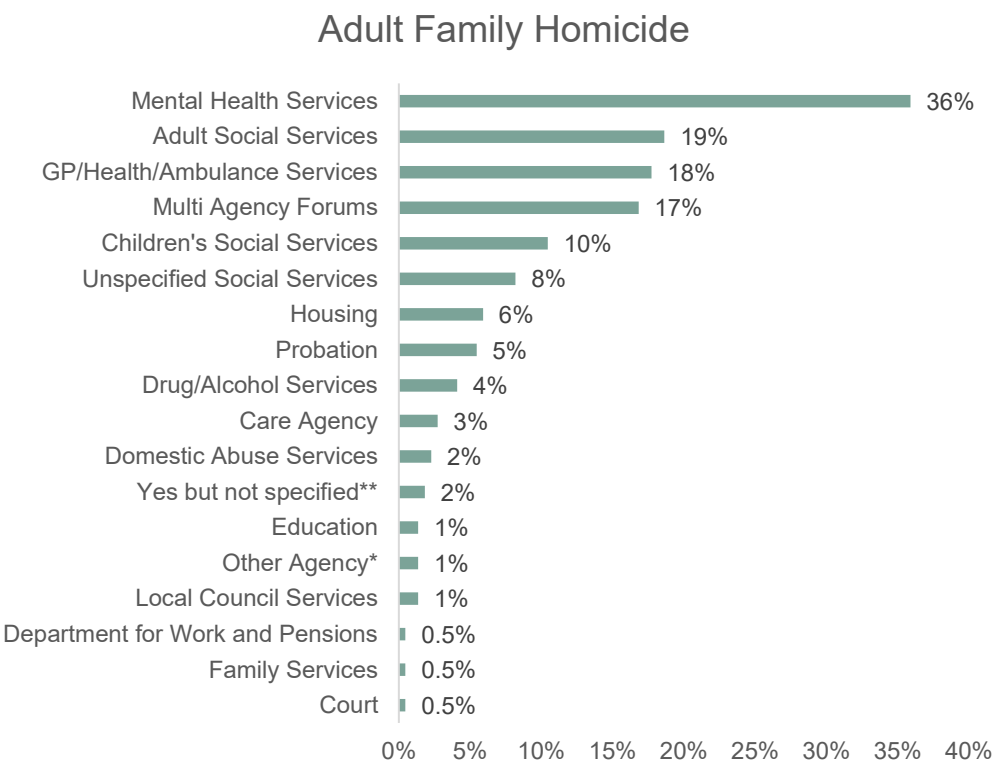
Figure 23 Proportion of victims and/or suspects known to other agencies by agency and typology (April 2024 – March 2025) [21]

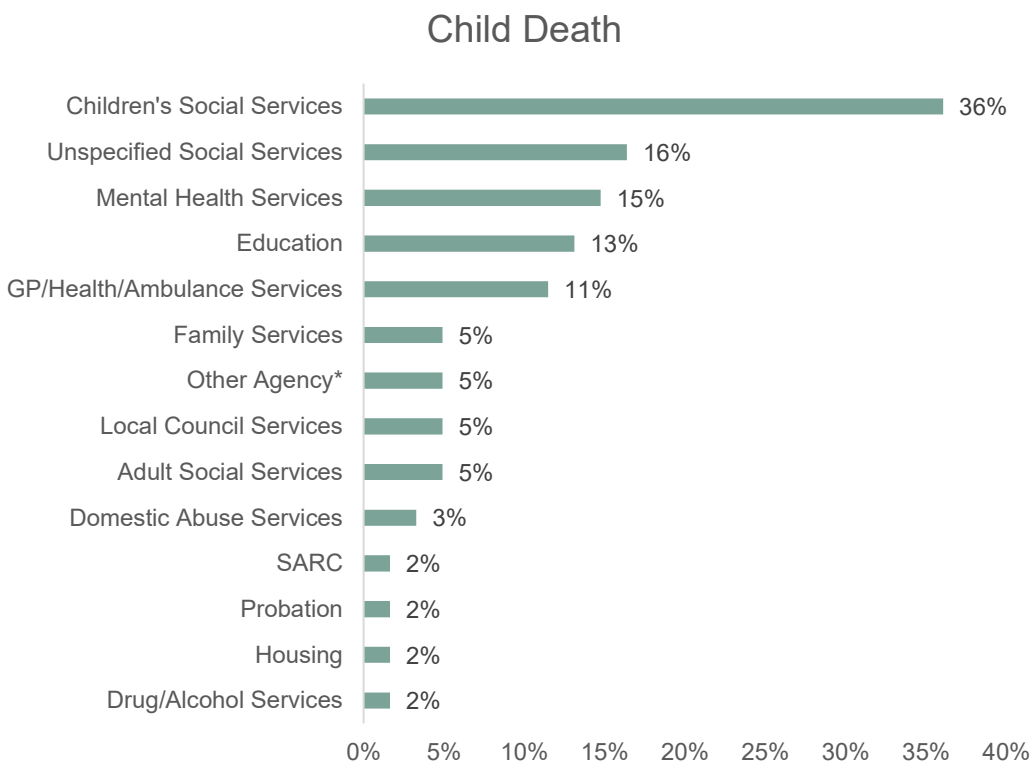


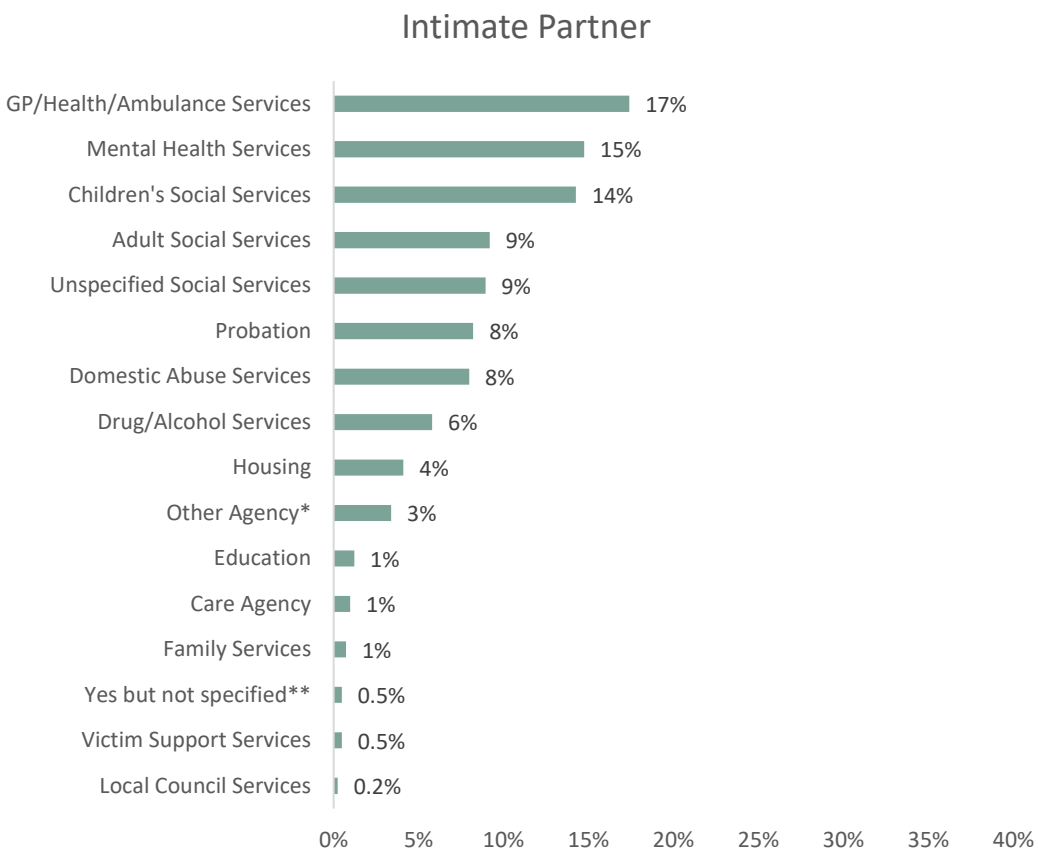
[20] Please note that the data collection for police knowledge of contact with other agencies is separate to the recording of suspects referred to MARAC, which would involve many of these partner agencies. In some cases when asked about other agency contact multi-agency forums were specifically listed, as shown in Figure 25. This means the figures will from those listed in section 5.3 and are also likely to be an underestimate.

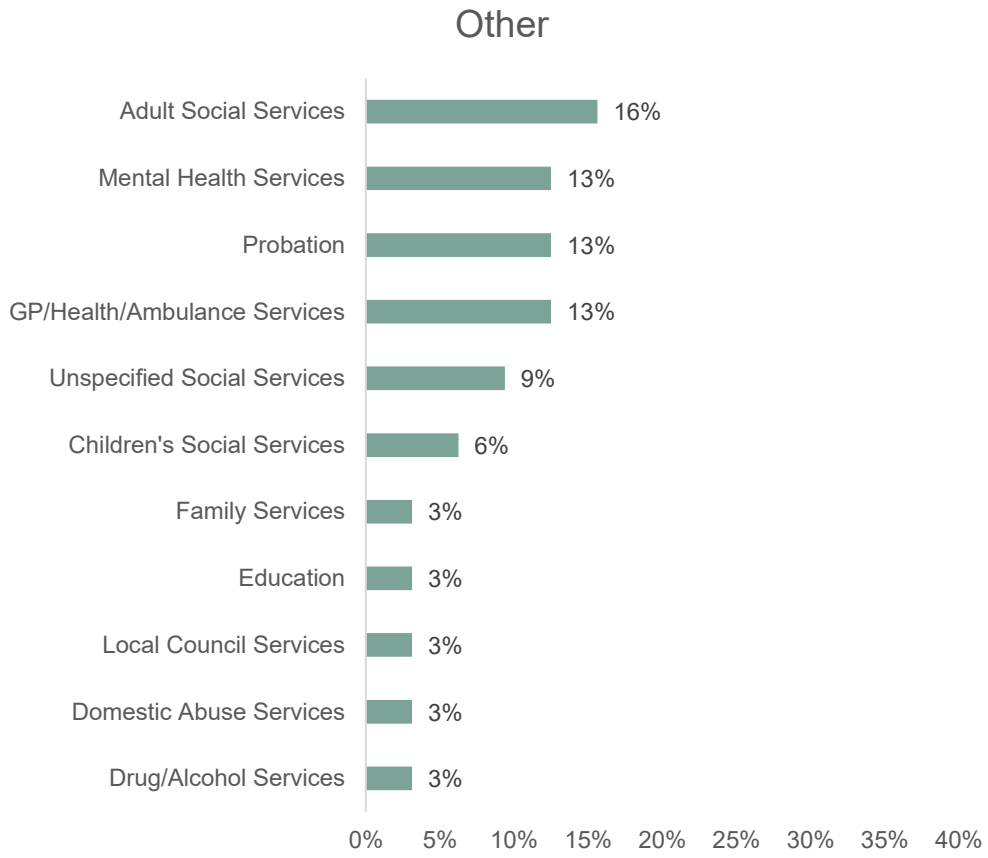
[21] 'Agency name(s) not specified' applies to cases where previous partner agency knowledge has been ticked on the submission form, though the free-text section for further detail either contains: (1) no information, (2) a generic statement without context, and/or (3) an unconfirmed acronym. 'Other Agency' refers to organisations not commonly involved in criminal justice proceedings, such the Driver and Vehicle Licensing Agency (DVLA), veteran support services, or specialised entities like agricultural societies.

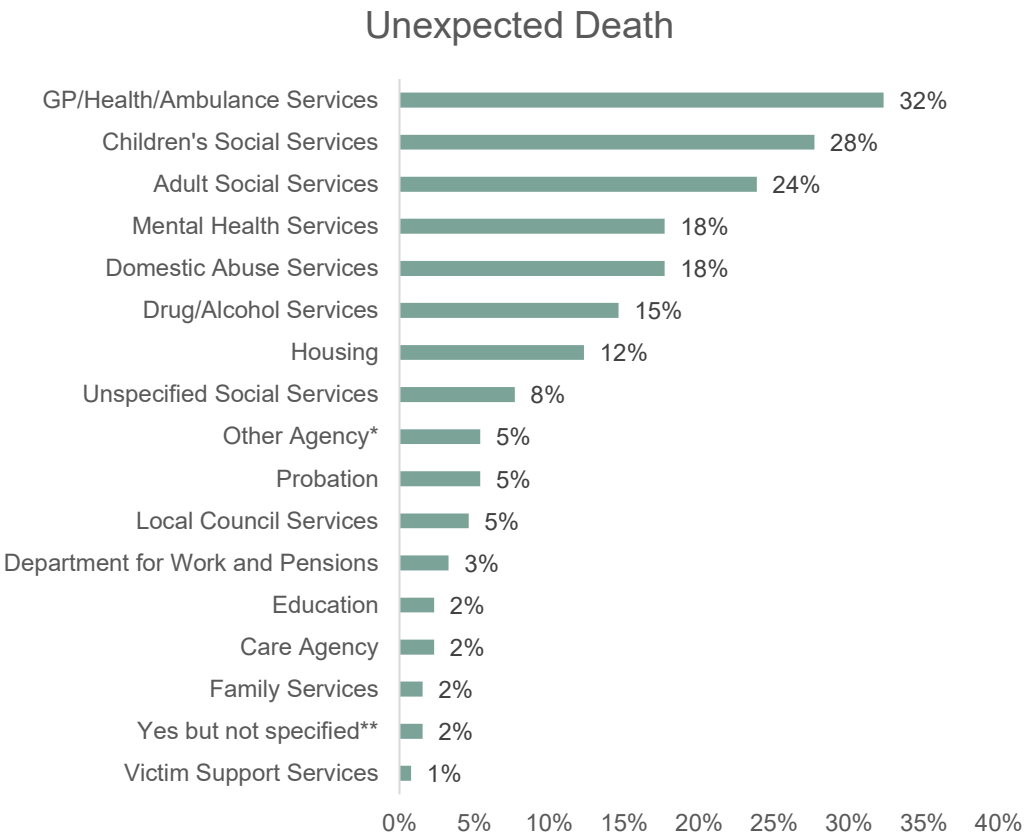
Figure 24 Proportion of cases known to other agencies by agency and typology

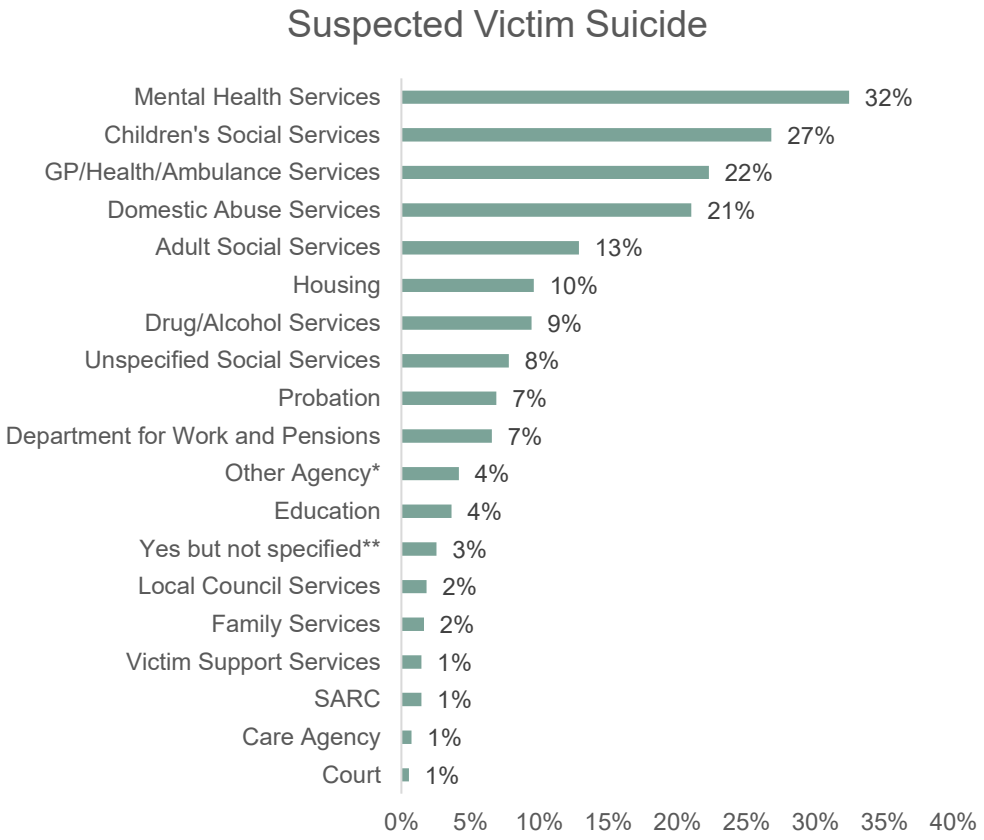





Intimate Partner
GP/Health/Ambulance Services 17%
Mental Health Services 15%
Children's Social Services 14%
Adult Social Services 9%
Unspecified Social Services 9%
Probation 8%
Domestic Abuse Services 8%
Drug/Alcohol Services 6%
Housing 4%
Other Agency* 3%
Education 1%
Care Agency 1%
Family Services 1%
Yes but not specified** 0.5%
Victim Support Services 0.5%
Local Council Services 0.2%
0% 5% 10% 15% 20% 25% 30% 35% 40%


Other
Adult Social Services 16%
Mental Health Services 13%
Probation 13%
GP/Health/Ambulance Services 13%
Unspecified Social Services 9%
Children's Social Services 6%
Family Services 3%
Education 3%
Local Council Services 3%
Domestic Abuse Services 3%
Drug/Alcohol Services 3%
0% 5% 10% 15% 20% 25% 30% 35% 40%

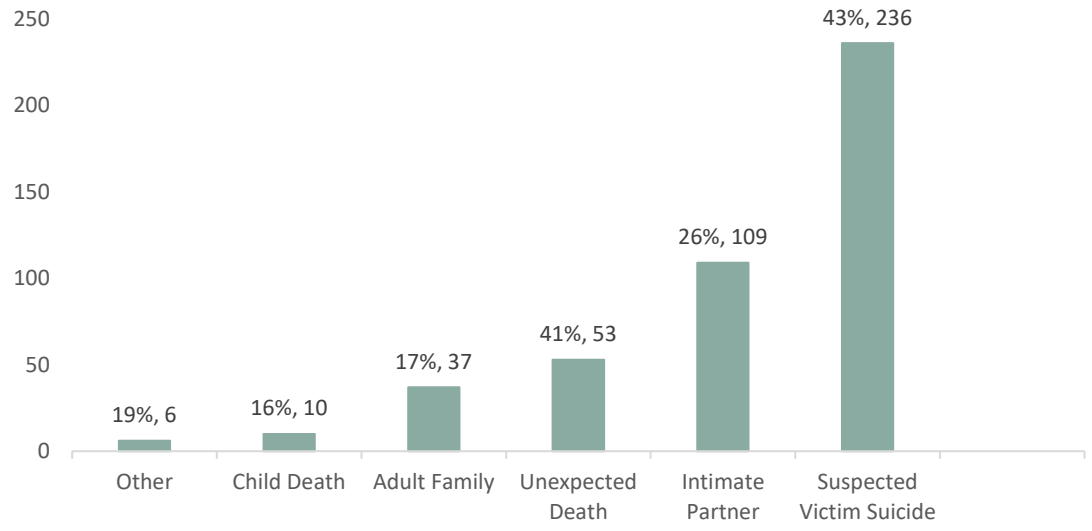

Unexpected Death
GP/Health/Ambulance Services 32%
Children's Social Services 28%
Adult Social Services 24%
Mental Health Services 18%
Domestic Abuse Services 18%
Drug/Alcohol Services 15%
Housing 12%
Unspecified Social Services 8%
Other Agency* 5%
Probation 5%
Local Council Services 5%
Department for Work and Pensions 3%
Education 2%
Care Agency 2%
Family Services 2%
Yes but not specified** 2%
Victim Support Services 1%
0% 5% 10% 15% 20% 25% 30% 35% 40%


Suspected Victim Suicide
Mental Health Services 32%
Children's Social Services 27%
GP/Health/Ambulance Services 22%
Domestic Abuse Services 21%
Adult Social Services 13%
Housing 10%
Drug/Alcohol Services 9%
Unspecified Social Services 8%
Probation 7%
Department for Work and Pensions 7%
Other Agency* 4%
Education 4%
Yes but not specified** 3%
Local Council Services 2%
Family Services 2%
Victim Support Services 1%
SARC 1%
Care Agency 1%
Court 1%
0% 5% 10% 15% 20% 25% 30% 35% 40%

The project team also coded cases where multi-agency forums were involved. These forums typically facilitate the sharing of information about a victim and/or suspect to inform safeguarding actions. Across these forums, agencies typically include social services, health, probation, housing, and the voluntary sector, with the police either acting as a core statutory partner (such as in MAPPA, MARAC and MATAC) or as a regular participant (such as in MASH, MARM and MDTs).

Whilst some forums are focused on responding to domestic abuse (such as MARAC, MATAC), other forums have broader remits. Across the five-year dataset, in 32% of cases (n=452/1410) the suspect and/or victim was known to a multi-agency forum. This was most common in cases of SVSDA (43%, n=236/553) and unexpected deaths (41%, n=53/130), again indicating the visibility of these cases to agencies that may provide opportunities for intervention.

Figure 25 Number of cases where multi-agency forums were involved (April 2020 - March 2025)



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Chapter 6 – Case review referral and acceptance rates

6.1 Domestic Homicide Reviews (DHR), and other types of reviews

Every death of a person aged 16 years or older where there is a history of DA should be referred by the police or other agency to the local Community Safety Partnership (CSP). The CSP then decides whether the case meets the criteria to be accepted for a Domestic Homicide Review (DHR).[22] Whilst most cases in the project dataset are referred for a DHR, the database also includes some cases which were referred/accepted for Safeguarding Adult Review (SAR) or other type of review process. Deaths relating to abuse or neglect and involving children under the age of 16 would be subject to a Child Safeguarding Practice Review (CSPR).

The project team requests information from the police on whether the case was referred, by them or by another agency, to the Community Safety Partnership for a DHR (or another type of review), and whether that referral was accepted. Due to the timeline of referral, acceptance and commissioning processes, this information may not be available when the death is submitted to the project or during the initial follow up process.

Overall, excluding child deaths (n=61 cases), for the five-year dataset whether or not a case had been referred to the Community Safety Partnership for a DHR or other type of review was known in 92% of cases (n= 1247/1349) (see Table 12 below: '% of incidents known if referred').

From the total of cases where the referral was known (n=1247), 1180 (95%) were referred and 67 (5%) were not. Of those cases that were referred, 65% (n=763/1180) were accepted for a DHR or other type of review across the five years of data collection. However, when cases in which the acceptance outcome was not (yet) known were removed, the proportion of those accepted rose to 84% (n=763/903).

Therefore, where the referral outcome was known and recorded, 16% (n=140/903) of cases between Year 1 and Year 5 which were referred for DHR or other types of review were not accepted. Comparing annual figures, Year 5 (20%) marks a seven-percentage point increase from Year 4 (13%) in the proportion of cases that were not accepted where the referral outcome was known. As the sample size is relatively small, proportions are liable to change and it is not possible to determine if any increase represents improved

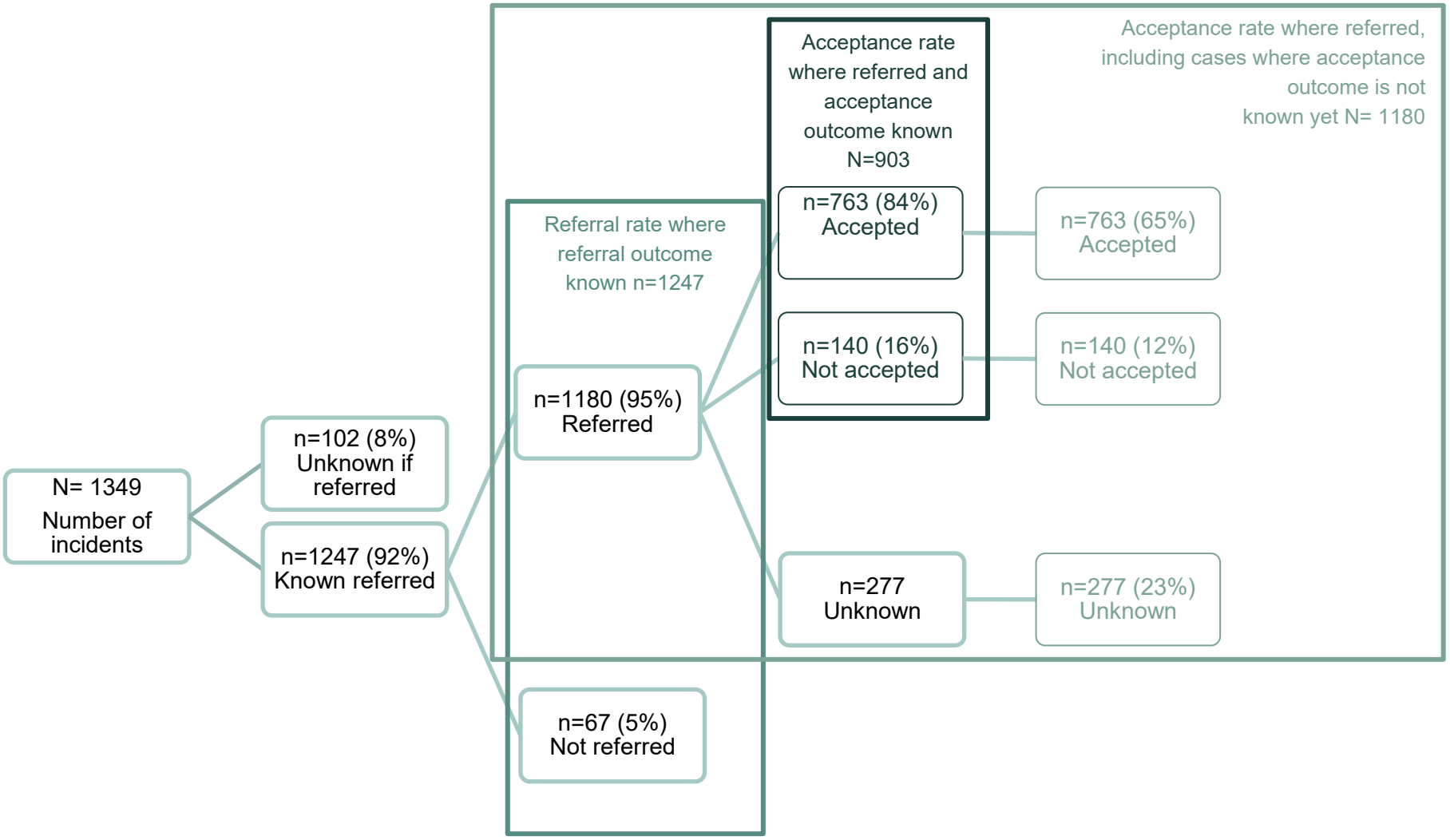
[22] DHRs focus on the deaths of victims aged 16 or over, as defined by existing statutory guidelines. In 2022 the Conservative-led government launched its Tackling Domestic Abuse Plan, where they committed to review and reform DHR procedures. Some of these changes included mandatory training for review Chairs and improving oversight mechanisms to ensure learning and recommendations implementation. After a public consultation in 2023, the Conservative-led government proposed updating the circumstances for commissioning a DHR to include the statutory definition of DA into legislation. They also proposed to update the name of DHRs to Domestic Abuse Related Death Reviews (DARDRs) in an effort to better recognise deaths by SVSDA. These changes are included in the Section 19 of the *Victims and Prisoners Act 2024* but notes this is 'not in force at Royal Assent.'

information from follow ups about referral outcomes, or whether there was an empirical rise in the proportion of cases that were not accepted.

Table 12 DHR (or other type of review) referral and acceptance status (April 2020 – March 2025)

DHR or Other Type of Review Referral and Acceptance Status				
	2024/2025		Total Year 1-5	
Referral/Acceptance Status	N	%	N	%
% of incidents known if referred	309(/326)	*95%*	1247(/1349)	*92%*
% of incidents referred (where known)	286(/309)	*93%*	1180(/1247)	*95%*
% of incidents accepted (where referred)	137(/286)	*48%*	763(/1180)	*65%*
% of incidents accepted (where referred and referral outcome known)	137(/172)	*80%*	763(/903)	*84%*
% of incidents not accepted (where referred)	35(/286)	*12%*	140(/1180)	*12%*
% of incidents not accepted (where referred and referral outcome known)	35(/172)	*20%*	140(/903)	*16%*

Figure 26 Flow chart from Year 1-5 review referral cases to illustrate analysis process, including acceptance rates for when the acceptance outcome is known and not known



Focusing on SVSDA cases, Figure 27 below presents the proportion of cases referred for a DHR (or other type of review) by year over the five years of data collection, where the referral outcome was known (n= 529), ranging from 81% to 97%. Figure 28 shows the acceptance rate where the acceptance outcome was known (n=387), ranging from 83% to 90%, except for data collected in Year 3 where the recorded acceptance rate was lower, at 65%. However, it is too early to identify any effects of proposed or new policies on overall referral and acceptance rates, particularly as 37% of acceptance outcomes remain unknown for Year 5.

Figure 27 DHR or other type of review referral rate for SVSDA cases, where referral outcome was known (April 2020 – March 2025)

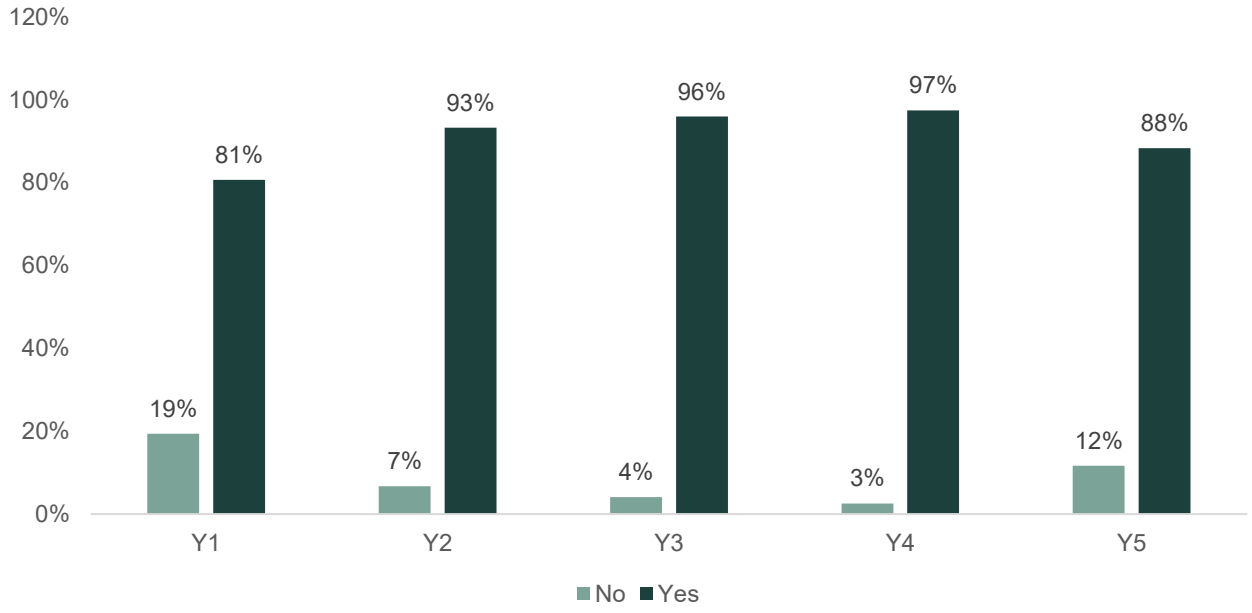
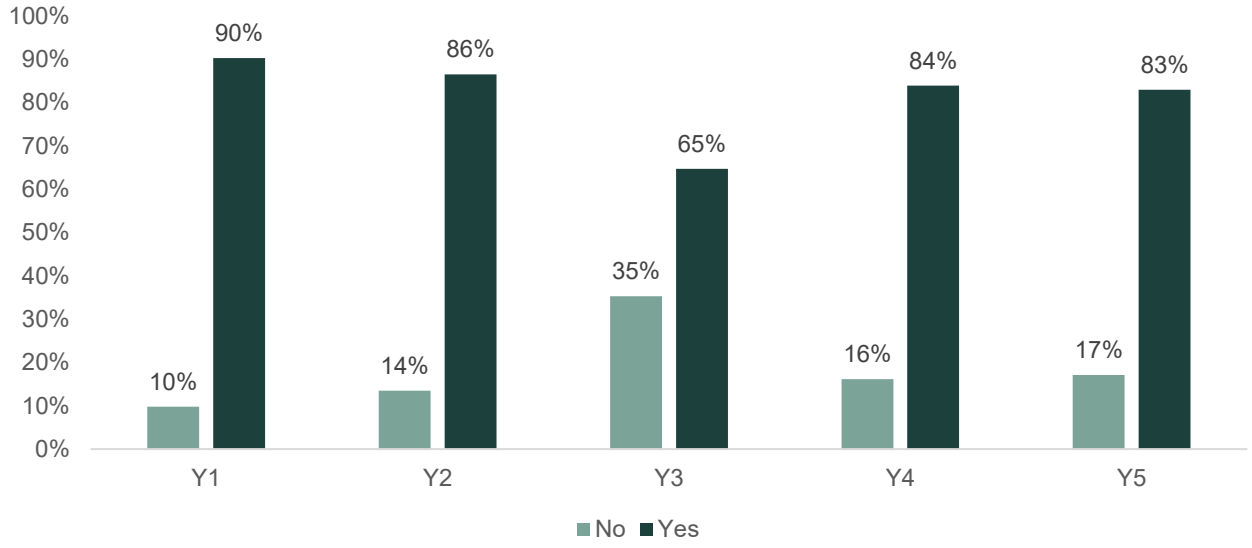


Figure 28 Review acceptance rate for SVSDA cases, where acceptance outcome is known (April 2020 – March 2025)



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Chapter 7: Spotlight on Suspected Victim Suicide Following Domestic Abuse – Investigation of unexpected deaths and posthumous prosecution efforts

7.1 Investigation of unexpected deaths

Last year's report (Hoeger et al., 2025), continued a focus on the analysis of SVSDA utilising data which is not captured systematically by other sources. Importantly, the guidance initially developed by this project team in partnership with the NPCC's Homicide Working Group and informed by consultation with bereaved family members was adapted into the College of Policing's Authorised Professional Practice (APP) in April 2025.

The first section of this chapter presents three case studies of unexpected deaths, including two reported as suspected victim suicides following domestic abuse. These cases were dip sampled and reviewed during 'deep dive' research in selected police forces to examine the police response to unexpected deaths. This 'deep dive' provided additional access to case file information with more detail than would be available on the general submission form, such as victim, witness and officer statements, investigation logs and reports to the coroner. The dip sampled cases were discussed with the project team alongside force representatives with expertise in domestic abuse, homicide, suicide as well as Professionalising Investigation Programme (PIP) Level 3 Senior Investigating Officers.

Case Study 1

The first case highlights the importance of speaking to friends and family as well as some of the challenges experienced during an initial investigation process. This case was submitted as an unexpected death of a female victim caused by a fall down the stairs, with her husband listed as the suspect. They lived separately but the suspect was at the house at the time of the reported fall and contacted emergency services. There was no recorded history of domestic abuse on police systems; however, whilst at the hospital the victim's adult daughter reported that her mother had been subjected to coercive controlling behaviour that included physical abuse by the suspect. The police were called, and the suspect was arrested on suspicion of Section 18 Grievous Bodily Harm (GBH). The victim died in hospital several days later due to the injuries caused by the fall.

The postmortem included the review of an expert who reported that the injuries could have been sustained during a fall and there was medical evidence supporting that the victim was unstable on her feet. The initial investigation was open for less than two weeks before receiving an outcome of no further action (NFA). However, the victim's daughter continued to request further investigation.

(Continued below)

Case Study 1 (cont.)

The death may have occurred due to a fall without third party involvement; however, the initial investigation material did not make clear whether there was any consideration to pursue a posthumous charge for the domestic abuse related offending described by the victim's daughter.

Due to high demand within the relevant teams, the individual designated as the 'SIO' (Senior Investigating Officer) was a Detective Inspector (DI) with Professionalising Investigation Programme (PIP) level 2 training. This case was assigned to a specialist team, but not one which would typically investigate a potential homicide and hold PIP3 level training.

Following continued engagement by the victim's daughter and referral of the case for a DHR, the force chose to review and re-open this investigation. There were potential witnesses that had not been spoken to, or from whom formal statements were not taken, who may have evidence that could be material to the investigation. The police force reviewers also considered that additional medical evidence could be provided, and relevant mobile devices had not yet been examined. On this basis, the suspect was re-arrested for assault and CCB with additional investigation carried out.

Case Study 2

The second case study was not originally submitted to the project in time for this year's analysis but was identified as part of the national near real-time suicide surveillance system (n-RTSSS) and included in the 'deep dive' referred to above. This suspected suicide was flagged on the n-RTSSS database to involve domestic abuse victimisation. It was also flagged by an officer in the force who was completing a review of suspected suicides, including in relation to domestic abuse.

The victim in this case was female, and the potential suspect was the victim's (ex) husband. Following a call from the victim's daughter, ambulance services attended and reported the death to the police, mentioning there appeared to be a suicide note but also said there was nothing 'suspicious' at the scene. This raises questions about the potential impact of requesting ambulance services to determine if there is anything 'suspicious' or using that terminology prior to police attendance. This call was sent for priority attendance, and it was noted that victim was known as a vulnerable adult due to her mental ill health.

(Continued below)

Case Study 2 (Cont.)

In this case, there was a failure to hit dispatch time targets due to patrol teams' engagement at other incidents. After several hours there were calls from the victim's family asking to move the body. When patrol officers attended the scene, they found numerous family members at the home who had covered the victim's body after the ambulance attended. The officers identified the suicide note which indicated the victim had 'done it properly' and named the suspect, her (ex-) husband. Medication tablets and empty blister packets were located, as well as the victim's mobile phone that was locked. Family members explained that the victim was diagnosed and on medication for depression with a previous suicide attempt recorded.

The Criminal Investigation Department (CID) were called to attend. Prior to their attendance CID requested several actions, such as securing the scene, further enquiries (CCTV review and house to house) and checking for anything indicating foul play. A Detective Constable (DC), Detective Inspector (DI) and Detective Sergeant (DS) attended alongside a Crime Scene Investigator.

The victim was known to the police for domestic abuse in relation to her husband. The first relevant record was two years prior to her death for controlling or coercive behaviour, which received no further action following the withdrawal of her statement and decline of referral to support agencies. The second was six months prior to her death when she reported physical violence and emotional abuse, saying she was scared and felt controlled. The victim said she had separated from her husband, but they were still living in the same home at the time. This report led to the suspect's arrest but received no further action for reasons regarding engagement withdrawal.

The victim's daughter also provided details about damage to the home that was caused by her brother who had mental ill health and was wanted by the police for a separate matter at the time of the victim's death. Whilst the report to the coroner did mention the victim's 'poor relationship' with her son, further information regarding the domestic abuse-related history in relation to the son and husband was not provided. Additionally, it did not appear in the records that the (ex-) husband was spoken to, although he was present at the scene when officers arrived. This case was reviewed by the force, with relevant learning disseminated.

Case Study 3

Demonstrating some of the challenges and barriers identified within Chapter Three, the third case study is a suspected suicide involving a male victim who identified as LGBTQ+, came from a minoritised ethnic group and had a family with religious beliefs. The victim was neurodivergent and presented mental health care needs. The suspect was the victim's male intimate partner who was 40 years older than the victim. The victim left his parental home the age of 17 due to his parent's religious beliefs conflicting with his sexuality and he moved into the suspect's home. The victim and suspect were in a seven-year relationship before the death, with concerns raised by multiple agencies over the years due to the suspect's significantly older age. Of note, given the context of their relationship, the suspect was also referred to by some agencies as the victim's 'friend', 'carer' and 'chaperone'.

Years before his death, a safeguarding concern was raised by the victim's college leading to police attendance and a disclosure by the victim about his controlling relationship. However, the victim stated he was not physically abused and did not want to make a complaint to the police. Later the same year, there was an agency referral to MARAC due to concerns about CCB by the victim's partner.

The victim had a history of mental health issues and suicidality. He saw his GP several times over the course of his relationship with the suspect, resulting in referrals for MH support services as well as six referrals to the local adult safeguarding team. However, most of these referrals were declined and passed between services without resolution as his circumstances did not appear to fit the criteria for the available MH services. The victim was also in contact with specialist DA services.

During the contact he made with numerous agencies the victim disclosed CCB. This included reports that the suspect belittled him, made him feel as though he could not care for himself, did not allow him to go out with his friends, checked his phone, tracked his movements, medicated him and made the victim financially dependent upon him. However, according to the inquest the victim frequently withdrew these statements at a later point, which appeared to impact the decision by the police to take 'no further action' (NFA). The year before his death, the suspect's controlling behaviour was described as exacerbated by the Covid-19 pandemic lockdown. Professionals held online appointments with the victim, and the suspect would not allow the victim to attend these alone. Following a further report of abuse to the police, another MARAC referral was made.

(Continued below)

Case Study 3 (Cont.)

On the day of the victim's death, the suspect found the victim at home not breathing. He commenced CPR and called emergency services. Attending officers were aware of the CCB allegations against the suspect and concerns were raised in relation the home's internal CCTV and lock on the outside of the bedroom door. Due to the suspicious circumstances, an investigation was opened with the victim's phone and suspect's electronic devices seized. The police could download content only from some of the suspect's devices and they never gained access to the victim's phone. The post-mortem revealed that this was a drug-related death and the investigation showed no signs of the perpetrator having supplied the drugs to the victim. In the report to the coroner, the suspect was recorded as the victim's NOK even though this report also included the history of DA by the suspect.

Following the initial investigation, the suspect was arrested on suspicion of CCB, however it was found that criteria for criminal prosecution was not met. A DHR and an inquest were completed. Both reports concluded that the victim experienced sustained CCB by the suspect and that some agencies failed to recognise CCB and understand the complexities around neurodiversity and DA.

Importantly, all deaths referred to in the case studies above (2022-2024) occurred prior to the formal change of the APP on the police response to unexpected death in April 2025. Furthermore, two cases received additional review, and these police forces have already instigated, or are in the process of introducing, practices that allow for the review of all unexpected deaths for a history of domestic abuse.

The above case examples demonstrate the importance of speaking to family and friends, using professional curiosity, not listing a potential domestic abuse perpetrator as the victim's next of kin (NOK) and including the history of domestic abuse on the report to the coroner. Excluding the demand-based impact on response time, these cases suggest that the initial police response identified suspicious circumstances, with potentially missed investigative opportunities later in the process and/or a lack of recorded rationale regarding not pursing posthumous charges for the domestic abuse if the death is not found to be a homicide.

7.2 Posthumous prosecution efforts in cases of suspected victim suicide following domestic abuse

This section considers posthumous prosecution efforts in SVSDA cases across all five years of data collection (1st April 2020 to 31st March 2025; n=553 victims, associated with n=622 prior DA perpetrators). This analysis represents a relatively small portion of data where the submission form included free text information regarding any charges or additional investigation. The project team conduct follow ups, but the following information represents only that which was available at the time of the report analysis. There will be additional cases that have attempted to pursue a charge and been unsuccessful or have not yet been submitted to or updated the project.

The Year 4 report (Hoeger et al., 2025, see Section 8.2) detailed the posthumous prosecution efforts in cases of SVSDA. This included a case study on the first known charge for Unlawful Act Manslaughter (UAM) since the start of this Project in April 2020 (first UAM conviction achieved in *R v Allen*, 2017). The case study detailed the evidence gathering and investigation process that led to the successful charge. Although the case did not result in a conviction for Unlawful Act Manslaughter, the suspect was found guilty of the CCB and assault charges. This section also detailed the 12 SVSDA cases that had achieved a posthumous charge.

At the time of analysis across the five-year dataset, there were 17 cases (approximately 3% of the overall SVSDA dataset) recorded as successfully achieving a posthumous charge. This indicates there were at least five further cases charged since the last annual reporting period. Furthermore, in three of these 17 cases there were ongoing investigations that may result in additional charges.

• Grievous Bodily Harm (GBH)
• Breach of a Harassment Order
• Harassment
• Common Assault; Assault Occasioning Actual Bodily Harm (ABH); Controlling or Coercive Behaviour (CCB); False Imprisonment
• Theft
• Unlawful Act Manslaughter (UAM)
• Threatening to disclose sexual images
• Common Assault
• 2 counts of ABH; Non-Fatal Strangulation; Harassment; Breach of a Restraining Order
• Assault by Beating
• Common Assault (suspect also died by suicide following conviction)
• Stalking

• Harassment (ongoing investigation into UAM and other offences)
• ABH
• CCB (several charges merged together*)
• Stalking; Criminal Damage; Assault by Beating; Harassment (ongoing investigation into UAM)
• CCB; Possession with Intent to Supply (ongoing investigation into UAM)

In addition to the ongoing three UAM investigations listed above, there were at least seven further submissions which indicated ongoing investigations to pursue posthumous charges (see below). In one additional case the information provided did not specify the potential charges or stage of that investigation and is not included below.

• UAM
• CCB; Encouraging or Assisting Suicide
• UAM; CCB
• CCB
• CCB
• CCB; Assault
• Rape; Harassment; CCB

Whilst not submitted to the project at the time of analysis, the project team are aware of an additional SVSDA case which achieved a charge for Unlawful Act Manslaughter in relation to a death that occurred in 2020. The project team also believe that another of the reported ongoing UAM investigations has also achieved a charge. Both cases should be moving to trial within the next year. Therefore, if available, the results of this and any other prosecutions that are progressed will be reported on in the following annual report.

The data collected by this project continues to show increasing efforts by the police and CPS to hold domestic abuse perpetrators to account by pursuing posthumous charges in a small proportion of SVSDA cases. However, the consistency of this proactive consideration across all forces and the challenges of achieving a successful conviction for Unlawful Act Manslaughter remain a concern for Advocacy After Fatal Domestic Abuse (AAFDA) and other campaigners (AAFDA, 2025; Guardian, 2025). The project team continue to aid efforts to share learning from attempted posthumous prosecutions of SVSDA cases across forces and raise awareness of this issue in forums with stakeholders.

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Chapter 8: Fourth consultation with bereaved family members

8.1 Findings from consultation with family members bereaved by suspected victim suicide following domestic abuse

In March 2025, the project team held our fourth consultation event in partnership with AAFDA who provide specialist advocacy and peer support for families bereaved by domestic homicide, unexpected death and SVSDA. The consultation event included 8 family members bereaved by fatal DA, one advocate and two members of AAFDA's leadership team, including their CEO Frank Mullane. We also had representation from the NPCC leads for domestic abuse, suicide prevention and homicide, as well as the Killed Women charity, the Home Office and the Domestic Abuse Commissioner, Dame Nicole Jacobs.

Many of the family members in attendance participated in one or all four consultation events and one was new to the consultation. The first part of the consultation focused on sharing key findings from the Year 4 report and updates on the activity of the project team and wider NPCC portfolios, including changes to policy, guidance and practice since the event held in March 2024. The second half of the consultation event allowed space for the family members to share their feedback for the police and their partner agencies. Based on table discussions, AAFDA provided the project team with notes and additional comments from the consultation event, which are summarised below[23]:

1. Solutions: The family members mentioned potential solutions that would help to improve the response to unexpected deaths, including suspected suicides, as well as the wider prevention of domestic abuse related deaths. Some examples were:

    - Continuing to collect relevant data, and applying learning from this research to inform work in other sectors;

    - Improved consistency of investigations: Speed of response, joined up, coordinated investigations to avoid task-based silos, use of forensic postmortems, accessing evidence via Cloud-based storage services, professional curiosity and considering the potential for homicide;

    - Support for families bereaved by suicide following domestic abuse: Duty of care to follow up with the family and listen to reflections and concerns, national bereavement service for families, funding and time to help families understand the large amount information they receive from legal and criminal justice agencies;

[23] As a consultation event rather than a focus group, whilst some of the points and comments in this summary have been grouped together into general themes this consultation did not involve systematic qualitative analysis and instead attempts to preserve the feedback as provided by the family members.

- Coronial process: Training for coroners that incorporates survivors' and victim's families' voices, developing their working relationship with the police and including circumstances surrounding the death in their conclusions.

2. Barriers: The families also described potential barriers to the process, many of which relate to the solutions described above:

   - Cases where there is more than one police force or multiple agencies involved, or the perpetrator has moved areas utilising different names;

   - Claims that the police do not utilise the full information or history available, suggesting Multi-Agency Risk Assessment Conferences (MARAC) should capture the wider context from all agencies;

   - Information suggesting that body worn camera (BWC) footage was captured, but then informed that this is 'not available';

   - Where a victim is not identified as having a police-recorded history of domestic abuse and coercive control, but this is raised by family members, there may be a struggle to receive a DHR referral;

   - Remit for coronial conclusions described as being 'too narrow';

   - Perpetrator's ability to raise the victim's children where no crime is recorded;

   - Ripple effect on the family: Energy required from families to navigate the system whilst being presented with constant challenges ('systematic mess', 'losing battle');

   - Balancing involvement vs. responsibility: Lack of communication between the police and coroners leaving families to be the link for information sharing, or in contrast, the lack of familial involvement in the process;

   - Unconscious bias and victim blaming: Lack of recognition of the use of DARVO ('deny, attack, reverse victim and offender') by perpetrators and professionals

   - Resources and timescales required for thorough investigations: Lack of thorough initial investigation by the police could prevent the collection of evidence that would be relevant to coronial processes in cases that do not receive criminal charges;

   - Role of linguistics and language in perception and interpretation: Assumptions that where there is mental ill health, alcohol and/or drug use reported in the victim's history that the death is inevitable, rather than looking for potential circumstances (e.g., abuse) that influenced the development of those vulnerabilities or decline of their wellbeing;

Moreover, previous concerns about the release of the victim's property to the 'next of kin', who is often listed as the domestic abuse perpetrator, were also raised. Whilst the potential for a perpetrator to use this designation to inappropriately influence the criminal justice and/or coronial process now features in the national APP guidance referenced earlier, it is important to continue to review how this is being translated into practice.

One of the family members who provided additional feedback after the consultation exemplified many of the points above saying,

'We are thrown into completely alien territory, yet are expected to deal with multiple complex professional bodies…learning a different language with all the acronyms…without the support to understand and navigate the processes … having to cope with the trauma, grief, loss, dynamics of our new life, working, funerals, inquests, estate management and other multiple everyday factors. It is overwhelming. This has a huge impact not only on our lives but on our mental health and support networks. The ripple effect is massive…we live with the consequences 24/7'.

Whilst some points from the consultation are not within the purview of this project, they have informed this report with the findings and recommendations aiming to help improve the experiences of future victims/survivors and their families. We are deeply appreciative of all those who gave up their time to be a part of this consultation and shared their stories. Their strength and courage to advocate for change and amplify the voices of their loved ones is admirable.

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Report Conclusion

This report presented five years of analysis of domestic homicides, child deaths, unexpected deaths and suspected victim suicides following domestic abuse (SVSDA) by the Domestic Homicide Project. The first six chapters of this report detailed the number of domestic abuse-related deaths by typology, victim and suspect demographics and protected characteristics, identified risk factors, police and partner agency contact and Domestic Homicide Review (DHR) referrals associated with deaths between the 1st of April 2020 and 31st of March 2025.

Chapter Seven focused on the response to unexpected deaths, through case studies and continued attempts to pursue posthumous charges and prosecutions for Unlawful Act Manslaughter and DA-related offences. Whilst posthumous prosecutions in cases of SVSDA remain relatively small in number, they have increased since the previous annual reporting period and indicate opportunities for future development through the sharing of emerging practice. Finally, Chapter Eight presented findings from the project's fourth consultation with bereaved family members and highlighted barriers and solutions to improving the police and partner agency response to unexpected deaths, including SVSDA.

The project's recommendations were informed by findings, including the persistent prevalence of risk factors for mental ill health, coercive controlling behaviour (CCB), and substance use, differing levels of contact with the police and partner agencies by typology and increased reporting facilitating further analysis of SVSDA and unexpected death cases. The developed recommendations should inform future work by police forces, the National Police Chiefs Council (NPCC), National Centre for VAWG and Public Protection (NCVPP), College of Policing, Crown Prosecution Service (CPS), Home Office, and statutory and third sector partners involved in safeguarding victims of domestic abuse.

This report illustrates the importance of collecting and analysing this dataset to develop evidence-based research supporting efforts to reduce and prevent domestic abuse related deaths.

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