Domestic Homicide Review Series
Part Three

An analysis of Domestic Homicide Reviews with fatal strangulation

Institute For
Addressing
Strangulation

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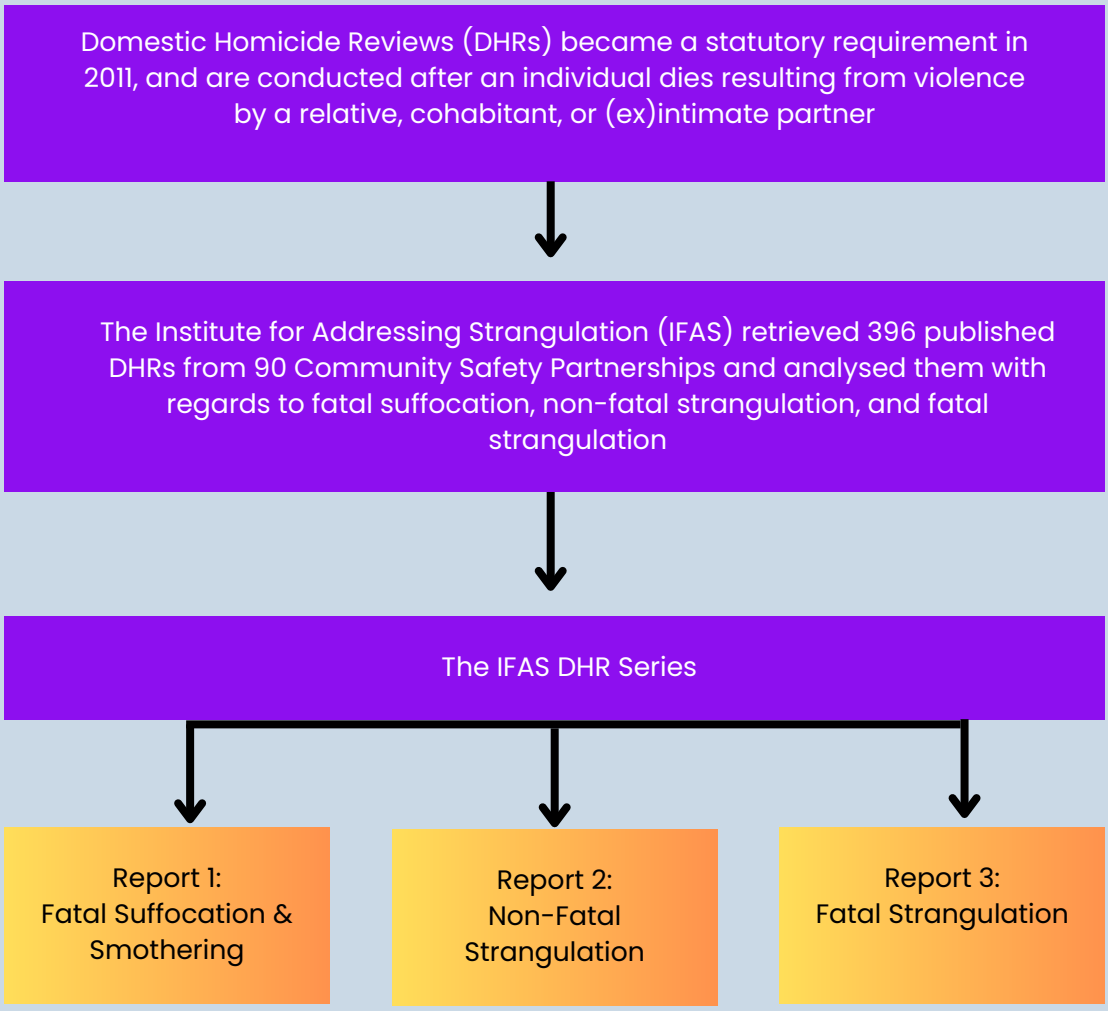
Institute For Addressing Strangulation

IFAS Domestic Homicide Review Series

The Institute for Addressing Strangulation (IFAS) conducted a three part series analysing Domestic Homicide Reviews (DHRs). This is the third report in the series, with a focus on fatal strangulation. Presented in the diagram below is the focus of each report in the series.



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Introduction

Strangulation and Suffocation were introduced in England and Wales as stand-alone offences in June 2022[1]. Following this new legislation, the Institute for Addressing Strangulation (IFAS) was established to raise awareness around the prevalence and risks of strangulation, and further the evidence base around strangulation from a UK-perspective. IFAS research has previously considered the number and progression of strangulation cases moving through criminal justice proceedings (see[2]) and the prevalence of strangulation-related deaths using Office for National Statistics Data (see[3]). This report is the third in the IFAS Domestic Homicide Review (DHR) series[4], analysing the presence of strangulation and suffocation in published DHR reports.

This series has been designed to provide an analysis of strangulation and suffocation related domestic homicide reviews, not just in relation to the nature of these homicides, but also with a critical lens on the process of conducting the DHR itself. The purpose of this series is to better understand strangulation and suffocation domestic homicides and subsequent review processes, considering trends within these cohorts. This has the potential to positively influence practice – for instance, within domestic abuse services or perpetrator programmes – by improving understanding of these crimes, as well as highlighting nuances previously unknown.

The intention of the DHR process is to identify any lessons that are to be learned from the death of the victim. The DHR process should also involve consideration of how these lessons may be applied to service responses and ultimately be used to prevent domestic abuse and homicide in the future. The Home Office statutory guidance on DHRs[5] provides far greater detail on the purpose and running of these reviews.

Previous research focused on DHRs has considered the DHR process broadly, highlighting commonalities across the nature of the homicides (e.g., in relation to victim and perpetrator demographics, the circumstances of the homicide etc.) and the learnings from the DHR processes (e.g., recommendations including training and awareness and better service provision and coordination). More recently, the HALT project[6] at Manchester Metropolitan University has considered the recommendations from DHRs more thematically, with considerations given to criminal justice proceedings, health services, children's services, and adult social care.

To the knowledge of the IFAS researchers, however, there have been no parallel analyses conducted with a specific focus on strangulation and suffocation.

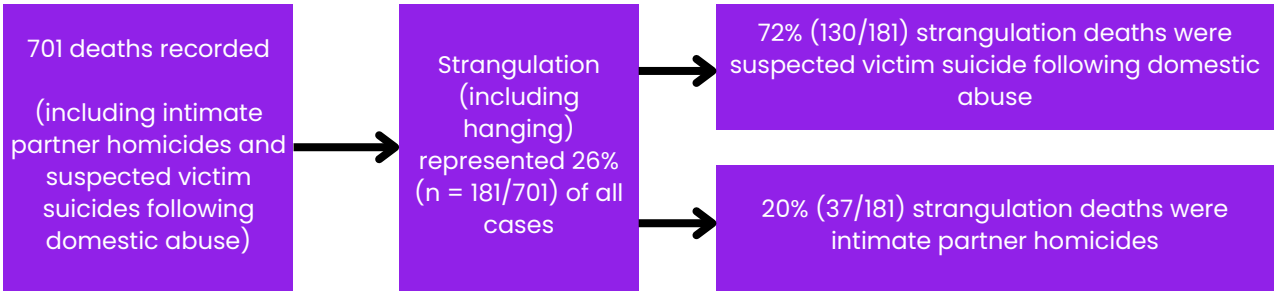
The purpose of a DHR is to review the circumstances of the death of an individual (aged 16 years or over) whereby the death has (or appears to have) resulted from violence, abuse, neglect from:

- 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"[5].

Note: Domestic Homicide Reviews (DHRs) are now referred to as Domestic Abuse Related Death Reviews. For consistency with the IFAS DHR series[4], the previous name (DHRs) will be retained for this report.

The focus of this report is DHRs where strangulation was used as the method of killing. This may have been used alongside other violent acts, but the DHR process identified strangulation as the ultimate cause of death.

According to recent findings from the Vulnerability Knowledge and Practice Programme (VKPP[7]), strangulation was the most common mode of death across their dataset of 701 domestic abuse-related or unexpected deaths and suspected suicide of individuals with a history of domestic abuse. The vast majority (72%) of deaths by strangulation were in domestic abuse related suicides. One fifth (20%) of the deaths by strangulation were intimate partner homicides (see Graphic 1 below). With regards to non-fatal strangulation (NFS) in the histories of the victims, there was an 11% increase in reports of previous NFS across the domestic abuse suicide cases. This was an increase from Year 2 (2021-2022) to Year 3 (2022-2023). For more information, please see the IFAS response to the recent VKPP data[8].



Graphic 1: The proportion of deaths by strangulation across a three year dataset (April 2020 - March 2023).

All of the above should be considered to recognise the importance of highlighting fatal strangulation within the context of domestic homicides. What are the consistencies amongst homicides by strangulation? What can we learn from analysing these cases in isolation?

The saying goes, "only the good die young". There's no more a truer saying when it comes to the passing of Helena. Helena loved being part of a big family, being a perfect daughter, a big sister, a loved granddaughter, and special niece. … We as a family hope this review will help anyone who is suffering from domestic violence and abuse. Helena would be so proud if it did help someone else. We as a family only had 21 years with Helena, nowhere near enough time, but in those 21 years Helena has left a massive legacy.
(Case 22)

Methodology

To better understand the prevalence and nature of strangulation used as a method of killing in domestic homicides, IFAS obtained 396 DHR reports from 90 Community Safety Partnerships in England and Wales (see previous reports for more information about earlier data collection methods). In addition, researchers cross-referenced and added to this sample using the Home Office Domestic Homicide Review Library[9]. At the time of analysis, there were 554 DHR reports on this online library.

To search the online library, the categories of 'Manual Strangulation', 'Strangulation with a ligature' and 'Suffocation, asphyxiation, or smothering' were selected in the 'Method of Killing' field. The latter category was included in case any strangulation homicides had been mis-categorised. Researchers then read through the 91 cases that were returned from this search and included the reports whereby strangulation was determined as the method of killing. The final sample from the CSPs and online DHR library included 75 cases. Removed cases included those whereby strangulation could not be confirmed as the method of killing – this is discussed further in 'Homicide Circumstances' below.

In reviewing the cases, researchers extracted details from the reports in relation to: 1) victim and perpetrator demographics, 2) the circumstances of the homicide, 3) previous domestic abuse histories, and 4) factors surrounding the DHR process more generally. These raw data were then coded by sub-category within each of the above four themes, to aid the descriptive data analysis presented in this report. A content analysis was conducted for the recommendations reported within the DHR reports to consider the re-occurrence of key concepts and recommendations. Findings are presented and discussed below.

Limitations

As per the first two reports in this series [4], the researchers are limited by the unknown total number of DHRs that have been carried out since they began in 2011. The number of DHRs uploaded to the online library is simply only the number that has been uploaded, not necessarily even an indicative total of completed DHRs (an estimate in 2021 suggested there had been around 800 DHRs completed by that point[10]).

The difficulty in analysing DHR reports comes from the lack of uniformity. This is not just in relation to the order in which information is presented, but in fact whether certain information is included at all. IFAS researchers are aware that it is possible information may have been obtained through the DHR process which is then not included in the DHR report. However, there would be benefit in making more consistent sources of information publicly available – this is discussed further in the final section on 'Key Points and Recommendations'. We are also encouraged to see new DHR statutory guidance is currently under review.

Finally, connected to the point above, the information presented in this analysis is therefore presented based on what has been taken from the DHR reports, which may not fully represent the reality of the lives or circumstances of the individuals involved. It may also not be fully representative of all domestic homicides, as not all domestic homicides result in a domestic homicide review. Where it is particularly important to appreciate the representativeness of the findings in this – for instance when reporting where domestic abuse was present within the relationships prior to the homicide – this point will be re-articulated.

Terminology

The terms 'victim' and 'perpetrator' are used throughout this report to make reference to the individual who was killed and the individual who killed them. Not all 'perpetrators' went through legal proceedings (i.e., some were deceased before this process could begin) so the use of this non-legal term compared to, for instance, 'offender', felt more applicable across all cases.

Findings and Discussion

Presented below are the findings from analysis across four themes: Victim and Perpetrator Demographics, Homicide Circumstances, Domestic Abuse Histories, Domestic Homicide Review Processes.

Victim and Perpetrator Demographics

Victim Demographics

Victim Sex and Age

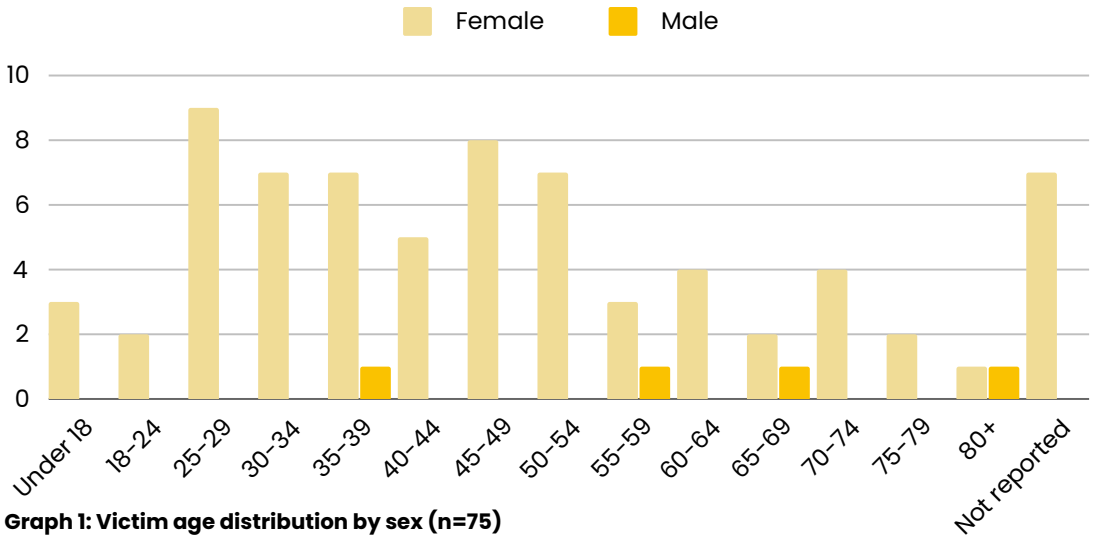
In our review of 554 DHR reports, there were 75 (14%) victims killed by strangulation.

- 95% (71/75) of the victims were female.
- 5% (4/75) of the victims were male.

With regards to the victims' ages, 9% (7/75) of the DHRs did not state their age. Where the victim's age was reported, they ranged from 16-91 years old, and the median age was 44 years old. It is worth highlighting that 3 of the victims were children, two aged 16 years old and one 17 years old.

Graph 1 presents age distribution by sex. For women, the highest number of victims were in the age bracket 25-29 years followed closely by 45-49 years.

In 92% (69/75) of the DHRs the victim's identity was anonymised with the use of a pseudonym. In 7% (5/75) of the cases, the victim's identity was not anonymised, and in 1 case it was not stated as to whether or not the identity of the victim was anonymised. Pseudonyms (or generally anonymising the victim with a label such as 'victim') are commonly used in line with statutory guidance, however some families of victims prefer that their real name be used: *"Dianne's family feel strongly that they would like her to be remembered and made a specific request to use her real name."* (Case 29). In some cases in this report, friends and family being able to choose the way in which they wanted their loved one to be referred to was an important way of marking their respects, for instance: *"Amolita means 'priceless' and was a choice approved by Ms X [a friend of the victim]."* (Case 10).



Graph 1: Victim age distribution by sex (n=75)

Victim Ethnicity

In terms of the victims' ethnicity, 20% (15/75) of the DHRs where the victim was killed by strangulation did not report the victim's ethnicity and in 11% (8/75) the victim's nationality rather than ethnicity was reported. Of the 52 victims where their ethnicity was reported 77% (40/52) of the victims were White, 21% (11/52) were Asian and 2% (1/52) were Black. Table 1 presents the percentages of victims killed by strangulation by ethnicity (including where ethnicity was not stated).

A key findings report from the Home Office analysing 124 DHRs between October 2019-September 2020 found that 8% of DHR victims were Asian or Asian British and that they accounted for 9% of all homicides[11]. A quantitative analysis by the Home Office the following year on DHRs similarly found that Asian or Asian British victims accounted for 9% of DHR victims. From our analysis, Asian victims are represented to a greater extent than would be expected given the existing Home Office homicide data referenced above. This raises questions around the over or under representation of different ethnic groups in strangulation homicides, specifically, with the caveat that the ethnicity picture is not necessarily complete given missing ('not stated') data from our analysis.

Victim Ethnicity	Number (and %) of victims by ethnicity
White	40 (53%)
Black	1 (1%)
Asian	11 (15%)
Mixed	0 (0%)
Not stated	15 (20%)
Not stated, but nationality reported	8 (11%)
Total	75 (100%)

Table 1: Number of victims by ethnicity (n=75)

Victim Disability and Vulnerability

From our analysis, 9% (7/75) of victims killed by strangulation had a physical health condition, and in 13% (10/75) the DHR reported the victim had a diagnosed mental health condition that was identified within the DHR as a registered disability. A learning disability was reported in relation to 1% (1/75) of the victims in this cohort, but in the majority of cases (76%, n=57) the victim had no reported disability. In many cases however, the DHR reported vulnerabilities that victims were experiencing that were not recorded or considered to be disabilities. Over a third of the victims (37%, 28/75) had a reported history of mental health difficulties (compared to the diagnosed conditions/disabilities referenced above) and 26% (27/75) had more than one vulnerability reported in the DHR. Table 2 outlines the number and percentage of victims by vulnerability.

It was reported that 36% (27/75) victims had more than one vulnerability, with 11% of victims reported having 3 or more separate vulnerabilities.

Types of Victim Vulnerability	Number of Victims by Vulnerability Type
Alcohol/drug misuse/dependence	10 (13%)
Mental health difficulties	28 (37%)
Homeless/ housing issues	3 (4%)
Financial dependency	14 (19%)
Recent/significant bereavement	4 (5%)
Pregnant/recently given birth	5 (5%)
None/not stated	22 (29%)

Table 2: Number of victims by reported vulnerability

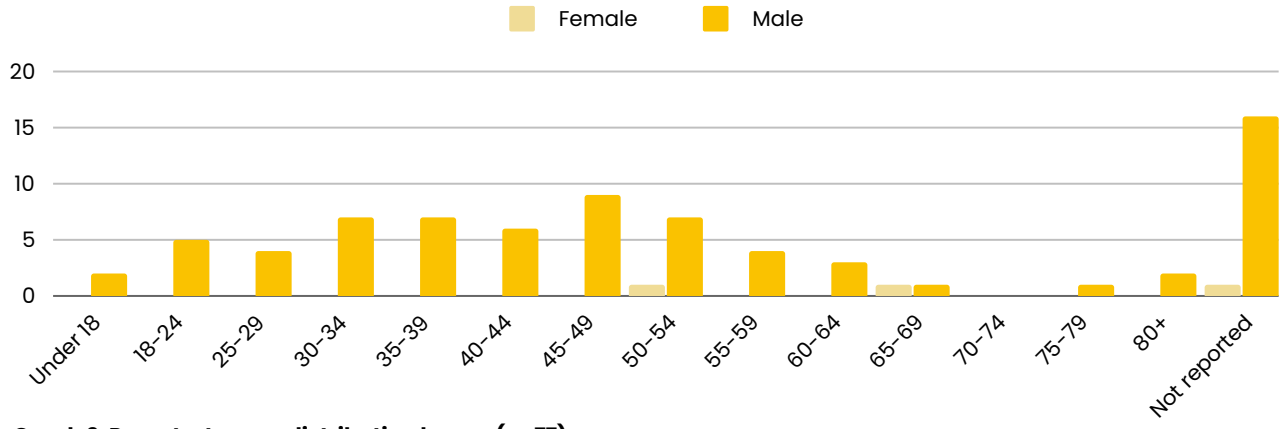
Perpetrator Demographics

Perpetrator Sex and Age

In this cohort of 75 domestic homicides by strangulation, there were 77 homicide perpetrators as two of the DHRs reported two perpetrators. In these cases, the victims were both male and were murdered jointly by male and female perpetrators. In both of these cases, the DHR was not able to identify which of the perpetrators had carried out the act of strangulation, both were convicted of murder and therefore have been included in this analysis. The identities of all 77 of the perpetrators were anonymised in the DHR reports.

In terms of sex, 96% (74/77) of the perpetrators were male and 4% (3/77) were female. As has been noted, two out of the three female perpetrators were convicted of murdering a male victim and were jointly convicted of murder alongside a male perpetrator. The third female perpetrator acted alone and killed a female victim.

With regard to the perpetrators' ages, 22% (17/77) of the ages were not included in the DHR report. Where the perpetrator's age was included, ages ranged from 17-81 years old, and the median age was 44 years old. The most common age group was 45-49 years old. This somewhat mirrors the age ranges of victims, with a tendency towards the older age categories for perpetrators. Graph 2 presents perpetrator age distribution by sex.



Graph 2: Perpetrator age distribution by sex (n=77)

Perpetrator Ethnicity

In terms of the perpetrator ethnicity, in 30% (23/77) of the DHRs where the victim was killed by strangulation, the perpetrator's ethnicity was not stated in the report and 10% (8/77) reported the perpetrator's nationality instead of ethnicity. Where the perpetrator's ethnicity was included in the report, 70% (32/46) were White, 26% (11/46) were Asian, and 6% (3/46) were Black.

Perpetrator Disability and Vulnerability

In the majority of DHRs where the victim was killed by strangulation, the perpetrator had no reported disability (74%, 57/77). Of the cases where the DHR reported that the perpetrator had a disability, three individuals had more than one disability.

- 6% (5/77) of the perpetrators had a reported physical health condition
- 21% (16/77) of the perpetrators had a reported mental health condition
- 3% (2/77) of the perpetrators had a learning disability reported

In many cases, perpetrators had one or more reported vulnerabilities. These are circumstances not identified by the DHR as a formal disability, for instance, alcohol dependency. More than a third of the perpetrators in this cohort had more than one vulnerability reported and 4% (3/77) of the sample had 5 comorbid vulnerabilities reported in the DHR. The most common vulnerabilities that perpetrators were reported to be experiencing included alcohol/drug misuse/dependence (29%, 22/77), mental health conditions (not formally identified as a disability) (49%, 38/77) and suicidal ideation/suicide attempts (13%, 10/77).

Victim-Perpetrator Relationship

Most of the victim-perpetrator relationships in DHRs in this sample were current or former intimate partners (65/77 perpetrators, 84%).

With regards to other relationships across the 75 cases (77 perpetrators), there were:

- Two cases where there were two perpetrators (as noted on page 7) - the victim's ex-partner and the victim's ex-partner's new partner. In both cases, they were jointly convicted of murder.
- Six cases where a son killed his mother.
- Three cases where a brother killed his sister.
- One case where a grandson killed his grandfather.

Reported separation or ending of a relationship was a significant feature in this cohort. In 66% (43/65) of the DHRs where the victim and perpetrator were in an intimate relationship, the DHR reported evidence that the relationship had ended or the victim was trying to end the relationship around the time of the homicide. Through this analysis we explored post separation triggers or events that aligned with Stage 4 in the 8 stages of homicide (Monckton-Smith, 2019[12]). An overview of the 8 stages of homicide in Monckton-Smith's timeline is provided below:

1. History – criminal record or allegations from former partners of domestic abuse, a history of routine jealousy and possessiveness
2. Early relationship – everything moves quickly, for instance, early declarations of love
3. Relationship – dominated by controlling patterns
4. Trigger – perpetrator's control is threatened, most often through separation or its threat
5. Escalation – an increase in frequency or severity of control tactics
6. Homicidal ideation – feelings of revenge, injustice or humiliation driving a decision to resolve issues through serious harm or homicide
7. Planning – including, for example, gathering weapons, creating opportunities to get the victim alone
8. Homicide – involving, for example, an obvious homicide or staged suicide or missing person

In some of the cases, Stage 7 – for example by ensuring the victim was alone – was evident. Even in cases where separation had occurred, the victim may have been in a new relationship but the perpetrator requested to meet for a walk or a talk. In some cases, the perpetrator gained access to the victim's property without their knowledge, with the intention of killing them. This planning stage also includes, for example, the purchasing of weapons. Strangulation is a method of killing which usually requires nothing more than the perpetrator's hands, which arguably makes it an incredibly accessible weapon. Where ligatures were used (discussed below), these were commonly items found in the home, rather than deliberately brought with the perpetrator – again, increasing the accessibility of this method of killing.

The most common post-separation circumstances across the 43 cases were (some with more than one trigger event):

- The victim trying to leave/ end the relationship (19 cases)
- A suspected or verified new relationship (9 cases)
- Formal notice (e.g., for Divorce) issued or applied for (6 cases)
- Money/housing was now stable for the victim so they could leave (4 cases)
- The abuse was reported to the police (4 cases)
- Pregnancy (2 cases)

Homicide Circumstances

Dates and Locations of Homicides

The earliest homicide in this dataset occurred in 2011 and the most recent was committed in 2021. This is not to say that no fatal strangulation domestic homicides have taken place since 2021 – it may be that the Domestic Homicide Review processes for those murders have not yet been completed, published, and/or added to the Home Office DHR online library. The analyses in this report did, however, capture all relevant DHR reports that were available up to April 2024.

The location of the majority of homicides (59/75, 79%) was the home of the victim – either where they lived alone, with family, and/or with the perpetrator. Sometimes it was unclear to those conducting the DHR whether the victim and perpetrator officially lived at the same address, hence why victim and victim/perpetrator homes have been grouped together. Seven homicides (9%) occurred at the home of the perpetrator (which was not also shared with the victim), and two homicides (3%) occurred outdoors. One homicide (1%) took place in hospital, and one (1%) was committed in a hotel room. The location of the homicide was not reported in five cases (7%). Overwhelmingly, therefore, the victims of these homicides were most at risk in their own home.

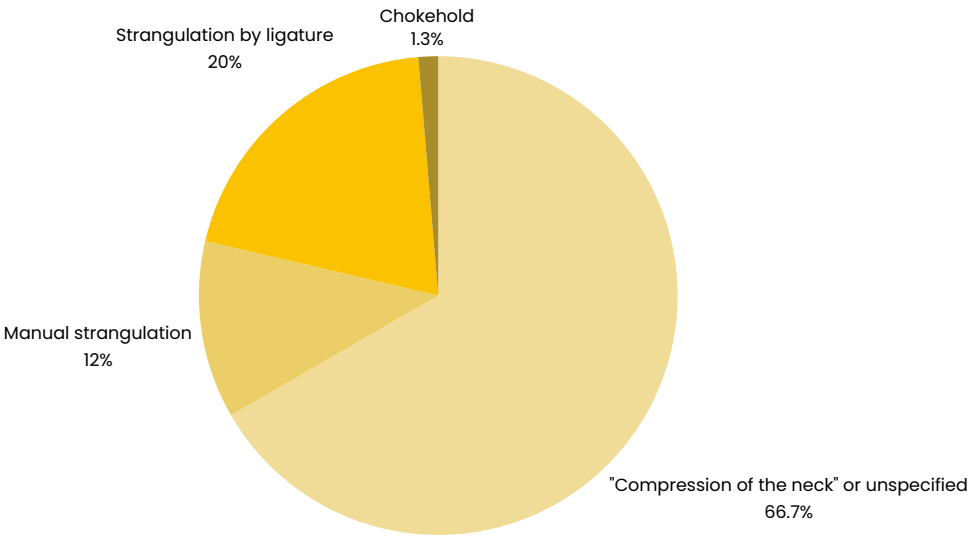
It was explicitly stated that children were present in 13/75 of the cases (17%). This included three cases whereby the victims themselves were children. This is an important finding when considering the risk to children through domestic abuse. With the victim's home being the most common location of strangulation homicides, it must always be considered what impact this will have on any children present, even if they did not hear or witness the murder.

Methods of Homicides

Where an official cause of death – for instance, from a pathologist report – has not been stated, homicides involving strangulation alongside other forms of violence such as blunt force trauma have not been included within the analysis as it is not clear whether strangulation might have been the ultimate cause of death. In these cases, the DHR may reference, for example, the cause of death being strangulation alongside blunt force trauma – for example: "*Alice had extensive and severe facial and head injuries as well as to her body, 71 in total. She had been strangled and then beaten with a heavy glass lamp holder as well as with fist blows and stamping. There was evidence of defence injuries. Such an attack would meet the definition of 'Overkill'…*" (Case 9). DHRs stating 'asphyxiation' as the only indication of cause of death have not been included in this analysis as there is a potential for these this to be alluding to death by suffocation or choking (mechanical obstruction of the windpipe), rather than strangulation.

Given these inclusion criteria, out of the 75 homicides, the methods of killing reported in the DHRs are shown in Graph 3.

Methods of Homicides



Graph 3: The number and percentage of reported method of killing across the sample of DHR cases in this report (n=75). (Note: 'unspecified' related to where the specific method of strangulation (e.g., manual) has not been specified.)

Although it may not always be possible to establish an exact method of killing, it can be important to distinguish between methods where possible. In strangulation homicides, this may be increasingly important with a move to the inclusion of domestic abuse related suicides with the DHR process (see e.g., AAFDA evidence[13] and from the Domestic Abuse Commissioner[14]). Being able to establish, for instance, a death by hanging (suicide) from a homicide by ligature strangulation is incredibly important in being able to investigate whether someone has taken their own life, or perhaps a perpetrator has staged a suicide (see, for example, Ferguson & Petherick, 2016[15]).

Perpetrator Behaviour Post-Homicide

Perpetrator Self-Harm

Self-harm by the perpetrator, at the time or shortly after the homicide, was reported in 20/75 (27%) cases. In some cases whereby the perpetrator had caused harm to themselves after the homicide, it was suggested that this may have been in an attempt to suggest an element of self-defence in their actions of killing the victim: "*His defence was based on 'self-defence', that his wife had attacked him and he had protected himself… [the perpetrator] also had a further two stab wounds and other cuts on his arms and face. Later expert opinion was that the injuries of [the perpetrator] were self-inflicted.*" (Case 23).

In other cases involving perpetrator self-harm post-homicide, it is not clear whether this was done in an attempt to take their own life: "*When the police arrested the perpetrator, he was asked about blood that was on his hand, he said it was from his neck where he had tried to kill himself. Upon checking, he was found to have superficial scratches on the right side of his neck which he said he had done to himself.*" (Case 27).

Some DHRs noted when perpetrators had what had been considered as defensive wounds, inflicted by the victim in an attempt to survive. Without witnesses at the time of the homicide, it is sometimes considered within the DHR process to be difficult to determine the cause or intention of visible injury to both perpetrator and victim. Whilst this may seem secondary to the focus on the homicide behaviour itself, it may be relevant within DHR processes to consider behaviours leading up to the fatal incident.

Perpetrator Suicide

Out of the 77 perpetrators of homicide, 13 (17%) took their own lives, either soon after the homicide or in prison whilst on remand. The method of suicide in 9/13 cases was hanging, one perpetrator died by drowning, one by self-inflicted stab wounds, and one perpetrator made multiple attempts on his life (including self-strangulation with a ligature), with the ultimate cause of death recorded as a self-inflicted stab wound to heart. One method of suicide was not stated. Included within this group of 13 perpetrator suicides is a case whereby the family of the deceased did not necessarily attribute blame to the perpetrator of the homicide, but considered the situation to be a tragic one for both parties involved.

One family member noted to the DHR chair that "*We are looking forward to having the matter closed so that we can remember both of them peacefully and together as they should be.*" (Case 12). Developing understanding, partially through the DHR process, around risks posed in relation to homicide and suicide should be an important facet of this work.

Reporting the Homicide

In 54/75 (72%) cases, there was a delay between the homicide and a report being made to authorities, for instance the police or ambulance service. In the majority of these cases, this was due to the perpetrator not taking action to report the homicide to anyone, either to friends, family, or professionals. For instance: "When concerned family members visited the home, the perpetrator tried to hide what he had done, but they saw the victim's body and alerted the police. By this time, the victim had been dead for over 24 hours. The perpetrator had not called for an ambulance but had apparently sat with her, watched television and gone out to get alcohol within that time." (Case 2). Additionally, "At 3.00am on Wednesday 31st December 2014, P presented himself to hotel duty staff and enquired about travel directions to London. He informed staff that his sister was asleep in the room and that she was not to be disturbed. P subsequently travelled to London and later obtained a flight to Tanzania." (Case 24).

In 16 cases (21%), there was not a delay in reporting or the victim being found. In some of these cases, however, this was not due to the actions of the perpetrator, but because of the crime being reported by a witness to the abuse or ultimate homicide e.g., "At 06:47 on a weekday in early August 2018, Daisy called police via 999 from the home address saying that her father was attacking her mum." (Case 15). The circumstances around how and when the body was found were not reported in five cases (7%).

Of the 13 cases whereby the perpetrator took their own lives after the homicide, one of the cases involved the perpetrator making authorities aware of what he had done and was about to do: "A letter had been posted by Peter to the regional Royal Mail Sorting Office with the following information written in red and underlined on the envelope 'Ring 999 and inform the police that this envelope contains admission of a recent murder + suicide'. The letter within the envelope written and signed by Peter read 'I Peter.....admit that I murdered my wife June this evening/night, I intend and have made preparations to hang myself'." (Case 45).

Perpetrator Outcomes

Out of the 77 perpetrators, 55 (71%) received a custodial sentence and five (6%) were sentenced to time in a secure hospital. The outcome in 14 cases (18%) was that the perpetrators had died (13 by suicide), and in three cases (4%), the outcome was not stated. Some of these sentences were for manslaughter rather than for murder, and some sentences included other offences in addition to the homicide (for instance, robbery), but the minimum sentence was seven years, three months and the maximum (other than unspecified 'life' sentences) was 32 years.

Domestic Abuse Histories

In the majority of DHRs in this cohort, domestic abuse was evident in the relationship prior to the homicide occurring. This section attempts to provide an overview of the victims' experiences of abuse, as reported in the DHR, prior to the homicide. It is worth acknowledging that the absence of information does not mean homicide victims were not experiencing any forms of abuse but might instead reflect how difficult it can be to seek help and tell others the reality of what is happening in an abusive relationship. This section also explores the perpetrators' prior offending where reported in the DHRs, and the victims' prior experiences of domestic abuse in previous relationships, again, where reported in the DHRs.

In 54/75 (72%) of the DHRs, there was a reported history of domestic abuse between the victim and perpetrator of the homicide. In the remaining 21/75 (28%) cases, the DHR found that friends, family, and services had no knowledge of any domestic abuse between the victim and perpetrator.

Of those 54 cases where a history of domestic abuse was reported in the DHR:

- 45/54 experiences of domestic abuse between the homicide victim and perpetrator were known about/reported to services (83%)
- 9/54 experiences of domestic abuse between the homicide victim and perpetrator were known about/reported to friends or family members and not services (17%)
- 28/54 (52%) of the DHRs reported evidence that the perpetrator had previously perpetrated domestic abuse towards someone other than the victim of the homicide
- 10/54 (18%) of the victims had experienced domestic abuse at the hands of someone other than the perpetrator of the homicide.

Victims' experiences of abuse were intersecting as detailed in Table 3. The most common forms of abuse were coercive and controlling behaviour, psychological and emotional abuse, closely followed by physical abuse.

Type of Abuse Reported	Number (and %) of Victims Experiencing by Type of Abuse (n=75 victims)
Coercive control (a pattern of intimidation, degradation, isolation and control with the use or threat of physical or sexual violence)	51 (68%)
Psychological and/or emotional abuse	52 (69%)
Physical or sexual abuse	43 (57%)
Financial or economic abuse	13 (17%)
Harassment and stalking	6 (8%)
Online or digital abuse	2 (3%)
Not stated (no awareness/unknown)*	1 (1%)

Table 3: Number of experiences of abuse categorised by abuse type.

*Case 1 - police called to disturbance, treated as a domestic incident, helplines provided to both parties no details on abuse included. Total number >75 as victims were experiencing multiple forms of abuse.

A History of Non-Fatal Strangulation

In addition to other forms of domestic abuse within relationships (reported above), a particular interest - given the DHR series conducted by IFAS[4] - has been shown with respect to the presence of non-fatal strangulation.

- In 24/54 (44%) of the DHRs with a reported history of domestic abuse between the homicide victim and perpetrator, there was evidence that the perpetrator had previously strangled the victim.
- In 12/54 (22%) of the DHRs, the perpetrator of the homicide had previously strangled someone other than the victim of the homicide.
- In 5/54 (9%) of the DHRs, the perpetrator had previously non-fatally strangled the victim of the homicide and someone else.
- In 1/54 (2%) of the DHRs the victim was non-fatally strangled by someone other than the homicide perpetrator, in this case her ex-husband.

Overall non-fatal strangulation was present in 32/54 (59%) cases where there was a prior history of domestic abuse reported in the DHR. Across the whole sample non-fatal strangulation was present in 43% (32/75) of the DHRs.

All homicide victims who experienced non-fatal strangulation by the homicide perpetrator (n=24) also had experienced coercive control and a form or physical or sexual abuse prior to their death. Other co-occurring abuse for victims who experienced non-fatal strangulation included financial abuse (7/24, 29%) and harassment and stalking (2/24, 8%).

This shows that non-fatal strangulation commonly occurs alongside other abusive behaviours in relationships, with coercive control and physical and sexual abuse being the most likely co-occurring behaviours.

NFS Risk Assessments

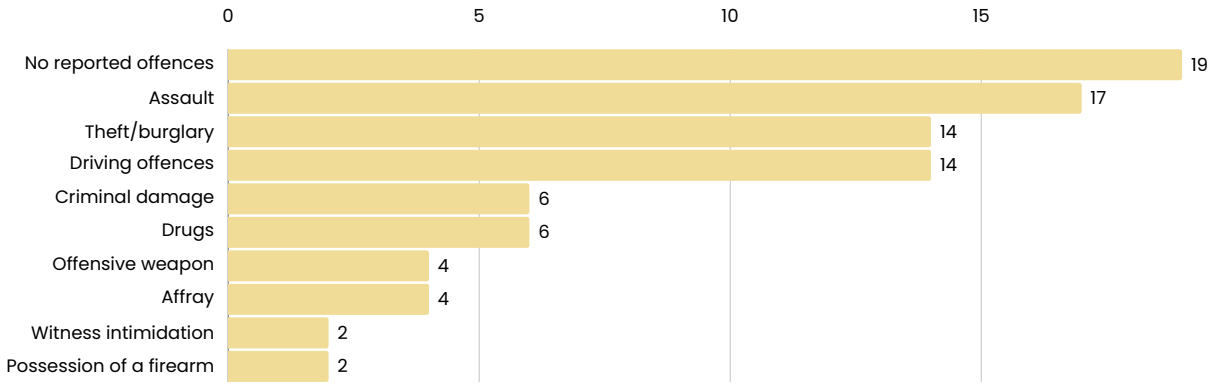
I It was not uncommon for there to have been no mention of risk assessments conducted following a disclosure to a professional relating to domestic abuse. If these assessments were conducted, they were not routinely reported in the DHR. Focusing on NFS, there were 12 cases where the completion of a domestic abuse risk assessment following an incident/disclosure was reported in the DHR. The risk classifications for these assessments are presented below:

- 8/12 were categorised as high risk
- 2/12 were medium
- 2/12 were standard

Where non-fatal strangulation is present within domestic abuse disclosures, it should be considered as a high-risk factor for domestic homicide in intimate partner violence (see, for example, Glass et al., 2008[16]). The domestic abuse risk assessment should therefore be classified as high risk regardless of the score assigned on the basis of the rest of the assessment.

Perpetrator Offence History

The majority (35/54, 65%) of the perpetrators in this cohort with a reported history of domestic abuse also had previous convictions other than DA related offences. Graph 4 presents an overview of reported crime types.



Graph 4: Prior convictions of perpetrators with a reported history of domestic abuse (n=54)

Taken together, these analyses present an important picture, with clear recommendations, that must be considered when working in the context of domestic abuse. Namely, domestic abuse behaviours such as strangulation will rarely exist in isolation, and may be likely to co-occur with other offence behaviours. This, therefore, should also be considered when working with perpetrators of domestic abuse – recognising multiple and specific escalating behaviours which may ultimately amount in a homicide.

Domestic Homicide Review Processes

Overview

Across the 75 cases, 57 different Community Safety Partnerships (CSPs) from England and Wales were represented. The highest number of DHRs from one area was four.

There was a considerable difference in the length of the DHR reports, with the longest being 160 pages and the shortest being 12 pages. The mean length of reports was 54 pages, however, given the considerable variation in length, neither the longest nor shortest reports were necessarily outliers.

Similarly, there was some variation in the length of time between the homicide and the completion of the review. None of the DHR processes in our sample were completed within the 6 month timeframe expected under the DHR guidelines - although, anecdotally, it is considered rare that any DHRs are completed within this timeframe. The mean length of the review process, from the time of the homicide until publication, was 26 months (2 years and 2 months), the longest review process took 70 months (5 years and 10 months).

Some of the common reasons for, particularly, the longer review timeframes included where there were criminal justice proceedings running in parallel and conducting the review at the same time would have restricted the information that would have been available to the panel and/or restricted involvement of the victim's family members. In at least two of the cases, significant concerns with the work of the DHR Panel Chairs necessitated a change in personnel which resulted in further delays to the process. The COVID-19 pandemic was also stated in some reviews as being the cause of the longer-than-desired timeframe.

Whilst prolonging proceedings is not necessarily considered beneficial, not least for the victims' families as noted by some panel Chairs, some DHR reviews noted that rushing through to meet the 6-month timeframe requirement would also be wholly unacceptable. It also appears common for families and panels alike to appreciate the process taking as long as it needs to be completed appropriately.

The resulting delay has had an inevitable impact on the family who have been highly distressed at the continuing delay in concluding these processes. It has further resulted in resource implications for this Review and resulted in the Review not achieving a timely completion as is recognised good practice. (Case 16)

This review was so complex that it was felt that to try and proceed without detailed discussion within the panel would be detrimental to the quality of the review. (Case 18)

Family Participation

It was stated in the report that the victims' families were involved in 53/75 (71%) cases. This involvement varied between cases – with some where families met with the DHR Panel Chair on multiple occasions to provide information and feedback on the DHR report, some providing 'pen portraits' (one is included below), and some perhaps engaging in an initial conversation and then deciding not to have further involvement. In cases where victims' families were involved, to whatever extent, this was seen as extremely beneficial to the process of conducting the DHR, both from the perspectives of the DHR panels, and the family members, with regard to better understanding and honouring the memory of the victim.

It is important to note, however, that the completion of these processes is not always seen as entirely beneficial for the families and friends of those involved. In Case 30, a family member noted that they did not accept the need to conduct a DHR as "*there was no evidence to suggest that the couple were in anything other than a loving relationship*". This case involved an elderly couple and the perpetrator of the homicide took his own life after fatally strangling his wife. A similar sentiment was noted in Case 12: "*We are looking forward to having the matter closed so that we can remember both of them peacefully and together as they should be.*". This highlights the need for extreme sensitivity and nuance to be shown by DHR Panels in conducting reviews – something that appears to have been demonstrated in this particular case but, ultimately – something that requires time and skill.

'Grace' was the light that brightened all of our lives with her smile, laughter and positive energy. 'Grace' was not only a daughter to her family, but also cousin, sister, work colleague, and friend to a lot of people.
'Grace' was strong-willed, loving, caring and funny. We all have been robbed of her smile, courage, presence and motivational abilities.
The amount of grief people have felt since her passing is testimony to how much she was loved. Her loved ones struggle daily with how early she was taken from this world. We all love and miss her every day.
'Grace' was God fearing and always grateful for her blessings. She leaves behind a legacy that only the people that knew her continue to cherish with great fondness.
Rest in peace our angel.
(Pen Portrait by Noah, Grace's Uncle, Case 35)

Perpetrator Participation

In contrast with family participation, the involvement of the perpetrator in the DHR process was only noted in 17/75 (23%) cases. In some instances, the perpetrators declined to be involved, in some cases, the DHR Panel deemed it to not be appropriate, for instance in one case where 'he had lied about the circumstances of the death and had attempted to escape the consequences of his actions' and therefore 'little would be gained by hearing those same lies again' (Case 46). In addition, the DHR Report authors in Case 46 felt strongly that 'he should not be given more of a voice than [the victim]'. Of course, in 13/75 of the cases, the perpetrator was deceased and therefore could not be involved. In some cases, involvement from the perpetrator's family was sought and specifically noted. This serves as a helpful reminder to consider the purpose of involving the perpetrator within these processes, which was articulated clearly in Case 16.

> *His contribution to this report, whilst by its very nature will be distressing, even distasteful to Child J's family, nevertheless has provided important material which contributes to our understanding of his perception of events and the services' responses to those events. (Case 16)*

Qualitative Analysis of DHR Recommendations

Across the 75 cases, the themes most commonly represented in the reported recommendations related to training or awareness raising amongst professionals and the general public. In some cases, references were made to considering "*whether [the Community Safety Partnership's] constituent agencies' training on assessment risk in domestic abuse cases needs enhancing…*" (Case 38). In other cases, recommendations were more specific to the type and implementation of training required "*Make accessible via training and awareness raising the understanding of Coercive Control, particularly in the context of the subsequent legislation.*" (Case 8). Training and awareness raising was not just recommended for practitioners, however, but also suggested for the wider public by, for example, "*launching a campaign around the legislation*" (Case 11) and supporting "*families, friends and communities be educated to recognise coercive and controlling behaviour and to understand the pathways to alerting professionals*" (Case 15).

Recommendations surrounding agencies working with victim/survivors of domestic abuse also featured consistently across cases in this sample. Specific recommendations included where work was to be done to improve how information becomes known to services i.e., routine enquiry, creating environments for spontaneous disclosure. Additionally, being able to improve "*the recognition of adults at risk of abuse or neglect*" (Case 71) without them having to disclose themselves was also seen as important. Some of these recommendations made specific reference to certain survivor groups, for instance: "*relating to the needs of BME [Black and Minority Ethnic] communities.*" (Case 35), or "*…include[ing] the impact of domestic abuse on sex-workers*" (Case 71). There was also a recognition of how to improve working with perpetrators, particularly where they were known to services and the disclosure of information may prevent further harm to, for example, new partners: "*Where offenders are known to present a risk to intimate female partners, agencies should put processes in place that provide the very best opportunity of detecting when such relationships are forming or have formed.*" (Case 67). Case 1 outlined a number of recommendations with regard to working with perpetrators, targeted at different services, for instance suggesting police should conduct "*intelligence checks on addresses as well as individuals for all DA [Domestic Abuse]*", and suggesting that MARACs (multi-agency risk assessment conferences) should "*review operating protocol to improve tracking and management of serial offenders*", noting the importance of a whole-systems approach.

Qualitative Analysis of DHR Recommendations

These recommendations around working with victim/survivors also have implications on ways of working related to the general management of cases. Examples of this theme include carrying out a dip sample of case notes to ensure risk processes are being followed, and accurate and timely case note recording. Also included here was consideration of how victim/survivors could/should be supported to move between services. "*All agencies involved in protecting the vulnerable should work together to confirm the most appropriate organisation is working with a vulnerable victim/patient /client /service user.*" (Case 29). Although better communication and 'joining-up' between services was sometimes raised as a trend throughout the analysis phase of the DHR process, this was less commonly explicitly identified as a recommendation. Where it was identified, how this recommendation might have been achieved still remained unclear, for instance: "*Improve communication and joint working arrangements between Devon Partnership NHS Trust and local drug and alcohol treatment providers for mental health patients with substance misuse problems.*" (Case 26). In this case, it may not be clear to those services involved, or service-users of services, as to how this recommendation may be achieved or 'completed'.

Given the broader context of risk within these domestic homicide cases – particularly where our analyses show that prior domestic abuse was known in 75% of cases – it could be suggested that recommendations relating to identifying and appropriately classifying risk of domestic abuse cases should have been more prominent than it appeared in this analysis. Whether this was because the concept of risk management was more implicitly woven through other recommendations relating to case management and working with victims, or whether it was not recognised for an area for improvement, is unknown. Good practice surrounding risk management recommendations referred to the content of risk assessments as well as the implementation and review of these processes e.g., "*All agencies within the North Yorkshire Community Safety Partnership should review their risk assessment training arrangements for domestic abuse cases*" (Case 29). The rating of risk related to domestic abuse cases must also be appreciated throughout: "*Whilst it may not have impacted the police management of the case, the Panel was of the view that the risk rating applied to incidents should have remained at high, given the seriousness of the first reported incident and the known history of the offender.*" (Case 20).

Underlining the above recommendations were suggestions around amendments to policies and procedures that would support the implementation of improved practice. For instance: "*That Lifeline's child safeguarding policies should make specific reference to MARAC procedures, where the procedures can be located and information about the role of the in-house nominated lead manager.*" (Case 71), and "*Consideration should be given to selective domestic abuse enquires being made in cases of presenting acute mental illness within A&E, for the patient and for any partner accompanying them.*" (Case 13). Without specific consideration of what it might mean for specific services to improve their operations with regards to a topic such as domestic abuse, it could be that more generic recommendations are not achievable, or even that 'success' with regards to recommendation implementation is unknown.

Summary and Key Recommendations

Taken together, the analyses in this report present an important picture of the makeup of domestic homicides whereby strangulation was the method of killing. We know that, overwhelmingly, victims of domestic fatal strangulation are women, and perpetrators are men, typically aged between 25 and 49. We know that unreported data around all demographic information makes it difficult to draw conclusions about commonly affected groups, but this is particularly the case with missing ethnicity data. Even with this, it is important to recognise that there are discrepancies between the number of victims killed in domestic homicides and the number of domestic homicide reviews completed. Evidence indicates that the largest discrepancy is for Black victims, whereby they make up just 5% of victims from DHRs, compared to 14% of all homicide victims[11] (see also Table 1). Of course, this difference could come from there being a larger proportion of Black victims murdered in circumstances other than domestic homicides, or this could represent something more specific to the process of domestic homicide reviews. This warrants further consideration.

Recommendation 1: For those involved in DHR processes to be considerate and critical of victim ethnicity data and be transparent with missing or unknown information.

The relationships reported here between victims and perpetrators mirror that of other research findings, not just with regards to the most common relationship being current or former intimate partners, but also noting key risk factors within those relationships. Our analyses on separation triggers, mapped onto the Homicide Timeline[12], further reinforces the need for professionals to recognise and appropriately assign high risk ratings to behaviours such as attempted/completed separation, new relationships, and reporting abuse to the police. Within these relationships, our analyses show that it is very common for victims to have disclosed/reported domestic abuse (including coercive and controlling behaviour) by the homicide perpetrator prior to the homicide occurring. The presence of any and all domestic abuse behaviours, should therefore at least be seen to be a risk factor for future homicide. Connected closely to this DHR analysis series[4], the presence of non-fatal strangulation in just under half of the cases requires recognition. As per our previous analyses in this series, we are reiterating the need to recognise the presence of non-fatal strangulation as a high risk indicator on any domestic abuse risk assessment.

Recommendation 2: For those who work with victim/survivors and perpetrators of domestic abuse to recognise risk factors related to relationship type and abusive behaviour, and act in accordance with these high risk indicators.

With regards to the circumstances of homicides, it is helpful to understand through the DHR process the behaviours in the lead up to and at the time of the fatal incident. Actions that could be described as 'overkill' provide important information about homicide perpetrators. As does the actions of the perpetrator after the fatal incident – the majority of whom, in this sample, did not seek any help or support for the victim from services, or even informal networks such as family, demonstrating a level of remorselessness and self-preservation that should be acknowledged.

Recommendation 3: We would like to call for consideration around the actions of perpetrators in the lead up to and immediate aftermath of a murder to be taken into account in the criminal proceedings following domestic homicides.

We were keen within this part of our DHR analysis series to pay particular attention to the processes around the DHR reviews themselves. As readers of the reports, we were heartened to see the positive impact that family involvement had on the DHR process and report. We observed that the contribution of friends and family enhanced our ability as readers to better relate to the homicide victim. The length of these DHR processes – particularly with reference to them consistently being longer than the statutory guidance currently directs – has been noted in previous reports. However, where this is unavoidable, positive strides have been made by some DHR panels to begin to implement key recommendations across services involved in the process, before the report is officially finalised and published. Whilst a delay on external publishing of findings is sometimes necessary, it is arguably more important for those services involved to be given specific, measurable and actionable recommendations in the meantime. In this way, DHR reports could serve as useful repositories for not just recommendations but examples of implementation and best practice for other similar services across the country to consider themselves.

Recommendation 4: DHR processes may consider the possibility of embedding, within published DHR reports, the outcomes of the recommendations (where complete), to serve as a best practice framework for future services, interventions, and DHR processes.

It has been suggested previously in our DHR analysis series[4] that DHR processes are not completed for the purpose of research, and this should be kept in mind when reading the findings from analyses of these data. However, we suggest that there may, in fact, be benefits from better understanding how DHR data could effectively be used by researchers to consider trends and patterns in a way that could further the impact of any one individual DHR process.

Recommendation 5: DHR processes may better consider the potential for the information published in DHR reports to be used for the purpose of identifying trends and understanding the overall picture, so maximum learning can be achieved from each individual tragedy.

Bibliography

1. Legislation. (2021). **Domestic Abuse Act**. https://www.legislation.gov.uk/ukpga/2021/17/section/70/enacted

2. Institute for Addressing Strangulation. (2024). **Police Data Report**. https://ifas.org.uk/police-data-reports-2024/

3. Institute for Addressing Strangulation. (2023). **ONS Statistics Reports**. https://ifas.org.uk/killed-by-strangulation-data-from-office-for-national-statistics-year-ending-march-2023/

4. Institute for Addressing Strangulation. (2024). **DHR Analysis Series**. https://ifas.org.uk/dhr-reports-2023/

5. Home Office. (2016). **DHR Statutory Guidance**. https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf

6. Manchester Metropolitan University. (n.d.) **The HALT Study.** https://domestichomicide-halt.co.uk/

7. **The Vulnerability and Knowledge Practice Programme (VKPP) (n.d.)**. https://www.vkpp.org.uk/

8. Institute for Addressing Strangulation. (2024). **VKPP response**. https://ifas.org.uk/vkpp-year-3-report-ifas-response/

9. Home Office. (n.d.) **Domestic Homicide Review Library**. https://www.gov.uk/guidance/search-the-domestic-homicide-review-library

10. Monckton-Smith, J. (2021). **In Control: Dangerous Relationships and How They End in Murder**. Bloomsbury Publishing.

11. Home Office. (2021). **Key findings from analysis of domestic homicide reviews**. https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews

12. Monckton-Smith, J. (2019). **Intimate partner Femicide: Using Foucauldian analysis to track an eight stage progression to homicide**. Violence Against Women, 26(11), 1267–1285. https:// doi.org/ 10.1177/ 10778 01219 863876

13. Advocacy After Fatal Domestic Abuse (AAFDA). (2021). **Suicide After Domestic Abuse evidence review**. https://aafda.org.uk/news/suicide-after-domestic-abuse

14. Domestic Abuse Commission. (n.d.) **Domestic Homicide and Suicide webpage**. https://domesticabusecommissioner.uk/domestic-homicide-and-suicide

15. Ferguson, C., & Petherick, W. (2016). **Getting Away with Murder: An Examination of Detected Homicides Staged as Suicides**. Social Science Research Network.

16. Glass, N., Laughon, K., Campbell, J., Block, C. R., Hanson, G., Sharps, P. W., & Taliaferro, E. (2008). **Non-fatal Strangulation is an Important Risk Factor for Homicide of Women**. The Journal of Emergency Medicine, 35(3), 329–335. https://doi.org/10.1016/j.jemermed.2007.02.065

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Lastly, IFAS acknowledges that behind every homicide statistic is a person who had friends, family, thoughts, feelings, dreams and hopes. We hope that all readers accessing our report will recognise the tragic loss of human life associated with the statistics we present.

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