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Domestic Abuse & Suicide

How can we learn lessons more effectively from Domestic Homicide Reviews and prevent future deaths?

Domestic Homicide Reviews (DHRs) are undertaken to learn lessons that will improve responses to domestic abuse and prevent future deaths.

Ensuring that public bodies like social services, councils, police and other community-based partnerships understand what happened prior to someone's death in the context of domestic abuse can help them to identify how future interventions could be improved.

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Advocacy After Fatal Domestic Abuse

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This toolkit summarises key findings from an analysis of 32 Domestic Homicide Reviews that involved death by suicide and provides recommendations to those involved operationally.

It can be used to improve practice at a local and national level, in order to better safeguard victims and ensure that families bereaved by suicide are better supported.

Who is the toolkit for?

- Services engaging with potential or known victims of domestic abuse
- Suicide prevention professionals
- Community Safety Partnership Leads
- Domestic Homicide Review Chairs and panel members

1 For services engaging with potential or known victims of domestic abuse

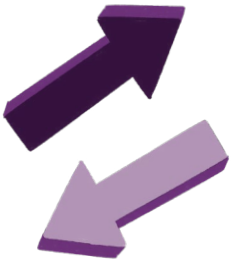
Key Messages:

- Improve risk assessment mechanisms to more effectively identify and understand the risk of suicide in cases of domestic abuse.
- Work together and share information more consistently across agencies.
- Where victims disengage from services, consider barriers to engagement and how these might be overcome, including whether disengagement reflects increased risk.

How do you improve risk assessment mechanisms?

Train specialist frontline services to connect suicide prevention with domestic abuse support, and to be fluent in the ways in which domestic abuse and its associated effects can increase suicidality. This should involve trauma-informed and holistic engagement with victims.

Continuous improvement and revisiting of risk assessments to ensure that risks of self-harm and suicidal ideation are identified. A focus on assessing the risks posed to victims by perpetrators should not preclude concern for risks posed to self.



Work with a range of experts, including 'by and for' services, to develop sensitive interventions, and to make reasonable adjustments as appropriate for victims across different communities.

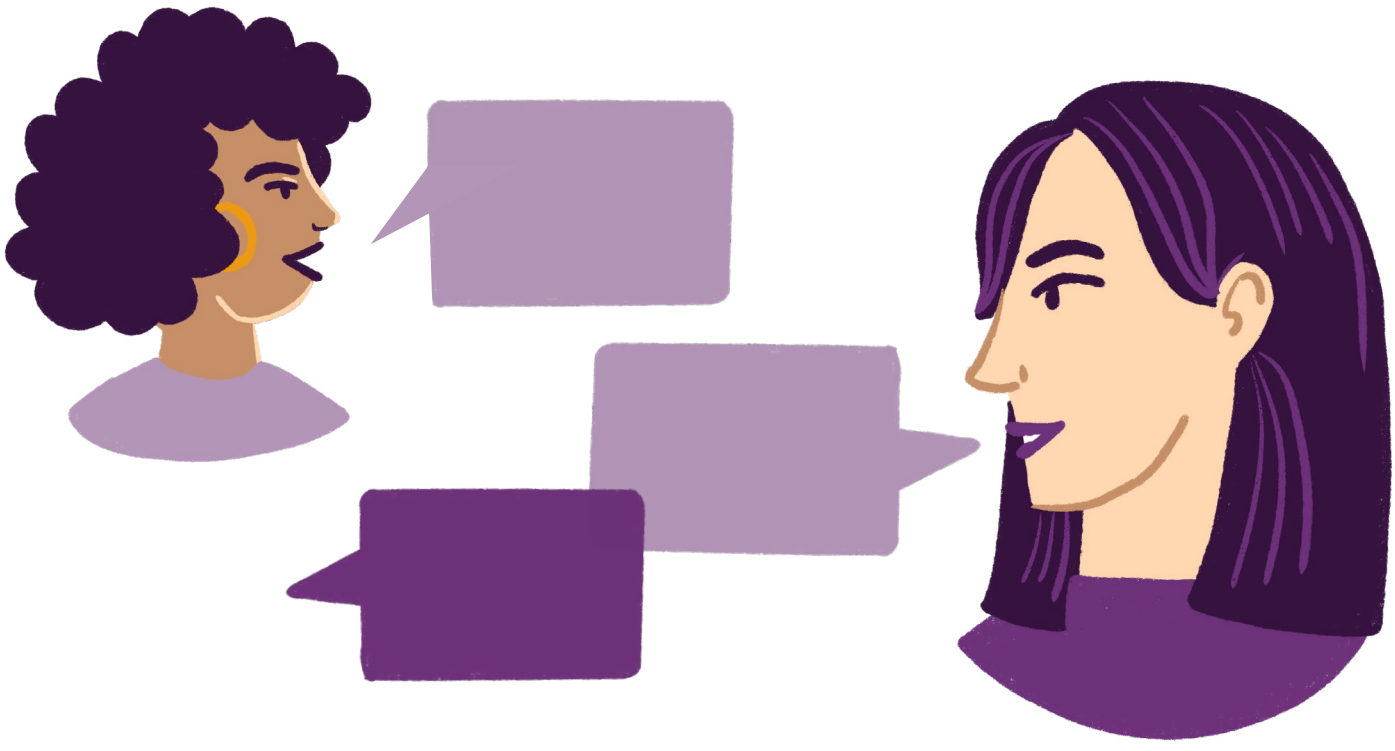
Increase awareness of, and sensitivity to, the fact that, for victims of domestic abuse, the threat or actuality of removal of children (even when done in their best interests) can significantly increase suicidal ideation and risk.

What does working together and sharing information mean in practice?

- Multi-agency partnership - supporting victim's intersectional needs through partnership working across services with different service specialisms.

- Multi-agency sharing of information - robust processes to share the information, and keep the information that is shared under regular review so that a more holistic picture can be developed regarding the needs of victims of domestic abuse.

- Where a potential or known victim of DA is withdrawing from services, this may be an indicator of increased risk (including of suicide). Services need to work flexibly, collaboratively and imaginatively to support engagement



2 For suicide prevention specialists

Key recommendations:

- Connections need to be made more consistently and robustly between experiencing domestic abuse and suicide, with addressing domestic abuse as a more prominent feature within wider suicide prevention initiatives.
- Develop and improve existing suicide safety planning to consider the impact of domestic abuse on a victim and to recognise the ways in which experiencing domestic abuse can create and exacerbate existing vulnerabilities that increase the risk of self-harm and suicide.

What Can Professionals Do?

Better connect the risks of suicide, self-harm, and suicidal ideation in domestic abuse cases. Recognise the psychological injury that perpetrators inflict on victims, and how this can further impact wellbeing.

Be curious. Ask questions that identify the needs of the victim of domestic abuse.

Work in partnership with specialist services, so that victims can benefit from holistic and trauma sensitive approaches to domestic abuse and suicide.

Understand that victims of domestic abuse may go to health care professionals first, before considering going to specialist domestic abuse professionals.

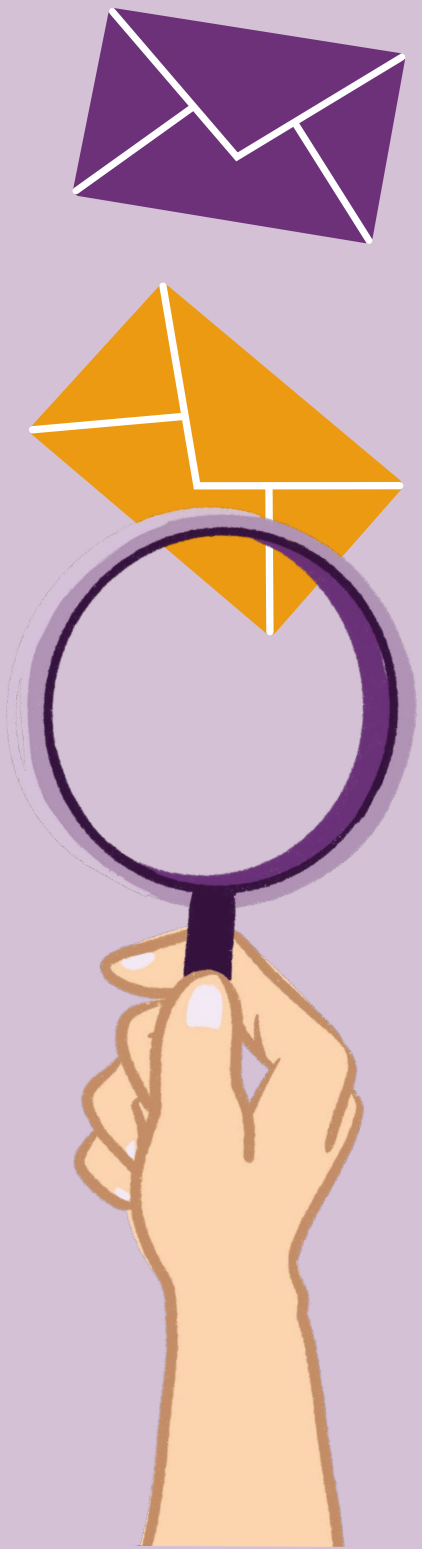
Where a victim of domestic abuse has long term mental ill-health diagnoses ensure special measures and reasonable adjustments are in place so that they can engage with other specialist services.

Do not automatically attribute suicidal ideation to the existence of a mental ill-health condition

Adapt risk assessment and safety planning to understand how domestic abuse is impacting an individual's mental health.

3 Community Safety Partnerships, DHR Chairs, and Panel Members

Key recommendations:



- A consistent approach should be taken at local and national level to the commissioning of DHRs in cases of domestic abuse suicide – this should clearly articulate the criteria that will be applied in determining whether a review should be commissioned and should ensure a representation on the DHR panel of specialists in domestic abuse and suicide prevention.
- Ensure that the DHR process is focussed on learning lessons: services with whom the deceased engaged should be encouraged to reflect critically and deeply on those interactions, to better understand how domestic abuse may have contributed to the death and how services might have intervened more effectively.
- Apply a lens of domestic abuse to the death by suicide. Ask probing questions of the services that engaged with the victim.
- Maintain a sensitive and trauma-informed approach that is alert to the complexity of the victim's experiences and the grief of participating bereaved family members.
- Be mindful throughout the DHR of appropriate interaction with other potential criminal justice or coronial processes.
- Be bold and innovative in your recommendations. Be specific and clear about where services could improve and responses strengthened to better prevent domestic abuse related suicide.

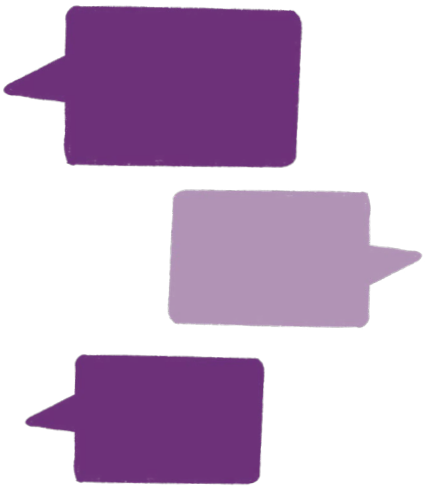
Trauma sensitive language

- Language around the victim's life and death must be trauma sensitive.
- Avoid any language or analysis that blames the victim in their life or death.

Family support

- Share details of specialist advocacy services with families and friends of victims and offer to make a referral on their behalf.
- Ensure families receive the best possible support, both emotional and practical, throughout the DHR process.

Family voice



- Make sure the families' voices are heard in DHR panel meetings - a loved one's story must be told, and the bereaved are entitled to tell it in a way that feels appropriate.
- Take special care to acknowledge the emotion and grief a family might be feeling.
- Ensure that panel members, CSPs, and other participants in the DHR process have the appropriate training to manage the emotional load of meetings, so that responses are trauma sensitive.
- Value the experiences of families and friends and ensure there is no heirarchy of testimony and that their voices hold equal weight to the voices of agencies and professionals.

Risks to other family members

- Consider risks to family members or others who have given accounts of a partner's abuse towards the deceased during the DHR process but who continue to have, or be exposed to the risk of, contact with that partner within the community.
- Consider what safeguarding and risk management should be highlighted to services where there are patterns of abusive behaviour that have been communicated in DHR meetings but are not possible to publish in a DHR report.

This may be especially important where there are children involved and/or evidence that the partner has perpetrated similar abusive behaviour in previous relationships and might pose a risk to future partners.

Post-death charging

- If a post-death charge was not explored by criminal justice agencies in a domestic abuse related suicide case, probe further to understand why this might be the case.
- Consider what learning could be possible if we knew more about the abuse that the victim was subjected to, and if there was an identified and convicted perpetrator.
- Recognise that greater use of post-death charging in appropriate cases could contribute to community safety, public protection and prevention of domestic abuse.

Appropriate knowledge and experience to understand the victim's life

- Consider whether there are gaps in the panel's knowledge that require engaging with specialists, and see this as a training and learning opportunity for the panel.
- Some examples of specialists to work with are:

Suicide prevention specialists.

Specialist services for minoritised groups - challenge racism, discrimination, and microagressions impacting access to services amongst racially minoritised communities.

Gender based violence specialists - including rape and serious sexual assault professionals - to provide further understanding on the risks associated with historic child sexual abuse, and/or adult sexual abuse.

Specialist services for deaf and disabled victims.

Specialist LGBT+ services and/or services that support underrepresented groups.

Domestic abuse professionals who work with male victims of domestic abuse.

Information used to produce this policy brief.

More details about the team and methodology mentioned.

To find out more - read our policy briefs and toolkit.

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Who produced this toolkit?

This toolkit has been co-produced by researchers from the University of Warwick and Advocacy After Fatal Domestic Abuse.

We are grateful for the practitioners and families who also supported the development of this toolkit.