AAFDA

Advocacy After Fatal Domestic Abuse

JUSTICE DENIED? ACCOUNTABILITY AFTER DOMESTIC ABUSE-RELATED SUICIDES AND UNEXPLAINED DEATHS

September 2025

About AAFDA

This report is authored by Advocacy After Fatal Domestic Abuse ("**AAFDA**") to aid participators at our conference: *"Tip of the Iceberg, a one-day conference exploring the prevention of and responses to suicide following domestic abuse."*

AAFDA provides specialist and expert advocacy and specialist peer support to families bereaved by domestic homicide and domestic abuse related suicides and unexplained deaths. Through its work with victims' families it has become a Centre of Excellence for reviews after fatal domestic abuse and provides the national accredited training for persons to chair Domestic Homicide Reviews (**"DHRs"**). Its CEO, Frank Mullane MBE, is widely published on this subject, was a 'reader' of DHRs (in which role he advised the Government's National Quality Assurance Panel on c.1200 DHRs), and sits on the Government's Victims' Panel. Further details of our work can be found at www.aafda.org.uk.

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1. Introduction

1.1.1 This report, developed and published by AAFDA for its 2025 conference, looks at some prosecutions and attempted prosecutions of perpetrators and suspected perpetrators of domestic abuse that was followed by suicide, assesses how the system otherwise tries to ensure some degree of accountability for the families of victims and ends in a call for a new law.

1.1.2 The high threshold for proving causation in manslaughter cases, particularly in cases with vulnerable victims, remains a significant barrier to successful prosecutions. While greater public understanding of coercive control is needed, AAFDA believes that further legal reform is also needed to secure justice for victims driven to suicide by their abuser.

1.1.3. We acknowledge all of the victims of domestic abuse who have taken their own lives. The criminal justice system often fails to recognise the culpability of a perpetrator in these deaths. This is a disservice to the victims and their families and it often means that the families embark on a long and sometimes unending journey to try to change this. Fatal domestic abuse casts a dark shadow over the lives of those left behind and AAFDA acknowledges these families. It is a testament to their resilience and to their sense of justice that they make such a profound impact on law makers and other professionals in the years afterwards.

1.1.4 AAFDA believes that a new law as requested in this proposal would properly acknowledge the victims of suicide after domestic abuse and enable their families to achieve justice.

1.2 Call to action

1.2.1 AAFDA calls for a new law which captures the culpability of perpetrators of domestic abuse as regards these deaths and which enables juries to see more clearly the causation of suicide from domestic abuse. Without a new law to clarify this culpability, AAFDA fears that many perpetrators will evade appropriate criminal accountability and that victims' families will have to continue to live with the pain of justice not being done. AAFDA therefore calls for:

a) A new law crafted to assist juries to recognise the causative relationship between domestic abuse and suicide and which would attract a similar sentence to the offence of manslaughter.

b) Coercive control to be brought under the remit of Extended Determinate Sentences.

1.2.2 We are also calling for a focused debate on whether the criminal justice system is failing victims who die by suicide and unexplained death after domestic abuse and their families as the start point for changing the law to deliver an improved approach as outlined above.

1.3 AAFDA's work with bereaved families

1.3.1 At AAFDA, we have supported c.200 families bereaved by domestic abuse related suicide and 65 families by domestic abuse related unexplained death. After suicides following domestic abuse, families have told us: "***after the death, it's almost like you're on another traumatic journey. There is no respite from it. And people just sit on the outside, they go, well it's nearly two years now. They just don't get it. They don't realise what comes next."*** [1]

1.3.2 We started doing this work because there was no specialist advocacy support available for these families. Since we began to do so in 2008, we have gained expertise, knowledge and insight from families who want to see greater accountability for perpetrators and lessons learned throughout the criminal justice system so that warning signs are spotted and there are fewer suicides.

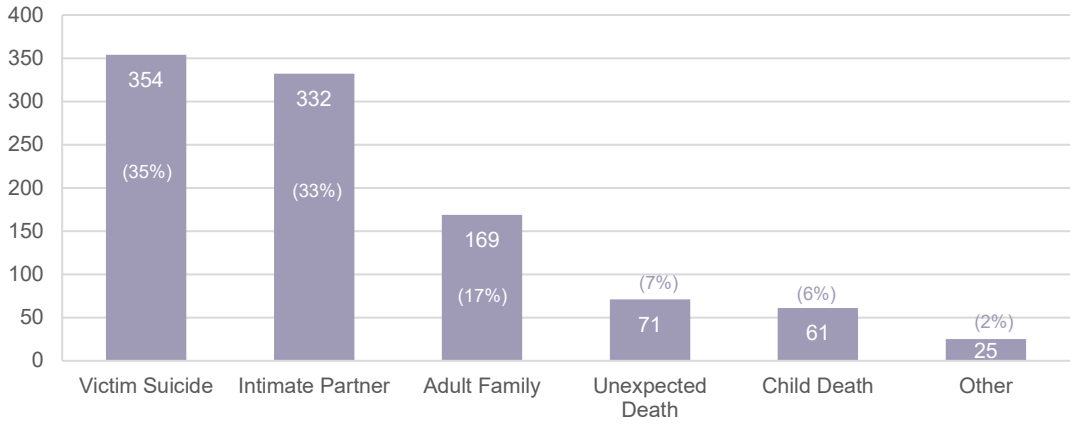
[1] *'Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide'*, Sarah Dangar, Vanessa E. Munro & Lotte Young Andrade, AAFDA, (July 2022), <https://aafda.org.uk/learning-legacies> accessed 5 September 2025.

2. Scale of the Problem: Tip of the Iceberg

2.1 In the UK, in the year to March 2024, 98 people died in suspected suicides following domestic abuse, while 80 were killed by an intimate partner. 2024 therefore marked the second year in which the Vulnerability Knowledge & Practice Programme identified the ***number of suspected suicides following domestic abuse being higher than the number of homicides involving current or previous partners***.[2] There may be many others where the link between domestic abuse and the suicide has not been made.[3]

2.2 Between April 2020 and March 2024 there were 1012 domestic abuse related deaths recorded by the Vulnerability Knowledge and Practice Programme's reporting on Domestic Homicides and Suspected Victim Suicides (the Domestic Homicide Project "**DHP**"). That total included 501 domestic homicides and 354 Suspected Victim Suicides after Domestic Abuse ("**SVSDAs**").[4]

Figure 1 *Number and proportion of deaths by typology (April 2020 – March 2024)*[5]



2.3 The awareness of the scale of suicides following domestic abuse, and the formidable representations made by bereaved families, have led to pressure for the suspected perpetrators in these cases to be held fully to account, with prosecutions for not just their abuse of the victim but, where appropriate, for the death that followed their abuse. We are only aware of a small number of cases of SVSDAs where the Crown Prosecution Service ("**CPS**") has attempted to prosecute for manslaughter. Only one of these prosecutions has been successful, following the guilty plea of Nicholas Allen in 2017. Dame Vera Baird DBE KC has referred to this as a "shocking record" and has joined with the Centre for Women's Justice to call for the CPS and police to do more to hold abusers to account.[6]

[2] Domestic Homicide Project, *Vulnerability Knowledge & Practice Programme* (2025) <https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/> accessed 10 September 2025.

[3] See Appendix 1.

[4] Katherine Hoeger et al, *Domestic Homicides and Suspected Victim Suicides 2020-2024: Year 4 Report*, Vulnerability Knowledge and Practice Programme, (March 2025) 16-17 <https://www.vkpp.org.uk/assets/Year-4-Report_publication-with-footnote.pdf> accessed 10 September 2025.

[5] Figure 1, taken from Katherine Hoeger et al, *Domestic Homicides and Suspected Victim Suicides 2020-2024: Year 4 Report*, Vulnerability Knowledge and Practice Programme (March 2025) 16-17 <https://www.vkpp.org.uk/assets/Year-4-Report_publication-with-footnote.pdf> accessed 10 September 2025.

[6] Dame Vera Baird DBE KC, '*Prosecuting perpetrators for manslaughter when domestic abuse leads to suicide*', Centre for Women's Justice, (19 February 2025) <https://www.centreforwomensjustice.org.uk/new-blog-1/2025/2/18/saving-women> accessed 10 September 2025.

3. What criminal offences are available to prosecute perpetrators of abuse after victims take their own life?

3.1 Under the law of England and Wales, there is no specific offence of causing suicide through domestic abuse. The common law offence of unlawful or dangerous act ('constructive') involuntary manslaughter is the primary charge in cases where an abuser's conduct is alleged to have caused the victim's suicide. We are aware of only a small number of attempts by the CPS to prosecute abusers for manslaughter in such cases, the first being in 2006.

3.2 What do you need to prove for the offence of manslaughter?

3.2.1 The offence of manslaughter ultimately has four key elements. All of these elements must be established for a conviction to be successful.[7]

a) the underlying act was done intentionally;

b) that the act done was unlawful (i.e. a criminal offence);

c) the act was dangerous as it was likely to cause harm to somebody; and

d) the unlawful and dangerous act caused death.

[7] This criteria and the relevant case authorities are summarised in Dr Anne Lodge, *'Domestic Abuse, Suicide and Liability for Manslaughter: In Pursuit of Justice for Victims'* (2020) The Journal of Criminal Law 84(4) 273-292.

3.3 What underlying unlawful act is present in cases of suicide after domestic abuse?

3.3.1 The following offences, while also being separate offences in their own right, may therefore constitute the 'unlawful act' needed to prosecute for the offence of involuntary manslaughter:

a) Controlling or Coercive Behaviour in an Intimate or Family Relationship.[8] This offence, introduced in December 2015, criminalizes a pattern of coercive or controlling acts against an intimate partner or family member that have serious effects on the victim (such as fear of violence or serious alarm/distress impacting daily life) and carries a maximum penalty of five years' imprisonment. Crucially, this offence covers psychological abuse and does not require physical harm to have been perpetrated. Many abuse-related suicide cases involve prolonged coercive control.

b) Harassment and Stalking Offences.[9] Before coercive control was criminalised as a standalone offence, prosecutors often charged harassment or stalking in cases of obsessive abuse, the most serious of these offences carry a maximum of ten years' imprisonment and/or a fine.[10]

c) Assault, Grievous or **Actual Bodily Harm** and related offences.[11] Many domestic abuse incidents preceding suicides involve physical assaults or threats, which can underpin a manslaughter charge.[12]

d) Other offences, such **as throwing corrosive fluid on a person with intent to do Grievous Bodily Harm**,[13] the offence which Wallace was convicted of after the death of Mark van Dongen.

3.4 Is there a dedicated offence for causing a suicide?

3.4.1 There is a separate statutory offence of Encouraging or Assisting Suicide[14] where someone encourages or assist another's suicide, punishable by up to 14 years imprisonment.[15] The test for this offence is narrow - an abuser would have to explicitly urge the victim to kill themselves or help them do so. Given how narrow the offence of encouraging or assisting suicide is, manslaughter is the natural charge to bring in the majority of SVSDA cases.

3.5 Multiple or overlapping charges

3.5.1 An unlawful act is required for the offence of manslaughter to be prosecuted. [16] The CPS may charge the suspect (where domestic abuse was followed by suicide) with both manslaughter and a separate, standalone offence such as coercive control. Therefore, if the manslaughter charge fails, the jury may still convict on the lesser offence which ensures that some criminal liability is recognised, providing a measure of acknowledgement and accountability for the victim's family and increased public protection.

[8] Serious Crime Act 2015, Section 76 (as amended by the Domestic Abuser Act 2021, Section 68).

[9] Protection from Harassment Act 1997, Section 2 (Harassment), Section 2A (Stalking), Section 4 (Putting People in Fear of Violence), Section 4A (Stalking Involving Fear of Violence or Serious Alarm or Distress).

[10] See, *R v Allen* (Stafford Crown Court, 28 July 2017).

[11] Various offences under Offence Against the Person Act 1861.

[12] See the Grievous Bodily Harm charge in *R v Dhaliwal*.

[13] Offence Against the Person Act 1861, s. 29.

[14] Suicide Act 1961, Section 2(1).

[15] Crown Prosecution Service, *'Suicide: Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide'*, (October 2014) <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide> accessed 10 September 2025.

[16] See relevant CPS guidance, for example *Controlling or Coercive Behaviour, Selecting the Most Appropriate Charge or Charges*, (February 2025) available via: <https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship> accessed 10 September 2025.

4. Evolving approaches to causation

4.1 ***<u>In order to successfully prove someone committed a criminal offence, the prosecution must demonstrate the necessary "causation" (i.e., that the accused "caused" the relevant harm).</u>*** The law requires both ***<u>factual</u>*** causation (showing that the harm wouldn't have happened if it hadn't been for the defendant's actions) and ***<u>legal</u>*** causation (ensuring it's fair to hold them responsible, which may look to whether there were any other events that played a role in the harm). This two-step test helps courts decide not just whether the defendant played a role in the outcome, but whether they should be legally responsible.

4.2 By way of background to cases of SVSDA, in 1985, aged 17, Emma Humphreys was convicted of murder after she stabbed her abuser, Trevor Armitage, who had sexually exploited her and subjected her to repeated rape and violence. In July 1995, the Court of Appeal quashed Emma's murder conviction and created a legal precedent that recognised the concept of 'cumulative provocation' – being the idea that the killing had not been triggered by a single explosive event, but by a series of incidents which gradually drove Emma as a victim to kill her tormentor. While not related to the question of causation, this case marked a cultural shift in the campaign that eventually led to coercive control/patterns of abuse being criminalised in 2015.

4.3 The following cases in this section were not all SVSDAs, but they track the changes in how the court has looked at the question of causation in ways that are relevant to how SVSDAs can be dealt with today.

4.4 Early cases – Can a defendant be responsible if the victim's reaction led to their death?

4.4.1 The courts have established that a victim's act will only break the chain of causation if it is so "daft" or unexpected that no reasonable person could have foreseen it. For example, in 1996, a man who violently assaulted another man was convicted of manslaughter when his victim ran away and was killed by a car as they fled trying to cross the road.[17] The court held that it was "reasonably foreseeable" that a frightened, intoxicated and mentally impaired person might panic and come to harm while escaping the attack. As this was within the range of foreseeable reactions of a person in that situation, the causal chain was not broken – the perpetrator was still culpable.

4.4.2 This case illustrates that a perpetrator can be held liable for involuntary manslaughter even if the victim's own act immediately caused the death, as long as that act was driven by reasonably foreseeable fear or danger caused by the perpetrator. Applying this principle to domestic abuse cases, if a victim dies by suicide following domestic abuse, the abuser could still be culpable for manslaughter provided the suicide is deemed a ***reasonably foreseeable*** outcome of the abuse (rather than an unforeseen intervention), taking account of any pre-existing vulnerabilities of the victim.

[17] *R v Corbett* [1996] Crim LR 594

4.5 How do courts establish the necessary level of "harm"?

4.5.1 The case of *R v Dhaliwal*[18] was the first attempted manslaughter prosecution for a domestic abuse-related suicide. Gurjit Dhaliwal took her own life after extreme psychological and physical abuse by her husband over the years preceding her death. In the criminal cases after Gurjit's death, the trial judge and ***the Court of Appeal acknowledged that it would be possible, where the necessary legal and factual causation are established, for unlawful violence that proves to be the material cause of death (even if as a result of suicide) to amount to manslaughter.***

4.5.2 The issue in the case in 2006 was whether Gurjit had suffered "actual bodily harm", which is required for the offence of assault occasioning actual bodily harm[19] (which was needed to therefore establish a successful manslaughter conviction). A previous case[20] established that "actual bodily harm" covers not only physical injury, but also psychiatric injury (which must be proved by medical evidence and does not include emotions or states of mind). This means that someone can be guilty of assault occasioning actual bodily harm where they have caused the victim to suffer psychiatric injury (even if there is no physical injury).

4.5.3 In this case, there was psychiatric evidence suggesting that the "*overwhelming primary cause*" for Gurjit's suicide "*was the experience of being physically abused by her husband in the context of experiencing many such episodes over a very prolonged period of time*". Despite this, only one of the three experts consulted was able to determine that Gurjit was suffering from an "*identifiable psychiatric illness*". The other two experts were unable to make such a diagnosis, although each concluded that the victim had suffered some form of psychological harm. As the law required *psychiatric* injury, rather than *psychological* injury, to demonstrate "actual bodily harm", the court could not conclude that Gurjit was suffering from sufficient harm (although it was not disputed that such harm was caused by the defendant). It was therefore not possible to establish the relevant unlawful act for the purposes of manslaughter in this case.

4.5.4 The Court of Appeal concluded by stating that, as a general point, such recognisable psychiatric illness could be caused by, for example, post-traumatic stress disorder, battered wife syndrome or reactive depression. If these illnesses were to lead to suicide, subject to the prosecution being able to prove the causal link between the defendant's actions and such psychiatric illness, a manslaughter conviction would be possible. This is therefore a key development showing that such a manslaughter conviction could be possible where a victim of domestic abuse takes their own life as a result of such abuse.

[18] *R v Dhaliwal* [2006] EWCA Crim 1139

[19] Offences Against the Person Act 1861, s 47

[20] *R v Chan-Fook* [1994] 99 CAR 147

4.6 What does the case following the death of Mark van Dongen tell us about causation and establishing criminal offences following suicide?

4.6.1 On 22 September 2015, Mark van Dongen was the victim of a deliberate acid attack by his former partner, Berlinah Wallace.[21] The attack left Mark paralysed below the neck, and also caused him to lose an ear, an eye, and his left leg. After over a year of suffering and medical intervention in Belgium, and three separate consultants examining Mark's case, it was confirmed that his was one of "***unbearable physical and psychological suffering***" so as to justify his application for euthanasia under Belgian law.[22] Following Mark's death, Wallace was charged with murder and separately with applying a corrosive substance with intent. At trial, the Judge had removed the charge of murder from the indictment on the basis that Mark's actions in asking for euthanasia, and the doctors administering the treatment, were "*independent free and voluntary acts which* ***broke the chain of causation***". This decision by the trial Judge on causation was appealed by the CPS.

4.6.2 In principle, the Court of Appeal noted that a defendant could not be responsible for the deliberate act of an informed adult of sound mind, who was to be treated in law "*as autonomous beings able to make their own decision about how they would act*".[23] However, it was very careful to distinguish and separate cases involving purely voluntary actions from those involving "*a* ***response by a victim to (extreme) circumstances created by a defendant's unlawful act****, which were persisting, and which had* ***put the victim into a position where he made a "choice" that he would never otherwise have had to make*** *or would have made where the victim's response was distinguished*" (emphasis added)[24]. Applying this to Mark, the Court was not convinced that the "voluntary" decision to undergo euthanasia for the purposes of Belgian law should necessarily be considered "voluntary" for the purposes of legal causation for the charges against Wallace.[25] ***In considering the link between Wallace's actions and Mark's death, the Court of Appeal considered the context of the extreme physical and psychological toll of Mark's injuries, and the lack of any pre-existing conditions or suicidal tendencies***, to find that "*…The* ***connection between the inflicted injuries and death*** *was therefore* ***a direct and discernible one***" (emphasis added).[26] The Court of Appeal continued to note that the subsequent actions by Mark and the doctors in engaging with the euthanasia process were not ultimately determinative of causation. Their actions could not be considered "*random extraneous events*", but rather were "***closely, indeed inextricably, bound up***" (emphasis added) with Wallace's attack, which the Court was convinced had intended to inflict permanent and horrific injuries.[27]

4.6.3 The Court of Appeal summarised their conclusion as follows:

> *"Mr van Dongen's death, his request to the doctors, and the act of euthanasia itself carried out in accordance with his wishes,* ***were not discrete acts or events independent of the defendant's conduct, nor were they voluntary*** *… Instead they were* ***a direct response to the inflicted injuries and to the circumstances created by them for which the defendant was responsible****. If the question is then asked whether, on a common sense view, the defendant's conduct merely set the stage for Mr van Dongen's death,* ***or was instrumental in bringing it about****, we consider* ***the jury could properly answer that question in the prosecution's favour***." (emphasis added)[28]

[21] *R v Wallace* [2018] EWCA Crim 690

[22] Steven Morris, *''Kill me now': the acid attack that led Mark van Dongen to euthanasia*', The Guardian, (17 May 2018) <https://www.theguardian.com/world/2018/may/17/kill-me-now-acid-attack-led-euthanasia-mark-van-dongen> accessed 9 September 2025

[23] *R v Wallace* [2018] EWCA Crim 690 [75]

[24] *R v Wallace* [2018] EWCA Crim 690 [76]

[25] *R v Wallace* [2018] EWCA Crim 690 [76]

[26] *R v Wallace* [2018] EWCA Crim 690 [58]

[27] *R v Wallace* [2018] EWCA Crim 690 [60]

[28] *R v Wallace* [2018] EWCA Crim 690 [61]

4.6.4 On this basis, the Court of Appeal allowed the appeal, reinserting the murder charge and leaving this matter of causation for the jury to determine on the evidence. However, when the case was returned to the jury to consider, Wallace was found not guilty on the murder charge but was convicted of throwing a corrosive substance with intent.[29] Notably, as the murder charge was not satisfied, the sentencing judge specifically acknowledged the fact that Wallace was not sentenced on the fact that Mark died by suicide as a result of the attack, but only on the basis that the attack was committed. Although this judgment did not relate to manslaughter, the Court of Appeal's statements on causation do perhaps indicate the judicial approach that may be applied when attempting to link domestic violence to subsequent suicide. For instance, as highlighted by Dr. Anne Lodge, "*it would seem that the courts have paved the way for the broader context of domestic abuse to be given careful consideration when determining the voluntariness of a vulnerable victim's suicidal response*".[30]

4.7 What do these cases mean for SVSDA today?

4.7.1 For a successful manslaughter conviction, the prosecution must establish that the defendant's actions caused the victim's death, which can be more challenging in the case of suicide where the ultimate act is that of the victim. ***A key issue which has proven challenging in the case of an SVSDA is establishing both of the following points:***

a) if it hadn't been for the defendant's abuse, the victim would not have taken their own life; and

b) the victim taking their own life was a reasonably foreseeable (predictable) outcome following the defendant's actions.

4.7.2 The cases described above show that, although courts have developed a broader and more open-minded approach to identifying a link between a defendant's abuse and the victim's resulting suicide, this has not necessarily translated into successful manslaughter convictions.

[29] Brett Wilson, '*Can suicide turn GBH into a murder?*', Brett Wilson LLP, (1 June 2018) <https://www.brettwilson.co.uk/can-suicide-turn-gbh-murder/> accessed 9 September 2025

[30] Dr Anne Lodge, *'Domestic Abuse, Suicide and Liability for Manslaughter: In Pursuit of Justice for Victims*' (2020) 84(4) The Journal of Criminal Law 273-292

5. Successful Manslaughter Conviction – following the death of Justene Reece

5.1 To date, the only successful prosecution for manslaughter in relation to an SVSDA was following the death of Justene Reece, a 47-year-old mother who took her own life following a "*sustained campaign of torment*" at the hands of her ex-partner, Nicholas Allen.[31]

What happened in the case of Justene Reece

5.2 Within 2 weeks of moving in with Allen, Justene reportedly told friends she was living with a "psychopath". Allen's abuse and controlling behaviour began to escalate as their relationship progressed, with Allen described as "*very manipulative, controlling and cold*". He controlled and tracked Justene's movements and on at least two occasions he "*put his hands around her neck and physically stopped her from leaving the house*". Allen had previously prevented Justene from leaving him 12 times, but when she finally managed to leave to a women's refuge in October 2016, Allen reportedly became "obsessed" with finding her. Allen began a pattern of threatening, stalking, and harassing Justene and those close to her (including her ex-partner and her son). Allen reportedly hacked Justene's social media accounts and used a variety of fake identities and accounts to reach her, reportedly sending Justene 300 threatening messages a day in early November 2016.[32] Even after Justene managed to obtain a non-molestation order which expressly forbade Allen from contact or being within 100 metres of Justene, Allen continued to routinely breach this over the following months, despite being arrested and fined for two of these incidents.

5.3 Justene eventually returned to Staffordshire but continued to live in constant fear of Allen, who Justene believed had put a "*bounty on her head for £1000*".[33] Allen's consistent harassment and threats resulted in Justene being hospitalised following an overdose on prescription and over the counter medication in January 2017. Shortly after, and following a police decision to take no further action against alleged breaches of bail conditions by Allen, Justene lodged a 'Victim's Right to Review' with Staffordshire Police. This review was conducted and rejected on the same day, with the decision being upheld by the Senior Police Officer at Staffordshire Police who previously advised that Allen should not be arrested for breaches of the non-molestation order in December 2016.[34] Two days later, on 22 February 2017, Justene's friends visited her address after her sister expressed concern over not being able to contact her. On arrival at the address, Justene's friends found that she had tragically taken her own life. Justene reportedly left notes attributing her suicide to the sustained abuse by Nicholas Allen, noting she had "*run out of fight*".[35]

[31] BBC News, *'Man jailed for manslaughter over ex-girlfriend's suicide*', (28 July 2017) <https://www.bbc.co.uk/news/uk-40758095> accessed 9 September 2025.

[32] Chris Few, '*Overview Report: Domestic Homicide Review in respect B February 2017*', Stafford Community Wellbeing Partnership, (December 2020), Para 12.20.1 <https://www.staffordbc.gov.uk/sites/default/files/cme/DocMan1/Community-Safety/Domestic-Homicide-Reviews/DHR- Overview-Report-SBP1703-Final.pdf> accessed 9 September 2025.

[33] Ibid, Para 12.34.2

[34] Ibid, Para 12.82.1

[35] Vikram Dodd, *'Police failed stalking victim who killed herself, watchdog finds*' The Guardian (29 April 2019) <https://www.theguardian.com/uk-news/2019/apr/29/police-failed-justene-reece-stalking-victim-driven-to-suicide-watchdog-finds> accessed 9 September 2025.

Successful Manslaughter Conviction

5.4 A DHR into Justene's death highlighted clear failings by law enforcement and noted that in the six months prior to Justene's death, Allen had attempted to contact and harass Justene around 3,500 times by call, text and social media message. The failures of law enforcement in protecting Justene were highlighted in an investigation conducted by the Independent Office for Police Conduct ("**IOPC**").[36]

5.5 As a result of his campaign of abuse against Justene, following her death Nicholas Allen was charged with coercive and controlling behaviour, stalking and manslaughter. Allen pled guilty to all charges. The Senior Crown Prosecutor called this as "***an exceptional case***" (emphasis added)[37], and in sentencing the Judge summarised:

*"You **clearly caused her to lose her life** and before that to experience, over a protracted period of time, what must have been a living nightmare … **She [took her own life] as a direct result of your sustained and determined criminal actions** – actions which you clearly knew were having a profound effect upon her."* (emphasis added)[38]

5.6 Allen was sentenced on 28 July 2017 to an extended sentence of 15 years (10 years imprisonment and a 5 year period on licence), given the abundance and severity of evidence of his campaign of abuse against Justene.[39]

5.7 What does the case of Justene Reece mean for future convictions?

5.7.1 The success of Allen's prosecution in 2017, and resulting extended sentence of 10 years in prison and 5 years on licence, was welcomed as a "***historic legal first***" **by organisations such as Women's Aid.[40] However, although this case marks the first (and only) time that a domestic abuser has been successfully prosecuted for manslaughter in relation to a suicide, the strong facts of the case showed a clear, extreme case of abuse and the legal merits and questions surrounding the suitability of the charge in this context were not contested and judged in open court. As a result, despite the success in prosecuting Nicholas Allen, the ruling itself does little to set out any legal authority or criteria for pursuing such a charge in future cases.**

[36] Nick Reid, *'Staffordshire Police accepts learning from IOPC investigation*' Staffordshire Live (1 May 2019) <https://www.staffordshire-live.co.uk/news/local-news/staffordshire-police-accepts-learning-iopc-2817292> accessed 10 September 2025.

[37] ITV News, *'Man jailed for manslaughter after stalking his former partner' ITVX* (28 July 2017) <https://www.itv.com/news/central/2017-07-28/man-jailed-for-manslaughter-after-stalking-his-former-partner> accessed 10 September 2025.

[38] David Connett, *'Stalker jailed for manslaughter of former partner who killed herself' The Guardian* (28 July 2017) <https://www.theguardian.com/uk-news/2017/jul/28/stalker-jailed-manslaughter-former-partner-killed-herself-nicholas-allen-justene-reece> accessed 10 September 2025.

[39] Ibid

[40] Katie Ghose, '*Women's Aid welcomes this historic legal first which has seen a perpetrator of domestic abuse, who drove his ex-partner to take her own life, sentenced to 10 years imprisonment for manslaughter*', End The Fear, (8 August 2017) <https://www.endthefear.co.uk/2017/08/08/womens-aid-welcomes-historic-legal-first-seen-perpetrator-domestic-abuse-drove-ex-partner-take-life-sentenced-10-years-imprisonment-manslaughte/> accessed 10 September 2025.

6. The recent failed manslaughter prosecution after the death of Kiena Dawes

6.1 Kiena Dawes, a 23-year-old hairdresser from Fleetwood, took her own life in July 2022 after enduring a sustained campaign of abuse by Ryan Wellings. In her final note, she wrote, *"I was murdered... Ryan Wellings killed me",* directly attributing her death to her abuser's actions before her death. Nevertheless, Wellings was acquitted of manslaughter, though convicted of assault, coercive and controlling behaviour.

6.2 The central challenge for the prosecution lay in establishing causation to the criminal standard. As discussed above, the law requires that the defendant's conduct must be shown to have caused the victim's death, and that the victim's act of suicide was not a voluntary, independent act breaking the chain of causation. In Kiena's case, the jury had to be sure, beyond reasonable doubt, that her decision to end her life was not a consequence of a voluntary and independent choice, but was effectively compelled by Wellings' actions - a threshold which remains exceptionally high.

6.3 The defence successfully argued that there was no direct, legally sufficient causal link between Wellings' conduct and Kiena's suicide. They relied heavily on evidence of Kiena's pre-existing vulnerabilities, particularly her diagnosis of Emotionally Unstable Personality Disorder (EUPD). The defence emphasised that Kiena's mental health condition rendered her more impulsive, with low self-esteem and a history of difficulties in relationships, and that she had made multiple suicide attempts prior to meeting Wellings.

6.4 Following the verdict, the CPS confirmed its commitment to pursuing similar cases where evidence points to a causative link between domestic abuse and a suicide.[41] Nonetheless, AAFDA is concerned that the test for causation in manslaughter cases remains a very high bar, especially so in cases with victims suffering pre-existing or exacerbated vulnerabilities, and that this may continue to inhibit the number of successful prosecutions. Partly, convictions by juries in such cases will need greater public awareness of the insidious effect of coercive and controlling abuse, but AAFDA believes it may be that greater reform to criminal law is needed to secure justice for victims who are driven to suicide by their abuser.

[41] Haroon Siddique and Alexandra Topping, *'Prosecutors to press on with manslaughter cases despite Kiena Dawes verdict'*, The Guardian (19 January 2025), available via <https://www.theguardian.com/law/2025/jan/19/manslaughter-cases-prosecutors-cps-kiena-dawes-verdict> accessed 10 September 2025.

7. What is the role of inquests and Domestic Homicide Reviews in achieving greater accountability for victims and their families?

7.1 DHRs and inquests have become increasingly vital mechanisms for investigating suicides linked to domestic abuse, particularly where criminal proceedings do not result in justice. While neither process determines criminal liability, both (but mostly DHRs) have evolved, to recognise the complex dynamics of coercive control, emotional abuse, and systemic failings that can lead to suicide. In some leading cases, their findings on the actions of accused perpetrators have led to public calls for stronger prosecutions.[42]

7.2 AAFDA CEO Frank Mullane MBE helped ensure that DHRs became law and helped to develop the Home Office DHR Guidance. Some coroners now wait for the DHR to make findings before resuming the inquest, quite often following representation from AAFDA. AAFDA has encouraged this practice as DHRs reveal such detail on the domestic abuse suffered by the victim.

7.3 There is increasing recognition that SVSDA is now the most common form of death after domestic abuse. AAFDA therefore welcomes the reforms that have led to real-time suicide surveillance, improved inter-agency coordination, and the renaming of DHRs as Domestic Abuse Related Death Reviews ("**DARDRs**").

7.4 Inquests, too, have broadened in scope, allowing coroners to consider contributory factors like coercive control and institutional failings. Landmark rulings underscore the growing recognition of psychological abuse as a cause of death and the need for systemic accountability. Together, DHRs and inquests (the latter a little more gradually) play a crucial role in uncovering hidden patterns of abuse, informing policy, and preventing future deaths.

7.5 Issues with police investigation

7.5.1 It is clear that DHRs are assisting coroners to recognise the part played by domestic abuse in suicides. Prior to DHRs, coroners tended to rely heavily on the evidence found as a result of police investigations where there had been a fatality. This proved problematic because, especially in the case of a suicide, it was not certain that a police investigation would take place and if it did, there is the risk that the investigation was insubstantial, or too narrow to produce sufficient evidence for the coroner to consider. For example, an investigation that remarks exclusively on information known to police and fails to interview the family and friends of the deceased risks omitting key information linked to the circumstances and context surrounding the deceased's death, including whether there were any instances of domestic abuse in their life.

[42] *R v South London Coroner ex p Thompson* (1982) 126 SJ 625 – the coroner has a duty to seek out as many facts as needed for the public interest; An inquest is not only concerned with 'the last link in the chain of causation' *R v Inner West London Coroner ex p Dallaglio* [1994] 4 All ER 139.

7.5.2 AAFDA is concerned that, among other issues, superficial and / or flawed police investigations of SVSDA's can hamper DHRs, inquest and criminal findings and therefore impede the achievement of justice. For example:

a) the victim's property (i.e., phone and/or laptop) may be handed over by the police to the victim's partner or ex-partner without due consideration that the next-of-kin may be involved in the death;

b) the home or location of death and the home of the partner / ex-partner may not be secured and identified as potential crime scenes; and

c) the investigation may be superficial or curtailed as there is not adequate consideration of the role of domestic abuse in the lead up to the death, for instance, due to a premature assumption that the victim's passing had no external cause.

7.5.3 In our previous report, AAFDA and the University of Warwick found that *"…..family members and professionals alike were concerned about the prospect that police might close investigations too quickly in the aftermath of suicide, resulting in a failure to identify or act upon links to domestic abuse. Family members spoke powerfully about the challenges they faced in trying to open up space for this to be considered, and about the additional ways in which the absence of dedicated family liaison officers and trauma-informed practice made communications with police (and other agencies) more difficult."*[43]

7.5.4 One family member "... *submitted 74 exhibits of screenshots and photographs in the aftermath of her daughter's death but* ***felt dismissed out of hand by the officer in charge*** *when she presented them: "I said to him, I've brought this because I think it's important information. Every time he took a piece of paper off me…[he] slammed it on the desk. I said to him, are you not going to look at them?* ***He said, there's no point. He said, 'it's irrelevant…your daughter took her own life'…It was like she wasn't important when she was alive and…she's not important now she's dead."*** [44]

7.5.5 AAFDA strongly supports recent proposals from Killed Women[45] and other campaigns to improve police responses to better support individuals at risk of domestic abuse and better investigate and prevent incidents of abuse.

7.6 Domestic Homicide Reviews

7.6.1 The aims of these reviews are to prevent domestic abuse and fatal domestic abuse and to improve service responses to all victims of domestic abuse. The statutory guidance has evolved to explicitly include suicides where domestic abuse is thought to have preceded the suicide. At AAFDA we have observed a positive evolution in the scope, outcomes and wider implications of DHRs in recent years.

[43] *'Learning Legacies: An Analysis of Domestic Homicide Reviews in Cases of Domestic Abuse Suicide'*, Sarah Dangar, Vanessa E. Munro & Lotte Young Andrade, AAFDA, (July 2022), <https://aafda.org.uk/learning-legacies> accessed 5 September 2025.

[44] Ibid

[45] "*You were told – a voice for killed women*" Killed Women, 5 December 2023 <https://www.ipsos.com/sites/default/files/ct/news/documents/2023-12/you-were-told-a-voice-for-killed-women-report.pdf> accessed 18 September 2025.

[46] See the announcement here: Laura Farris, the Home Office, 'Fatal domestic abuse reviews renamed to better recognise suicide cases' (5 February 2024) <https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases> accessed 18 September 2025.

[47] Given that the relatively recent change of language has not been universally adopted by centralised government, and to ensure continuity throughout this Report, the term "DHR" will continue to be used; however, DHR and DARDR may be used interchangeably.

[48] Domestic Abuse Commissioner, '*Domestic Homicide Oversight Mechanism report 2025: Learning from Loss'* (July 2025), <https://domesticabusecommissioner.uk/wp-content/uploads/2025/07/Learning-from-Loss.pdf> accessed 5 September 2025.

7.6.2 In February 2024, the UK government announced that DHRs would be renamed as DARDRs. This updated language is expected to be formally adopted once new statutory guidance is published. It reflects a positive, broader understanding of domestic abuse, including deaths by suicide resulting from coercive control, emotional, and economic abuse.[47]

7.6.3 Worryingly, the July 2025 report from the Domestic Abuse Commissioner has highlighted that only 25% of recommendations from DHRs between 2019 and 2021 have been fully implemented. In a majority of reviews, the national body or government department was not aware of the recommendation made for them or was unable to confirm that they were aware (56%).[48] AAFDA is disappointed by these statistics. We believe DHRs are a vital way in which government, police and agencies can learn how to prevent deaths, but clearly, DHR recommendations are only going to be effective so long as their recommendations are acted on. AAFDA acknowledges the Oversight Mechanism and welcomes this as a measure to address the poor implementation of recommendations.

7.6.4 Are enough DHRs commissioned in cases involving suicide?

a. Most recently, the 2025 case of R. (*on the application of Charnwood BC) v Secretary of State for the Home Department*[49] provided guidance on the circumstances in which the Secretary of State could direct a specified person or body to establish a DHR, pursuant to s.9(1) of the Domestic Violence, Crime and Victims Act 2004 ("**the 2004 Act**"). The case was brought after a woman was found dead in her home in June 2021, having been home alone with her partner and the subsequent police investigation and inquest found the death to have been "accidental", with no third-party involvement. The family sought AAFDA's help. AAFDA provided information to Charnwood Borough Council ("**CBC**") and requested that CBC commission a DHR. CBC refused. AAFDA sought an intervention from the Home Office, which directed CBC to establish a DHR. CBC challenged this direction, contending that there was no objective evidence that the woman's death resulted from violence, abuse, or neglect, as set out in section 9(1) of the 2004 Act, and that, consequently, the minister's direction for a DHR to be established was, irrational. The challenge was dismissed by the High Court, in a ruling that emphasised that the legal threshold for establishing a DHR is low and may include where evidence shows only potential for neglect (i.e. failure to seek medical help), rather than actual neglect (a position supported by the DHR Statutory Guidance). In particular, a DHR is warranted on the appearance of causation, rather than the proof of causation[50], and the evidential threshold for an appearance is lower than a balance of probabilities test[51]. This judgment underscores the importance of taking a broad, preventive approach to deaths in domestic settings. Even in the absence of criminal findings, a DHR may be mandated where there is a reasonable appearance of neglect or abuse.

[49] *R (on the application of Charnwood Borough Council) v Secretary of State for the Home Department* [2025] EWHC 33 (Admin) https://www.bailii.org/ew/cases/EWHC/Admin/2025/33.html

[50] Ibid [82]

[51] Ibid [83]

[55] Ibid [83]

7.7 Inquests

7.7.1 How do inquests provide justice and accountability for families?

a. A coroner has a duty to undertake an inquest where either (1) the cause of death remains unknown; (2) the person might have died a violent or unnatural death; or (3) the person might have died in prison or police custody. The coroner's duty in this fact-finding investigation extends to "*seek out and record as many of the facts concerning the death as the public interest requires*". Consequently, an inquest's scope, especially in the context of a suicide, can extend to the presence and impact of the victim's relationships, including any instances of suspected domestic abuse. However, a coroner's discretion does not extend to making findings of criminal or civil liability. The link between the efficacy of the police investigation and the coroner's likelihood to undertake an inquest, or at least an inquest with a wider scope, is key, highlighting the importance of a thorough and accurate police investigation.

7.7.2 How have inquests evolved to deal with cases of suicide after domestic abuse?

a) The 2020 case of the suicide of James Maughan, who died while in prison in 2016, set a new precedent regarding the burden of proof required for a coroner to make findings of suicide and unlawful killings. The coroner's jury concluded on the balance of probabilities that he had intended to take his own life. His brother challenged this conclusion, arguing that such a finding should require the criminal standard of proof - beyond reasonable doubt - due to its serious implications. The case reached the UK Supreme Court, which held by a 3–2 majority[54] that ***the balance of probabilities standard of proof applies to all inquest conclusions, including suicide and unlawful killing***. This decision had significant implications for coronial law, making it easier for coroners and juries to reach such conclusions and potentially increasing the number of recorded suicides and unlawful killings.

b) The inquest into the death of Jessica Laverack in June 2022,[55] ***was the first known time a coroner made a Prevention of Future Death ("PFD") report[56] linking domestic abuse with a suicide*** (following an Article 2 inquest).[57] Jessica was a vulnerable person who had been subjected to physical, psychological and sexual abuse by her partner. The PFD report[58] highlighted that there is a "need for the recognition for the link between domestic abuse and suicide" and it identified a lack of training and an information-sharing failure on the part of several agencies. The report was sent to the Secretary of State for the Home Department, for Justice and for Health and Social Care.

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[52] See Gov.UK "*What to do after someone dies*" <https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner> accessed 5 September 2025.

[53] *R v South London Coroner ex p Thompson* (1982) 126 SJ 625 [37]

[54] *R (on the application of Maughan) (AP) (Appellant) v Her Majesty's Senior Coroner for Oxfordshire (Respondent)* [2020] UKSC 46 <https://supremecourt.uk/uploads/uksc_2019_0137_judgment_d102a1d4c6.pdf> accessed 5 September 2025.

[55] *Jessica Laverack: prevention of future deaths report*, ref no 2022-0344, (27 June 2022), <https://www.judiciary.uk/prevention-of-future-death-reports/jessica-laverack-prevention-of-future-deaths-report/> accessed 5 September 2025.

[56] A Preventable Future Deaths (PFD) Report, also known as a Regulation 28 report, is a document produced by a coroner which is issued following an inquest. The purpose of a PFD report is to identify circumstances that could lead to future deaths and to recommend actions to relevant organisations or authorities to mitigate these risks. The recipients of a PFD report have an obligation to respond, see the Coroners (Investigations) Regulations 2013, Part 7.

[57] S. Naftalin, V. Munro, *'Investigations into suicides in the context of domestic abuse'*, Legal Action Group (15 September 2023), <https://www.lag.org.uk/article/214523/investigations-into-suicides-in-the-context-of-domestic-abuse> accessed 5 September 2025.

[58] *Jessica Laverack: prevention of future deaths report*, ref no 2022-0344, (27 June 2022), <https://www.judiciary.uk/prevention-of-future-death-reports/jessica-laverack-prevention-of-future-deaths-report/> accessed 5 September 2025.

c) The parents of Roisin Hunter Bennett, who died by suicide, successfully sought judicial review[59] of the coroner's summary of their daughter's death in the inquest report (the "Record of Inquest"). The Record of Inquest referenced the end of a relationship and academic pressures as the causes of Roisin's low mood, and the parents argued instead that the ***coroner should have attributed her death to an emotionally abusive relationship,*** following evidence of abusive messages received from Roisin's ex-partner, including on the day before her death. The coroner agreed that this should have been included in the Record of Inquest, as a factor attributing towards Roisin's death, and the High Court agreed that amending the record was in the interests of justice.

d) In a 2023 judgment, the Court of Appeal found in this case that coroners could and should consider the actions of third parties (beyond Article 2 ECHR requests) in the lead up to a suicide.[60] Jodey Whiting died by suicide in 2017, shortly after the Department for Work and Pensions ("**DWP**") abruptly stopped her disability benefits due to a missed assessment, despite her complex mental health history. Her mother, Joy Dove, sought a fresh inquest, arguing that new evidence - including an Independent Case Examiner's report and a psychiatric opinion - showed the DWP's failings likely contributed to Jodey's mental health deterioration. The Divisional Court rejected the application, but the Court of Appeal allowed it in part, ruling that a fresh Jamieson inquest[61] was desirable to explore whether the DWP's actions materially contributed to the death. ***The Court clarified that coroners may consider contributory factors to mental health decline in suicide cases, even outside the scope of an Article 2 inquest***, (which refers to state bodies), thereby broadening the understanding of causation in coronial law and reinforcing the importance of accountability of third parties in deaths by suicide.

[59] *R. (on the application of Hunter) v HM Assistant Coroner for County Durham and Darlington* [2024] EWHC 1275 (Admin)

[60] *Dove v HM Assistant Coroner for Teesside and Hartlepool and Rahman* [2023] EWCA Civ 28Judgment: <https://www.bailii.org/ew/cases/EWCA/Civ/2023/289.html> accessed 5 September 2025.

[61] Jamieson inquests must try to establish who the deceased was and how, when, and where they died, whereas Article 2 inquests (also known as Middleton inquests) are broader in scope and also investigate whether the state breached its duty to protect the right to life under the European Convention on Human Rights. See the Coroners and Justice Act 2009 section 5, which determines the questions coroners must determine in both types of inquest. See: Landmark Chambers, *'Article 2 Inquests: An Overview and Update'* (29 November 2024) <https://www.landmarkchambers.co.uk/news-and-cases/article-2-inquests-an-overview-and-update> accessed 5 September 2025.

7.7.3 The case of Kellie Sutton

a) The inquest into the death of Kellie Sutton, a 30-year-old mother of three from Welwyn Garden City, marked another groundbreaking legal milestone in the UK.[62] Kellie died in August 2017 following months of coercive control and physical abuse by her partner, Steven Gane. The abuse included isolation, threats, financial control, and assaults. On the morning of her death, Gane sent her messages encouraging her to take her own life.

b) Initially, a 2020 inquest concluded suicide contributed by domestic abuse, but it was later quashed due to procedural irregularities, including the failure to recognise Gane as an interested party. A second inquest, held in 2023, heard extensive evidence of abuse and police failings, including a July 2017 incident where officers failed to properly assess risk or safeguard Kellie and her children. The information from the DHR was hugely important to this inquest. ***The jury concluded that Kellie had been unlawfully killed, finding that the coercive and controlling behaviour amounted to an unlawful act that caused her death***.

7.7.4 This is believed to be the first time an inquest in England and Wales has returned an unlawful killing verdict in such a case. The coroner issued a Prevention of Future Deaths report, identifying systemic failings and calling for urgent reforms in how domestic abuse is understood and responded to by frontline officers.

[62] See documents from Kellie's inquest here <https://bhattmurphy.co.uk/newsroom/kellie-sutton-coroner-issues-prevention-of-future-death-report/>; PFD report <https://www.judiciary.uk/prevention-of-future-death-reports/kellie-sutton-prevention-of-future-deaths-report/> both accessed 5 September 2025.

8. Conclusion

8.1 AAFDA considers that suicide following domestic abuse is not only being recognised as a deeply concerning issue, but also one that continues to challenge the boundaries of our criminal justice system. Despite the introduction of new offences (such as coercive and controlling behaviour) and developments in case law, there has only been one successful manslaughter conviction in the UK. That case (following Justene Reece's death) stands as an exception, and sadly does not offer a clear legal route for future cases, since it was obtained through a guilty plea. Similar cases have failed to result in a manslaughter conviction, largely due to the complex challenge of proving causation. Recent cases, such as Kellie Sutton and Kiena Dawes, highlight the persistent difficulties in securing justice for victims and their families. Therefore, AAFDA would like to raise the question: is the current legal framework fit for purpose? DHRs and inquests have become increasingly critical for identifying systemic failings, but they cannot replace criminal accountability. Their effectiveness is undermined by inconsistent implementation of findings and recommendations and, in some cases, reluctance to commission reviews in suicide cases.

8.2 Call to Action

8.2.1 AAFDA calls for consideration of **whether the criminal justice system is failing victims and fully holding perpetrators to account in cases of suicides following domestic abuse.**

8.2.2 *A new law*

AAFDA is concerned that the test for causation in manslaughter cases remains difficult to meet, especially in cases with victims suffering pre-existing or exacerbated vulnerabilities, and that this may continue to inhibit the number of successful prosecutions. Partly, convictions by juries in such cases will need greater public awareness of the insidious effect of coercive and controlling abuse, but it seems to AAFDA that greater reform to criminal law is needed to secure justice for victims who are driven to suicide by their abuser. A new law could assist juries to recognise the causative relationship between domestic abuse and suicide. This new law should attract a similar sentence to the offence of manslaughter.

8.2.3 *Tougher sentencing on coercive and controlling behaviour*

The offence of coercive control cannot currently be met with an Extended Determinate Sentence, a mechanism for managing dangerous offenders. The maximum sentence for coercive control is five years (interestingly, a similar but more extensive Scottish offence attracts a maximum sentence of fourteen years).[64] If coercive control could attract an Extended Determinate Sentence, the public would be better protected.

8.3 Creating the law will likely require new legislation. At AAFDA, we will reflect on the feedback on this issue received at our September 2025 conference ("Tip of the Iceberg") and consult with a range of policy experts, MPs, journalists and other domestic abuse organisations and stakeholders. Similarly, in order to see the offence of controlling or coercive behaviour attract extended determinate sentences, AAFDA will consult on advocating for an amendment to the Serious Crime Act 2015 which brought in the offence, and/or an amendment of the Sentencing Act 2020."

8.4 At a time when the government has committed to halving violence against women and girls[65], AAFDA is calling for a focused debate on whether the criminal justice system is failing victims who die by suicide after domestic abuse as the start point for delivering an improved approach.

8.5 AAFDA's experience supporting bereaved families highlights the urgent need for reform. AAFDA remains committed to advocating for victims and bereaved families, promoting accountability, and stopping domestic abuse and fatal domestic abuse.

[63] Sentencing Council, '*Controlling or coercive behaviour in an intimate or family relationship*', <https://sentencingcouncil.org.uk/guidelines/controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship/> accessed 5 September 2025.

[64] See Domestic Abuse (Scotland) Act 2018, Part 1

[65] Home Office and Yvette Cooper, '*Top perpetrators of VAWG targeted under new national strategy*', (21 September 2024) <https://www.gov.uk/government/news/top-perpetrators-of-vawg-targeted-under-new-national-strategy> accessed 10 September 2025.

Appendix: A note on death and suicide data monitoring

1. When examining statistics relating to suicide it is important to understand both the methods of monitoring and data collection to appreciate any inherent limitations. Near to real-time suspected suicide surveillance (**"nRTSSS"**) is a methodology designed to identify emerging trends and to inform prevention strategies by analysing data on suspected suicides.[66] In England under nRTSSS, data supplied by local police forces goes to the National Police Chiefs' Council Suicide Prevention Portfolio, who provide it on a monthly basis to the Office for Health Improvement and Disparities (**"OHID"**). OHID carries out quarterly analysis and reporting. [67] However, this dataset is often incomplete. For example, in October 2024, 367 suspected suicide records were received, but 59 could not be included in the report due to data quality issues. [68] Similarly, when conducting a statistical analysis of DHRs the option for answers to questions to be marked as "not known" or left blank can distort the findings. [69] The DHP adopt a different methodology as part of their Home Office multi-year research project. The project looks specifically at all deaths identified by police as domestic abuse related and conducts data reconciliation with other public data sources that are checked against police records, including Counting Dead Women and the ManKind Initiative. [70]

[66] Office for Health Improvement and Disparities, *Statistical report: near to real-time suspected suicide surveillance (nRTSSS) for England for the 15 months to August 2023* (GOV.UK, 31 July 2025) <https://www.gov.uk/government/statistics/near-to-real-time-suspected-suicide-surveillance-nrtsss-for-england/statistical-report-near-to-real-time-suspected-suicide-surveillance-nrtsss-for-england-for-the-15-months-to-august-2023> accessed 11 September 2025.

[67] Office for Health Improvement and Disparities, Guidance: Methodology: near to real-time suspected suicide surveillance (nRTSSS) for England, (31 July 2025) <https://www.gov.uk/government/publications/methodology-near-to-real-time-suspected-suicide-surveillance-for-england/methodology-near-to-real-time-suspected-suicide-surveillance-nrtsss-for-england--2> accessed 11 September 2025.

[68] Office for Health Improvement and Disparities, *Statistical report: near to real-time suspected suicide surveillance (nRTSSS) for England for the 15 months to August 2023* (GOV.UK, 31 July 2025) <https://www.gov.uk/government/statistics/near-to-real-time-suspected-suicide-surveillance-nrtsss-for-england/statistical-report-near-to-real-time-suspected-suicide-surveillance-nrtsss-for-england-for-the-15-months-to-august-2023> accessed 11 September 2025.

[69] Home Office and Richard Potter, *Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) (GOV.UK, 31 October 2024)* <https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews-september-2021-to-october-2022-accessible> accessed 11 September 2025.

[70] Domestic Homicide Project, *Vulnerability Knowledge & Practice Programme* (2025) <https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project> accessed 10 September 2025.

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