Learning Legacies: Bringing visibility to domestic abuse related suicide

“It’s like she’s been erased, she doesn’t count, she’s invisible”

Mother, bereaved by domestic abuse related suicide

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Domestic abuse suicide – a ‘known unknown’

1/3 of all female suicide in England and Wales may have been caused by domestic abuse	44% - contemplated suicide 18% - made an attempt	18.9% reported feeling suicidal 3.1% - at least one failed attempt
Approx. 30% of all suspected suicides impacted by domestic abuse	10% of suicides – offenders of DA 7% of suicides – victims of DA	Suicide attempts – 49.7% had experienced IPV & 23.1% in the last year

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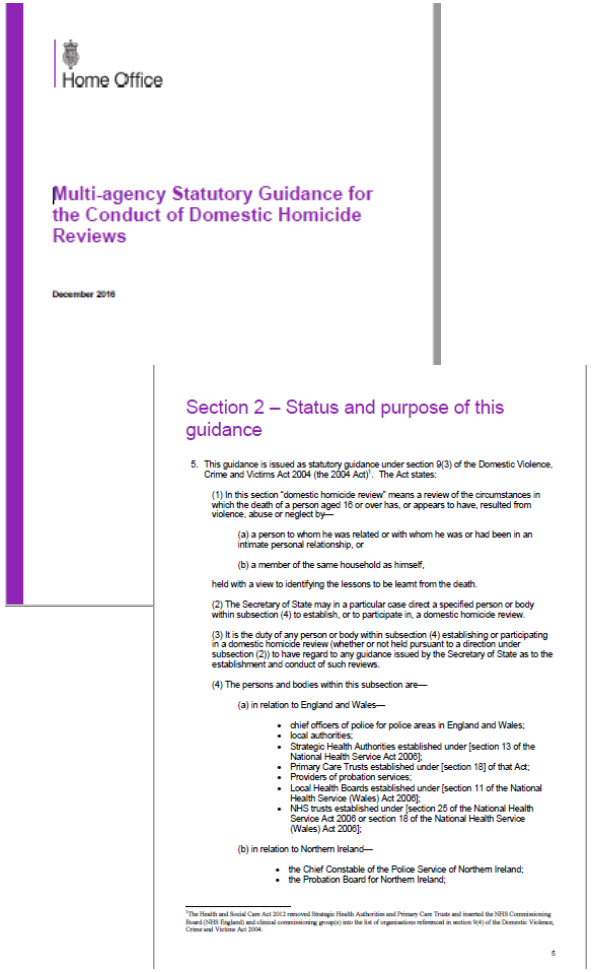
‘Suicide’ Domestic Homicide Reviews (DHRs)



Home Office

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

December 2016

Section 2 – Status and purpose of this guidance

5. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)[1]. The Act states:

(1) In this section "domestic homicide review" means 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,

held with a view to identifying the lessons to be learnt from the death.

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

(4) The persons and bodies within this subsection are—

(a) in relation to England and Wales—

- chief officers of police for police areas in England and Wales;
- local authorities;
- Strategic Health Authorities established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts established under [section 18] of that Act;
- Providers of probation services;
- Local Health Boards established under [section 11 of the National Health Service (Wales) Act 2006];
- NHS trusts established under [section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006];

(b) in relation to Northern Ireland—

- the Chief Constable of the Police Service of Northern Ireland;
- the Probation Board for Northern Ireland;

[1]The Health and Social Care Act 2012 removed Strategic Health Authorities and Primary Care Trusts and inserted the NHS Commissioning Board (NHS England) and clinical commissioning group(s) into the list of organisations referenced in section 9(4) of the Domestic Violence, Crime and Victims Act 2004.

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Home Office Statutory Guidance for the conduct of DHRs – Paragraph 18:

‘Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable. ‘

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Working with families bereaved by domestic abuse suicide

Distinct from bereavement by suicide – lack of specialist postvention support	Continued risk from the perpetrator	Stigma and guilt
Lack of consistency in commissioning of Domestic Homicide Reviews	Hierarchy of testimony	Inquest - recognising DA as a factor in a death. Being counted

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Learning Legacies: An analysis of Domestic Homicide Reviews in cases of Domestic Abuse Suicide

- Parties' Profiles, Vulnerabilities and Needs
- Agency Engagements and Responses
- Context and Aftermath of Death
- Commissioning and Commencing DHRs
- Running Successful DHRs

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Recommendations

Consider domestic abuse in local and national suicide prevention strategies.

Ask about domestic abuse when talking to individuals who have self harmed

A collaborative approach - suicide prevention and domestic abuse sectors

Engage with DHR processes where possible

Further research to understand prevalence & risk factors

Consider specialist postvention support for families bereaved by suicide where there was a history of domestic abuse

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