Learning from Domestic Abuse Related Deaths

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Domestic Abuse Guided Intervention Service

30th January 2025

Waythrough & the Think Family Model

Consultation based support designed to increase knowledge of domestic abuse while encouraging safe working practices that place victim safety at the center of all decision making. The model seeks to identify opportunities for escalation, challenges misleading language that may indirectly place responsibility on victims and instead seeks to hold those who harm to account.

Domestic Abuse Related Death Review

Formerly Domestic Homicide Reviews (DHR's)

A Domestic Abuse Related Death Review is a multi-agency review which seeks to identify and implement lessons learnt from deaths which have, or appear to have, resulted from domestic abuse. Their aim is to better protect victims in future and prevent further tragedies – by highlighting to the police and other agencies what can be done in future to strengthen the response.

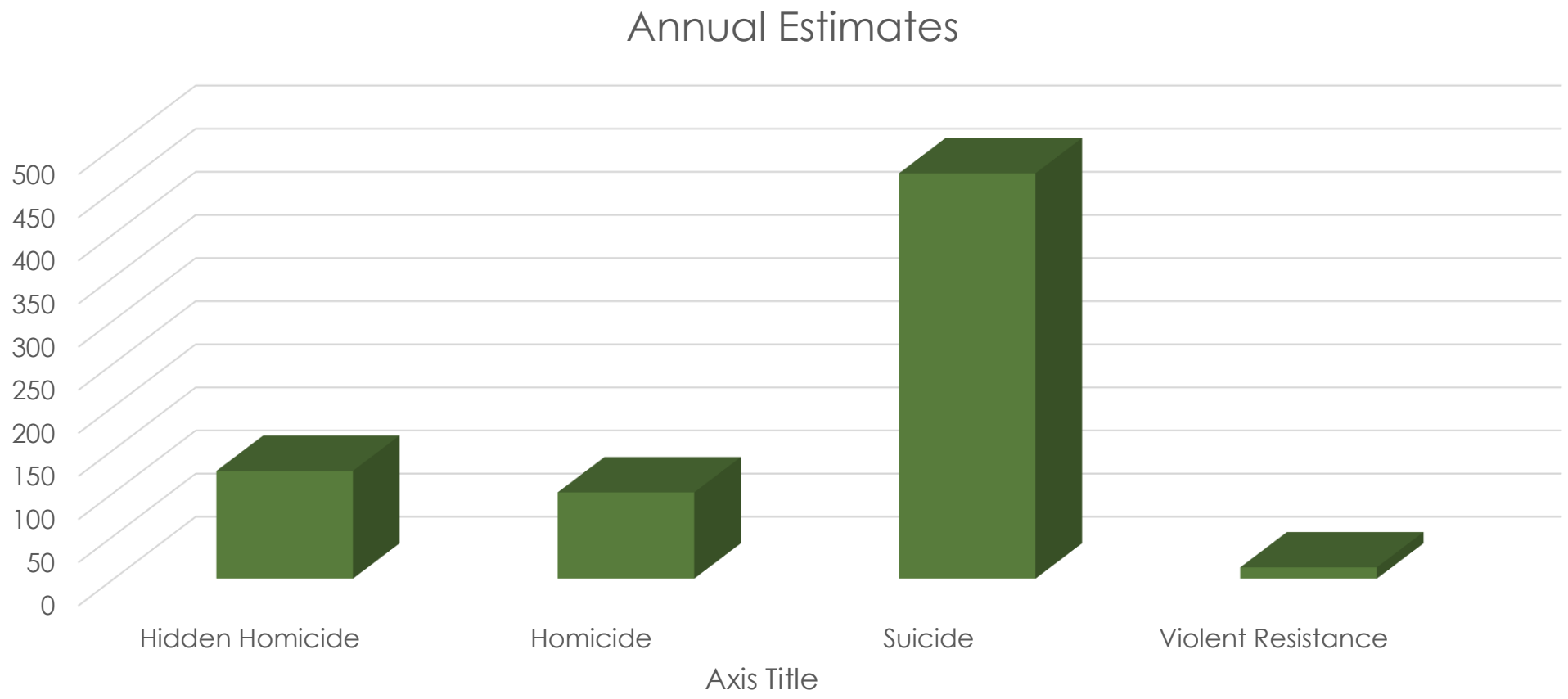
Domestic Homicide Project

Year 3 findings (April 2022 – March 2023) identified a total of 242 recorded deaths.

This included;

- 80 intimate partner homicides
- 23 unexpected deaths
- 11 child deaths
- 4 deaths classified as ‘other’
- 31 adult family homicides
- 93 suspected victim suicides

Domestic Abuse Related Sudden Deaths



Victim Suicide Following Domestic Abuse

- Women who experience abuse from a partner are **three times more likely** to have made a suicide attempt in the past year, compared to those who have not experienced abuse.

- Women living in **poverty** are at increased risk.

- **Sexual abuse** further increases the risk of self-harm and suicide attempts.

Home Office - Key Findings

contact: the need for greater contact with victims and recognition that the perpetrator can control the victim's contacts with agencies

assessment: the need to improve risk assessments, carer's assessments, or mental health assessments

records: information can be missing and not shared between agencies

support: for staff whose work involved cases of domestic abuse and cases where support for victim was not identified or, where the need for support was identified, but there was no plan to provide it

information: the need to improve information sharing between agencies, to hold accurate information and then use it effectively to manage risk

Home Office - Key Findings…

risk: the right risk level needs to be identified, with information held by other agencies included.

referrals: are not always made when needed

training: the need to update training and make it accessible

policy: occasions when action taken was not in line with policy and there were agencies without a domestic abuse policy

Contact us

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