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Domestic abuse related deaths by suicide

It is devastating when someone takes their own life. Where there was a history of domestic abuse that preceded the suicide, examining agency responses to the victim during their lives is critical to preventing future deaths. Appropriate responses post-death are also needed to protect children or other family members who might be at risk.

Home Office funded research undertaken by the University of Warwick and AAFDA has analysed Domestic Homicide Reviews in cases involving death by suicide to provide further insight.

AAFDA
Advocacy After Fatal Domestic Abuse

WARWICK
THE UNIVERSITY OF WARWICK

This POLICY BRIEF is designed to help policy makers better understand how we should respond after a domestic abuse related suicide, including:

- Undertaking robust investigations in the immediate aftermath of death
- Pursuing post-death charging of perpetrators where appropriate
- Commissioning Domestic Homicide Reviews on a consistent basis
- Conducting effective and trauma-informed Domestic Homicide Reviews
- Providing support and advocacy to bereaved families

Key Messages:

- Post-death responses need to explore how patterns of domestic abuse may have contributed to the victim's death, and robust investigations must be conducted in order to gather evidence in relation to an abuser's potential criminal liability.

- Domestic Homicide Reviews should be commissioned on a consistent and transparent basis in cases of domestic abuse related suicide, with those processes being sufficiently probing and detailed to ensure effective learning for future prevention.

- Bereaved family members and children, who may continue to be at risk from abusers, need to be effectively protected and supported through trauma-informed advocacy.

Post-Death Responses to Suicide

- It is imperative that, in their responses in the aftermath to death, agencies recognise how physical and psychological harm perpetrated by abusers can lead to deterioration of mental health, self-harm and suicidal ideation, posing a risk to victims' lives.
- Post-death responses need to explore how such patterns of abuse may have contributed to the victim's death, and robust investigations must be conducted in order to gather evidence in relation to an abuser's potential criminal liability.
- Greater police investigative training, and resources, are required to improve immediate responses to deaths by suicide, and to ensure perpetrators are held to account.

Understanding Complex Pathways to Victim Suicidality

Language ascribed to the circumstances around a victim's death needs to be sensitive to the ways in which victims may have relied upon certain coping mechanisms, such as substance misuse, in order to manage the abuse that they were subjected to.

Across our DHR sample, there was evidence of agencies positioning a victim's death as a reaction to, and reflection of, mental-ill health, but this only illuminates a small part of the wider context of psychological injury associated with domestic abuse.

Perpetrators of domestic abuse often seek to control, manipulate, and isolate victims from their friends and families which can lead to feelings of hopelessness and suicidal ideation.

Ensuring Robust Police Responses

There is a disparity between the resources devoted to police investigation of suspected suicides compared to suspected domestic homicides.

"my biggest issue that I see over and over again... it's the police not linking a death to domestic abuse therefore everything is built on a house of sand, you know, you lose everything. There's no DHR, there's no investigation, you know, there's no justice at all."

Advocate

"no one took her mobile phone, no one took her computer, no one searched the house... by the time a detective came round... he looked, saw there was a note, it didn't mention domestic abuse, although he knew there was a marker on the house saying this is a known address for domestic abuse... He knew about that, but he said, there was no mention, I read the note and realised it was just a suicide, so nothing happened. That's when the case was destroyed."

DHR Chair, former police officer

Police who attend the immediate aftermath of a death by suicide must be encouraged to display greater professional curiosity about the circumstances. This includes, but is not limited to - making appropriate inquiries, gathering all relevant evidence at the scene, investigating the nature of any prior interactions with the police, exploring any interactions that the deceased had with agencies which may suggest a history of domestic abuse, and taking the concerns of family members seriously if reports emerge that the deceased was being subjected to domestic abuse.

Post-Death Charging of Perpetrators

- Early partnership working between Coroners, the police, and the CPS is essential in exploring post-death charging of perpetrators in cases of domestic abuse suicide.

Without a robust investigation response in the immediate aftermath of a suspected suicide, the likelihood of links to domestic abuse being identified and documented are diminished. This reduces the possibility of perpetrators being held accountable for abuse inflicted on victims during their lifetime, as well as for any liability they may have in terms of that behaviour having caused the victim's death. It also thereby fails to protect potential future victims.

There is precedent for post-death charging of perpetrators, both in relation to physical assaults or coercive and controlling behaviours against the victim during their lifetime, or (though more rarely pursued to date in England and Wales) in relation to manslaughter liability for the death.

Police should be actively investigating any unlawful acts that may have preceded a death by suicide in the context of domestic abuse

Across our DHR sample, there was only a small number of cases in which there was any indication that post-death charging was being considered. Given that this was a sample in which the evidence that was available in relation to domestic abuse was so substantial as to commission a DHR, this is concerning.

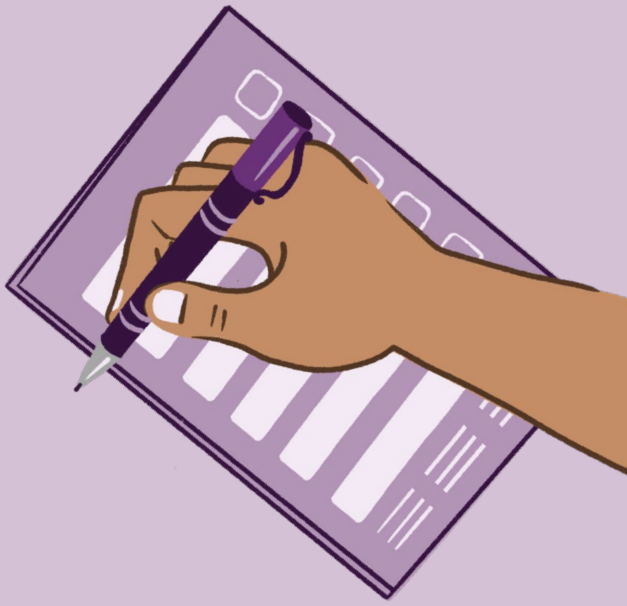
Though prevention and intervention before death is clearly the goal, the investigation, charge and conviction of perpetrators in cases where death by suicide occurs in the context of domestic abuse, can improve:

- public protection: if perpetrators of abuse are not identified and their behaviour addressed, there are clear risks to future partners.
- justice outcomes for victims
  - personal safety of bereaved family members
  - engagement in future disputes around child custody
- prospects for understanding and future learning through the DHR process.

Many stakeholders currently involved in running suicide DHRs raised concerns as to the risk of reputational damage and invasion of privacy of suspected perpetrators in the absence of a criminal investigation and/or convictions. As there is still so much that is unknown about domestic abuse suicide cases, insight into suspected abusers' profiles and service interactions are crucial for understanding future prevention.

The Domestic Homicide Review Process

- Whilst the inclusion of domestic abuse suicide in the DHR mechanism remains a critical tool for learning, the existing statutory guidance lacks adequate clarity around reviewing these cases.
- Domestic abuse related suicide cases pose distinctive challenges that need to be more carefully acknowledged and addressed.
- The lack of clarity surrounding DHRs in cases of domestic abuse related suicide places additional and unnecessary emotional burdens on bereaved family members. As valued representatives of the victim's voice in the DHR process, families should receive clear and accurate information at all times.



The inconsistency and lack of clarity around the commissioning and running of DHR processes in suicide cases is hugely problematic. Steps to address this are coming via changes to the statutory guidance, but they need to be pursued urgently with a close eye to the specific and distinctive challenges encountered in suicide cases. These include:

Better guidance as to when DHRs should be commissioned in suicide cases, with greater consistency across local community safety partnerships in terms of how this is applied.

Ensuring robust and professional training of DHR chairs in suicide cases and appropriate engagement from relevant specialists, including in suicide prevention, as part of the review process.

Clearer guidance and support on how to navigate the challenges associated with privacy rights of partners who may not be recognised formally as perpetrators, as well as addressing concerns about the safety of panel members where those partners are still at liberty.

Effective mechanisms for responding to the needs that family members bring to the DHR process in suicide cases, as well as assisting them in navigating interconnections between DHR, coronial and criminal justice process.

Supporting Families

- All families should have access to better and more consistent support. This should include in the immediate aftermath of their traumatic bereavement but also advocacy throughout the DHR process. Eligibility criteria for legal aid should be extended to facilitate representation in coronial processes.

- The DHR process places significant demands on families at a time of immense grief. Engagement by professionals with loved ones should be trauma-informed, sensitive and respectful of their loss.

- Families should be treated as experts with equal status alongside other DHR contributors, and empowered to provide contributions as they would wish to. There should be no hierarchy of testimony.

Language

The language of 'homicide' in itself can often be ill-fitting and off-putting in suicide cases. Some families may be unaware of the abuse that their loved one had lived through, and there can be particular challenges where the partner was either living with family members or now solely responsible for dependent children. In such instances, approaching families with the language of a 'Domestic Homicide Review' can be, as described by a DHR Chair "an absolute blocker" to family engagement in the DHR process.

Personal risk

Where there is evidence of domestic abuse perpetrated by the deceased's partner, engagement with services in the DHR process can lead to considerable risks for family members. So too, members of the community who may have received disclosures from the deceased and provided evidence accordingly during the DHR process may have to maintain contact with the partner.

Family support

Advocacy for families is difficult to access–they do not routinely benefit from the support that those bereaved by domestic homicide receive, and knowledge about specialist organisations is not routinely made available. There is clear evidence from family members, advocates and DHR Chairs alike about the benefits that advocacy of this sort can bring for all involved.

A lack of adequate guidance and training can also lead to the risk of professionals approaching family members without the appropriate skills required.

"Families of the deceased get... no support at all for suicide. If it's a murder the police will appoint a family liaison officer and... victim support will provide someone to help them through... but it has to be murder for them to get involved. And I've realised that on a number of occasions as well, that families do not get any support unless you go to organisations like AAFDA to provide that support".

DHR Chair

Family voice

Family voices in this research underscored the unjust position that families bereaved by domestic abuse suicide often experience throughout coronial inquests and DHRs, particularly when they are required to navigate them without advocacy or legal representation. They often put themselves through these processes not for their own benefit but to assist in future learning and in the hopes of preventing other families experiencing the same traumas.

"there's got to be change. I wouldn't wish this pain on anybody. I can't do anything for my darling [name of victim] but I'd like to think in her name, I can save other young women".

Vanessa Munro is a Professor at Warwick Law School. She has researched and published extensively on the topic of law and policy responses to gender-based violence, including sexual and domestic abuse.

Lotte Young Andrade is a PhD candidate from the University of Warwick, with research interests in gender-based violence, feminist activism, gender and the law, and intersectional feminist theories. Her doctoral research is exploring how domestic violence charities in England have adapted their support for victim-survivors after legal aid cuts.

Sarah Dangar is a Doctoral Researcher at City, University of London researching statutory fatality reviews in the context of domestic abuse related suicide. She is also a Violence Against Women and Girls Consultant and Domestic Homicide Review Chair and Reader with over a decade of experience in the domestic abuse sector, most recently as the CEO of a domestic abuse charity.

Appendix

In the early 2000s, research started to indicate that more work was needed to understand the links between domestic abuse and suicidality (Chantler et al 2001) (Walby, 2004) (see further, Devries et al, 2011). This issue was brought to the forefront in the Court of Appeal case of R v Dhaliwal ([2006] EWCA Crim 1139), in which there was a failed attempt by the Crown Prosecution Service to bring manslaughter charges against an abusive husband who had subjected his wife to sustained psychological abuse prior to her suicide. Although the case fell at the first hurdle, with bodily harm being defined to exclude psychological forms of injury, this case has been significant in bringing further light to the devastating consequences for victims subjected to domestic abuse. In the aftermath of this case, Siddiqui & Patel produced the 'Safe and Sane Report' for Southall Black Sisters (2011), which found that across a sample of 409 women that had been subjected to domestic abuse working with the organisation, 44% had contemplated suicide or self-harm and a further 18% had made attempts to do so. Further, during the 8-year period reviewed, 8 women sadly lost their lives to suicide.

To further explore the causal links between domestic abuse and suicidality, Aitken & Munro produced a report that had analysed 3,519 case files of clients who had interacted with REFUGE between April 2015 and March 2017, all of whom had completed a CORE-10 psychological distress questionnaire as part of that interaction. Across these questionnaires, it was found that 18.9% of clients reported feeling suicidal currently or recently, and 18.3% confirmed having made plans to end their lives, with 3.1% declaring that they had made at least one attempt to do so previously. Overall, the findings in this research indicated that suicidality was particularly heightened where victims had been subjected to abuse over a long period of time, or perpetrated by more than one person. In addition, clients who had expressed suicidality scored higher than peers in measures tied to despair, hopelessness, depression and / or isolation in particular (Munro & Aitken 2018) (Munro & Aitken 2020).

More recently, a Home Office funded Domestic Homicide Project reported there were 39 victim-suicides following domestic abuse in England and Wales in the year to March 2021; and work between Kent and Medway Suicide Prevention Programme and Kent Police found that 20% of all suspected suicides in their region between 2019 to 2021 were linked to domestic abuse (2021).

Researchers and campaigners have emphasised that the number of deaths through suicide in domestic abuse contexts are likely to substantially exceed deaths caused by violent perpetrators. In response to this, the Government's most recent Domestic Abuse plan has expressed "concern" about the effects of domestic abuse on suicides (2022:7), stating that "it is devastating to know that those trapped by domestic abuse, can feel so hopeless that they believe that the only way out is suicide" (2022:60).