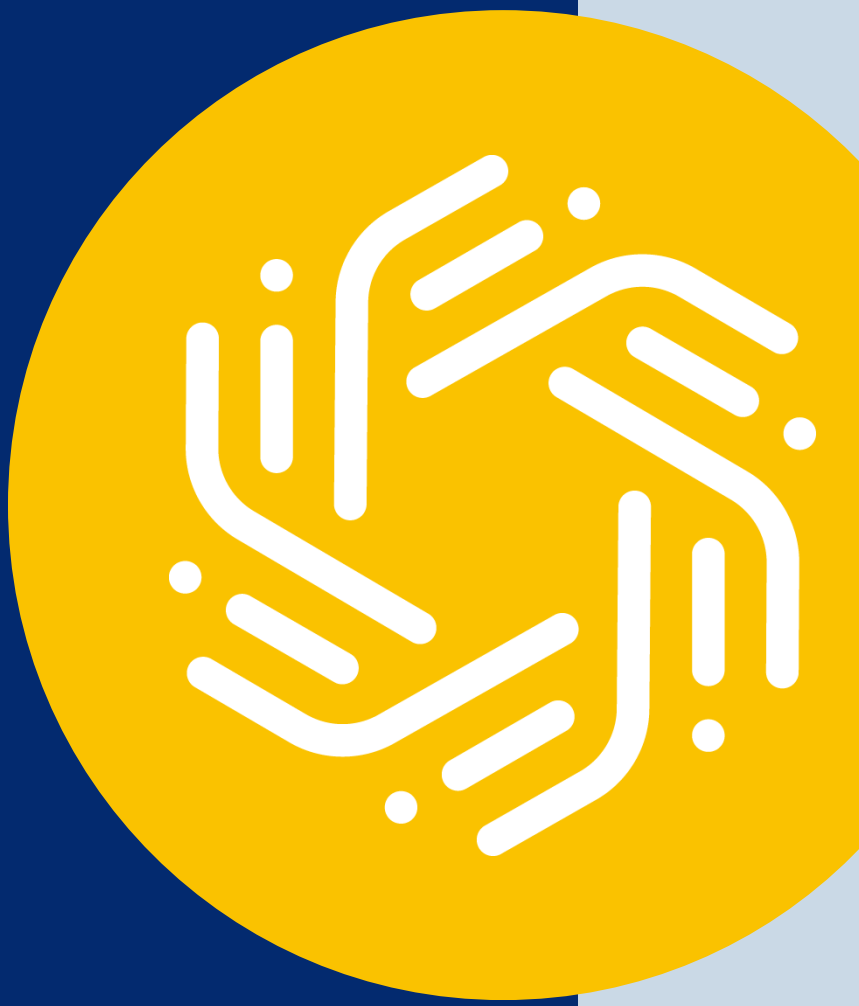
Domestic Homicide Review Series
Part One

An analysis of Domestic Homicide Reviews with fatal suffocation and smothering



Institute For
Addressing
Strangulation

Domestic Homicide Review Series Part One

An analysis of Domestic Homicide Reviews with fatal suffocation and smothering

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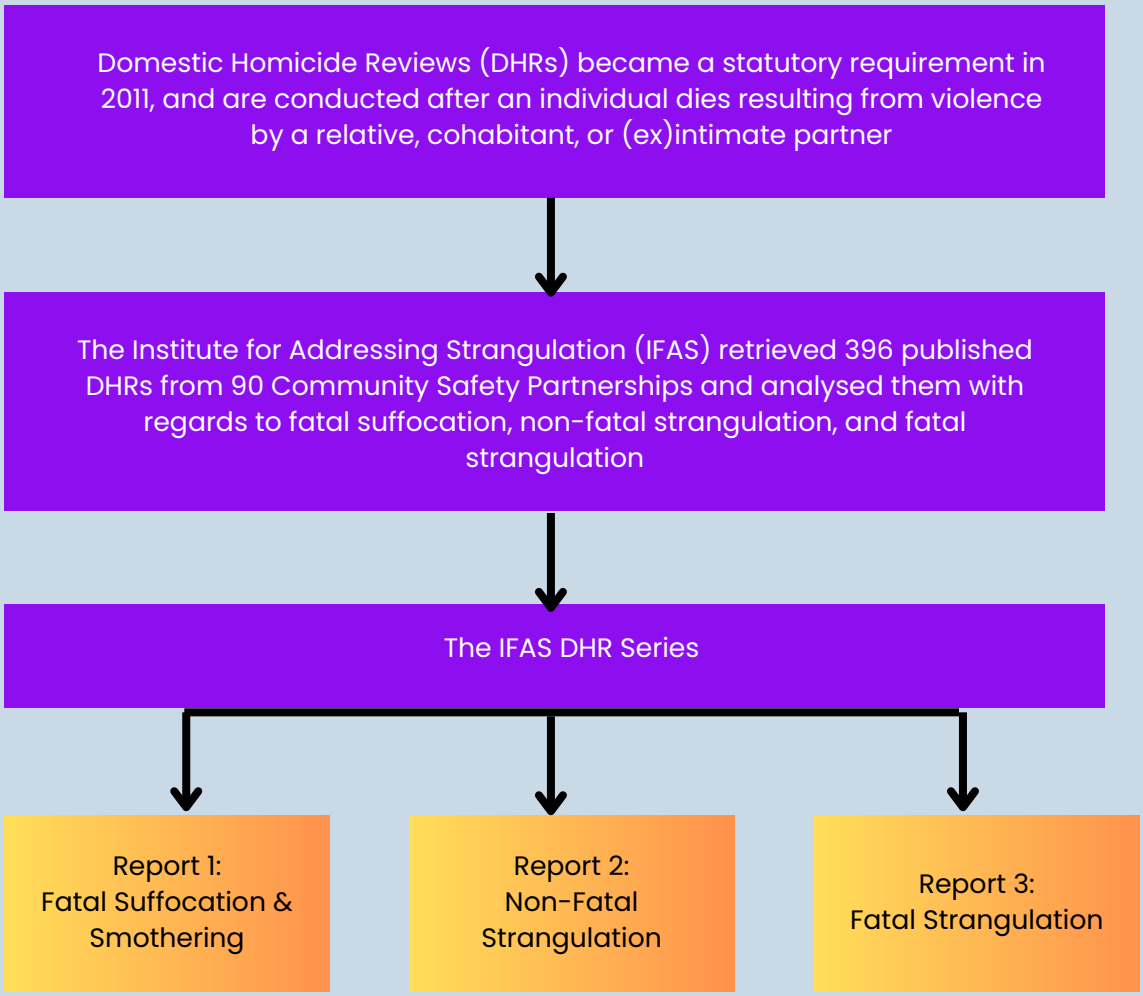
Institute For Addressing Strangulation

IFAS Domestic Homicide Review Series

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



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Introduction

Following the introduction of Strangulation and Suffocation as a standalone offence[1] in England and Wales in June 2022, the Institute for Addressing Strangulation (IFAS) has been funded, by the Home Office, to raise awareness of the risks associated with strangulation to professionals and the general public. Feedback from a Domestic Homicide Review (DHR) Network event prompted this series of reports to better understand strangulation and suffocation in the context of domestic homicide. The focus of this report is suffocation as the method of killing in the domestic homicide. The second and third reports in the series focus on non-fatal strangulation and fatal strangulation respectively.

DHRs aim to improve professional responses to domestic abuse by analysing the interactions that a victim of domestic homicide had with relevant agencies prior to their death occurring.

The DHR statutory guidance[3] states that the purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

DHRs can therefore provide a wealth of information pertaining to forms of abuse experienced by victims including strangulation.

A decision to conduct a DHR is made "*following the death of a person over the age of 16 that has been the result of violence, abuse or neglect by a relative, [intimate] partner or member of the same household*"[3]. When a death relating to domestic violence occurs, the police contact the local Community Safety Partnership (CSP)[4]. If the CSP decides a review is appropriate they appoint an Independent Chair and supporting panel to conduct it. Agencies related to the victim are then required to submit Individual Management Reviews (IMRs) in which they "*look openly and critically at individual and organisational practice*"[5]. The Chair and panel then analyse the IMRs alongside any other relevant information, draw conclusions and make recommendations. The decision whether or not to undertake a review should be made within 1 month of the case coming to the attention of the CSP and completed within 6 months of that date "*unless the review panel formally agrees an alternative timescale with the CSP*" [5]. The CSP is then responsible for publishing the completed DHR online. Until July 2023, when the Home Office made available the online Domestic Homicide Review Library[6], there was no one place or central repository of DHRs.

There is a growing body of research on domestic homicide reviews [7],[8],[9]. However, until now, there has been no specific analysis of DHRs pertaining to strangulation and suffocation.

Suffocation

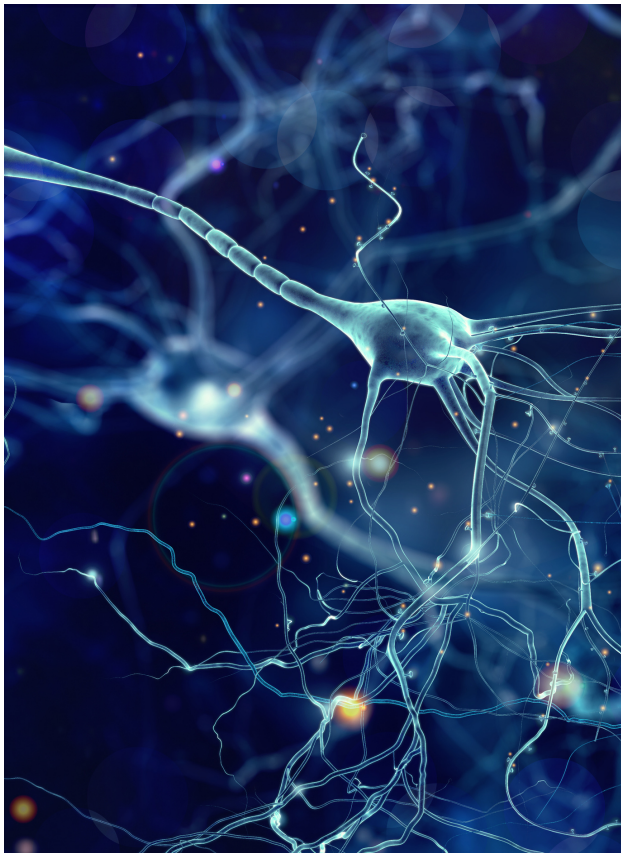
Suffocation occurs when "a person is deprived of air which affects their normal breathing"[10] . Suffocation is often used interchangeably with other words such as asphyxiation and smothering. However, there are subtle differences between the terms. Positional asphyxiation (or positional asphyxia) for example, is applied to situations where a person is suffocated due to the physical position they are in.

Chmieliauskas and colleagues (2018)[11] use the following definition:

Positional (postural) asphyxia is a form of mechanical asphyxia that occurs when a person is immobilized in a position which impairs adequate pulmonary ventilation and thus, results in a respiratory failure. (p.1)

Examples of this would be when a person is hog-tied, restrained in a face down position on the floor, or when someone kneels or sits on a victim's chest.

Most relevant to the DHRs in this study is the term 'smothering.' Nolan et al (2021)[12] describe smothering as "*...a form of mechanical asphyxia caused by occlusion of the nose and the mouth.*" (p.799). In other words, smothering relates to the covering of a person's nose and mouth so that they cannot breathe. This is the type of suffocation that most frequently occurred in the DHRs included in this study.



Methodology

To better understand the presence of fatal suffocation, non-fatal strangulation, and fatal strangulation in DHRs in England and Wales, IFAS obtained 396 DHRs from 90 CSPs between the years 2011-2023. There are over 300 CSPs across England and Wales[4], and the 90 CSPs included in this analysis were randomly selected using the Government list of CSPs, including CSPs from both England and Wales. The number of DHRs per CSP ranged from 0 up to 22. This was a large and time-consuming task and the cohort of 90 CSPs reflect our time limited resourcing for the project. Those DHRs that were readily available were downloaded and others had to be formally requested via email.

Until July 2023, when the Home Office made available a list of DHRs[6], there was no one place or central repository of DHRs. The DHRs that included a history of the incidents we were analysing were further reviewed and data was recorded in respective spreadsheets.

Until now, there has been no specific analysis of DHRs pertaining to suffocation. The importance of understanding suffocation as a form of domestic homicide links to the fact that the act does not require a weapon and in government statistics it is frequently coupled with strangulation.

Strangulation is considered a gendered crime [13] and therefore one associated with unequal power dynamics. Based on our previous research [14] around strangulation and suffocation homicides, it is questionable as to whether the same conclusions can be drawn with regards to suffocation homicide.

For this report (compared to the other reports in this series), following the publication of the Home Office DHR library [6] on 4th July 2023, a search of this database was made and a further 7 relevant DHRs were found. The DHR Library search function returned several reports that proved not to be suffocation homicides; rather once these cases were checked online via news reports, the cause of death was strangulation. Strangulation is a different mode of killing and is not the focus of this report but is discussed further in Report 3 of this series. Furthermore, some cases retrieved from the DHR library were suicides and these were not included in the analysis.

Sixteen DHRs were therefore included in this study. The analysis of the reports began on 23rd July 2023. Consequently, any suffocation DHRs published after that date are not included in the review.

It should also be noted that this study contains deaths of children aged under 16. As noted above, DHRs are only typically conducted in relation to the deaths of people aged 16 or over. However, in the two cases included, the DHR panel decided to incorporate the children's deaths into their reports as they took place during a domestic homicide in which the children's mothers were also killed. In these cases therefore, it made sense for the DHR panel to also analyse the circumstances of the children's deaths. In this report, we have therefore included the children's homicides in our analysis.

Each suffocation DHR was read in full. We interrogated the content via a series of questions. The questions were separated into two sets. The first set explored the homicide and the second set explored the quality of the DHR and its process. The questions were deliberately simple and aimed to provide an overview of the phenomenon given the lack of existing research on suffocation homicides and DHRs.

Research Questions

Given the dearth of research on suffocation homicides within the sphere of domestic abuse, IFAS was keen to gain a holistic understanding of these cases. The research questions were therefore:

1. **What are the demographics of victims and perpetrators included in suffocation Domestic Homicide Reviews?**
2. **What are the circumstances of these homicides, including vulnerabilities of victims/perpetrators and their interactions with agencies?**
3. **Are there any commonalities between the suffocation domestic homicides?**
4. **What are the outcomes of suffocation domestic homicides for perpetrators?**

With regards to the DHRs, we were interested in the following:

1. **Is there any variation in quality between the reviews?**
2. **Are there any areas of concern?**
3. **Are there any potential areas for improvement?**

Limitations

It is difficult to know how many DHRs have been published. One estimate in 2021 put the figure at around 800 [15]. Consequently, any DHR analysis can only be a sample of an unknown overall number. Trends therefore cannot be generalised or presumed to be representative of all DHRs.

One key limitation to this series of IFAS DHR reports is that DHRs are not uniform and therefore, often key information relating to victim and perpetrator demographics are not reported. In some cases demographic information has been changed by the report writers in a bid to protect the confidentiality of the victim/family. As each DHR is written by a different panel and Independent Chair, the style and quality of the reports vary a great deal. There is no consistent format for DHR reports which can make extracting such information difficult. Importantly, this means that the findings reported across the series reflect the information provided in DHRs alone, and not necessarily the full reality of the circumstances. We are aware there will be cases where victims have not previously disclosed incidences of non-fatal strangulation or suffocation prior to their death, and even where these incidences have been disclosed to professionals, they may have not been sufficiently recorded. This is something to be considered whilst reading this series. Further recommendations for development to research and practice are provided at the end of each report in this series.

Terminology

Throughout this series we use the term 'perpetrator' to describe the person who carried out the homicide and/or the non-fatal act of strangulation or suffocation. We have used this as a non-legal, umbrella term which includes individuals who have not necessarily been found guilty as part of a criminal trial. However in the cases we reviewed, other terms such as 'offender' or 'suspect' may be even less appropriate. As a result, we have opted for 'perpetrator' but acknowledge its potential limitations and problematic nature.

Findings

Table 1 provides information on cases included in this analysis with regards to the year of the homicide and the year of the publication of the DHR. To note, none of the DHRs were completed in the six month period suggested by Home Office statutory guidance. This may be indicative that the 6 month guideline is unrealistic for the publication of a DHR. It is worth considering whether this is particular to suffocation homicides or whether this is apparent in other forms of domestic homicide.

Table 1. An overview of dates pertinent to the Domestic Homicide Reviews (DHRs) included in the following analyses.

Case	Year of Homicide	Year of DHR Publication	Time Elapsed between Homicide and Publication*
1	2016	2019	3 years
2	2016	2017	1 year
3	2012	2014	2 years
4	2014	2016	2 years
5	2011	2012	1 year
6	2017	2018	1 year
7	2014	2015	1 year
8	2015	2017	2 years
9	2016	2021	5 years
10	2015	2018	3 years
11	2016	2018	2 years
12	2021	2022	1 year
13	2015	2016	1 year
14	2017	2019	2 years
15	2014	2016	2 years
16	2018	2020	2 years

**This is estimated based on the years of homicide and publication, this isn't an exact elapsed time duration.*

Overview of the facts of each case

A short summary of each case is provided below. Given that there is no consistency in the way in which DHRs are titled and that pseudonyms are often used which become cumbersome (e.g. Adult X, Adult Y etc), we have simply given each case a number from 1-16. The terms 'victim' and 'perpetrator' have been used as descriptors throughout, with the exception of Case 10 where the real name of the victim was used in the DHR (Becky). The cases are in no particular order.

16 domestic homicides by suffocation or smothering

Case 1
A daughter (aged 55), who had mental health problems, including suicidal thoughts and had previously been sectioned, was the carer for her 77 year old mother who had dementia, cancer and diabetes. No carer's assessment had been conducted. The daughter suffocated her mother during a psychotic episode.

Case 2
The perpetrator had a history of violence. The victim was his partner who had informed friends but not agencies about domestic abuse within the relationship. The perpetrator broke into the victim's home, physically assaulted her and killed her by pouring paint down her throat.

Case 3
The victim was in a relationship with Perpetrator 1. The three perpetrators conspired to kill the victim for financial reasons. An elaborate plan was staged involving fake social media accounts and messages to suggest the victim was having an affair with another man. The victim was suffocated whilst asleep in bed.

Case 4
This couple had been married for over 50 years. They had made a promise to one another that if one of them developed dementia they would not put that partner in a care home. When the wife was diagnosed with dementia, her husband attempted to care for her himself. When he experienced his own health problems he tried to find a suitable care home. The DHR notes that the husband was 'at the end of his tether.' The care home he selected managed only one day before returning his wife to him. That night the husband suffocated his wife before attempting to take his own life. They were both described as being 'in their eighties' at the time.

Case 5
The victim was a Thai national and married to the perpetrator. There had been some previous engagement with police regarding domestic violence. The perpetrator suffocated his wife although the DHR provides no details of the circumstances.

Case 6
The husband (aged 86) was the carer for his wife (age 85) who had been diagnosed with Parkinson's and dementia. It was decided that the wife would need to go into residential care. The husband regularly visited and supported her. However, on a day trip back home, the husband suffocated his wife and then took his own life.

Case 7
The victim was aged 87, had dementia and was living in a care home. Her step-grandson had a history of mental health problems. He suffocated her during a visit stating that he did not want her to end up a 'zombie' due to her dementia.

Case 8
A daughter (aged 36) was the carer for her 67 year old father who had multiple sclerosis, was bedbound and required round the clock support. No carer's assessment was conducted. The daughter suffocated her father in an attempted suicide pact. In notes left after the homicide, it was suggested that the father had had enough of his illness.

Case 9
Two 14 year old children who were in a relationship killed Perpetrator 1's mother via stabbing and 13 year old sister via suffocation and stabbing. Both families had had considerable interaction with agencies prior to the homicides.

Case 10

This case does not anonymise the victim. Her name was Becky. She was aged 16 and had received support from agencies for various mental health needs. Her step-brother (aged 28) and his partner (aged 21) kidnapped, suffocated and dismembered Becky. The offence was premediated and had a sexual element.

Case 11

The couple had been married for 69 years and were both in their nineties. A pact had been made by the couple that if the health of one deteriorated, 'they would end the suffering rather than be put in a home.' The wife had a stroke and developed dementia. The couple moved in with family to ensure their care needs were being met. It was then decided that they should move into residential care. Four days before the planned move, the husband suffocated the wife.

Case 12

This couple had been married for 51 years and lived geographically and socially isolated lives. They were largely estranged from their 4 children. The wife (aged 71) wrote in her diary about experiencing considerable pain and wanting to die. She was suffocated by her husband (aged 81) before he took his own life.

Case 13

A father killed his wife, suffocated his 14 year old daughter and then took his own life. The parents had been experiencing financial difficulties. There was no evidence of previous direct abuse between the father and daughter.

Case 14

The wife of a couple married for 55 years developed terminal cancer. Unable to cope with the circumstances of the illness and inevitable death, the husband suffocated his wife and then took his own life.

Case 15

The couple met at a mental health in-patients hospital and both had considerable mental health difficulties. They began living together. The male partner beat and asphyxiated the victim by crushing her chest. He was found to be unfit to stand trial and was given a hospital order.

Case 16

The adult son had a history of violence, drug misuse and mental health difficulties. He entered his parents' home acting violently. In an attempt to protect himself and family, the father restrained his son. Police took 40 minutes to arrive. By the time that they did, the son had gone into cardiac arrest and later died due to being accidentally asphyxiated. The father was released without charge.

Demographics

Tables 2 and 3 provide an overview of the demographics of the people involved in the homicide. Where details are not provided in the DHR, these have been sourced by IFAS from online news reports. Where the age has been sourced from news reports, this is denoted with an asterix (*).

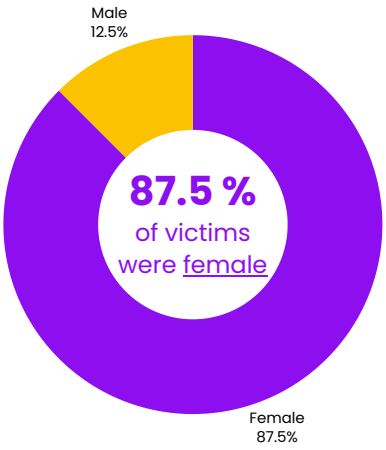
Table 2. Overview of victim demographics

Case	Sex of Victim	Age of Victim	Ethnicity of Victim
1	Female	77	South Indian
2	Female	39	White British
3	Female	23	DHR does not state
4	Female	80	DHR does not state
5	Female	28*	Thai
6	Female	85*	DHR does not state
7	Female	87	DHR does not state
8	Male	67	White British
9	Female	13	White British
10	Female	16	DHR does not state
11	Female	93	DHR does not state
12	Female	71	White British
13	Female	14	White British
14	Female	DHR does not state	DHR does not state
15	Female	DHR does not state	Not stated
16	Male	23*	White/Gypsy and Traveller

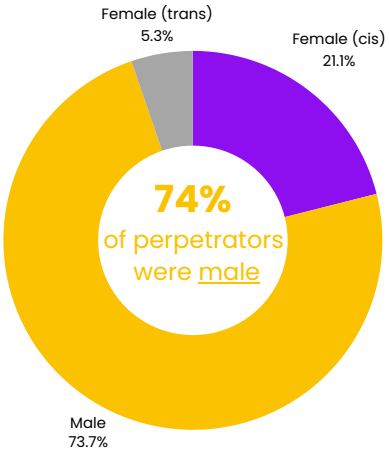
Table 3. Overview of perpetrator demographics

Case	Sex of Perpetrator	Age of Perpetrator	Ethnicity of Perpetrator
1	Female	55	South Indian
2	Male	32	Mixed White British/Black Jamaican
3	1 Female/2 Male	31, 32, 38	All White/Polish
4	Male	80s	DHR does not state
5	Male	30*	DHR does not state
6	Male	86*	DHR does not state
7	Male	33	DHR does not state
8	Transwoman	36	White British
9	1 Female/1 Male	Both age 14	White British
10	1 Female/ 1 Male	21 and 28	DHR does not state
11	Male	90s	DHR does not state
12	Male	81	White British
13	Male	50	White British
14	Male	60s	DHR does not state
15	Male	DHR does not state	Not stated
16	Male	DHR does not state	Not stated

Graph 1. Percentage of victims by sex



Graph 2. Percentage of perpetrators by sex



There were 16 cases published between 2012 and 2022. These included 20 perpetrators: 15 male, 4 female and 1 transwoman. In three cases, there was more than one perpetrator. 14/16 of the victims were female and 2/16 were male.

Tables 2 and 3 highlight the way in which basic demographics are often lacking in DHRs. In 9 cases, there was no ethnicity given for either the victim and/or the perpetrator. In the remaining cases, most victims and perpetrators were described as White/British.

In Case 1 however, both victim and perpetrator were South Indian and in Case 2 the perpetrator was described as Mixed White British/Black Jamaican. In Case 3, all perpetrators were described as Polish and the victim in Case 16 was described as White British with a 'Gypsy Roma and Traveller background'.

The failure to report on ethnicity means that any effect that minoritisation, culture or ethnicity may have had on the homicide remains unexplored. Equally, when ethnicity is provided, this does not automatically mean that its relevance is scrutinised within the DHR. Case 5 for example, involved a Thai national who had been perceived by police as both victim and perpetrator of domestic abuse. The DHR is only 17 pages long. It does not include any input or perspective from a representative of the Thai community. In addition, no input was included from an organisation that may be able to speak to the potential impact of the victim's ethnicity and immigration status on her vulnerability to domestic homicide. As a result, her cultural background is dismissed as irrelevant to the outcome of the review.

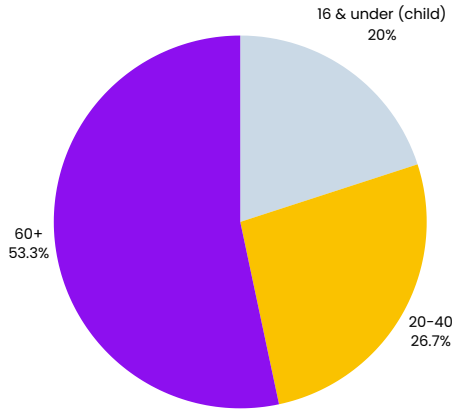
The ages of the victims varied. As highlighted above, there were gaps in this data and where possible these have been filled with information from news reports. The exceptions are where the victim is labelled as '60+' (Case 14) and in Case 15. In both reviews no information was available in the DHR or online. In Case 14, the age has been approximated by the fact that the victim had been married for 55 years. Text Box 1 provides the ages of the victims from youngest to oldest. Again, where the age has been sourced from news reports, this is denoted with an asterix (*).

Text Box 1. Ages of Victims (Youngest to Eldest)

13, 14, 16, 23, 23*, 28*, 39, 60+, 67, 71, 77, 80, 85*, 87, 93
In Case 15, the age is unknown.

As can be seen in Text Box 1, where the information is available, there are three general age categories of victims (see Graph 3).

Graph 3. Age categories of victims



Graph 3 demonstrates how suffocation victims in this cohort were most frequently aged over 60. As will be highlighted later, the three age categories typically denote similar themes.

The ages of the perpetrators were wide ranging although in some cases the perpetrator's age was not included in the report. Similarly, the age of one perpetrator is given as '60+' as no information is available beyond that he had been married for 55 years. In Cases 15 and 16, no information was available on the perpetrators' ages.

In one case two 14 year old children were the perpetrators. On the opposite end of the spectrum, four perpetrators were aged 80 and above, with one perpetrator described as being over 90. Most frequently, perpetrators were aged in their thirties (7 cases).

Text Box 2. Ages of Perpetrator (Youngest to Eldest)

14, 14, 21, 28, 30*, 31, 32, 32, 33, 36, 38, 50, 55, 60+, 80s, 81, 86*, 90s

In cases 15 and 16, the age of the perpetrators is unknown.

Location of homicide

Geographical location

The homicides took place in the following CSPs : Croydon, Swindon, Somerset, Carlisle, Wigan, Monmouthshire, Gloucestershire, Barking and Dagenham, Lincolnshire, Bristol, Bassetlaw, Pembrokeshire, Elmbridge, Kent and Medway (x3).

It is interesting that three suffocation homicides took place in Kent and Medway. From the DHRs, there is no indication about why that would be the case. Beyond this, there was no particular pattern with regards to the geographical location of the deaths. Further, there was no suggestion in this cohort that smothering domestic homicides are more prevalent in specific areas, for example rural versus metropolitan.

Setting of the homicide

In all cases where the information is provided, the victim was killed in a home environment. No detail was provided in Case 5. The majority of homes were the victims' (Cases 6, 10) or victims' and perpetrators' jointly (Cases 1, 2, 3, 4, 8, 9, 11, 12, 13, 14, 15), one was that of the victim's parents (Case 16), and in Case 7, the victim was killed in her room in a residential care home.

Method of killing

The DHRs did not always provide details on the method of killing beyond a pathologist's conclusion. Where detail is given, reference is most frequently given to the victim being suffocated in bed (Cases 3 and 9) or smothered with a pillow (Cases 1, 4, and 7). In Cases 5 and 6, the circumstances were unclear and news articles confirmed the victim was smothered with a pillow in bed. In Cases 13 and 14, the victims were found in bed, possibly indicating this was where the homicide took place.

In Cases 4, 8 and 12, a plastic bag was used. In Case 2, there was a range of brutal acts carried out on the victim and the cause of death was concluded as 'inhalation of foreign material'. Two further DHRs indicated that the smothering had been accompanied by other forms of violence: beating (Case 6) and stabbing (Case 9). In Case 15, the victim had been beaten and her chest was crushed.

Case 16 is an example of positional asphyxia in which the victim's physical positioning prevented him from being able to breathe. In this incident, the victim was in the prone position and being restrained by his father.

Vulnerabilities of victims

What becomes apparent in the DHRs is the vulnerability of the homicide victims. These largely related to physical and mental health issues. In most of the cases, there were no reports of the victims having drug or alcohol dependencies. The exceptions are in Cases 15 and 16 in which the victims had struggled with dependency. Further, in Case 2, the victim did have cocaine in her blood at the time of death, but there was no indication that this was linked to any form of addiction.

Bearing in mind the age categories noted above, patterns in the type of vulnerability victims experienced arise. The following paragraphs provide an overview of these vulnerabilities.

Children aged 16+

In Cases 9, 10 and 13, the victims were children. All children are vulnerable to the extent that they are financially dependent on others, subject to the decisions of adults around them, and are still developing both physically and emotionally. The child in Case 10 had a history of mental health problems including anorexia and numerous agencies had been involved in supporting her.

The children in Cases 9 and 10 had also spent time in foster care, although not at the time of their deaths. In Case 13, the child lived in a household in which her mother had previously complained to police about domestic abuse.

In Case 9, the victim had initially lived in a house with extreme domestic abuse before her mother separated from her husband and moved the family away from him.

Adults aged 20-40

In the three cases in which female victims were aged between 20 and 40 the women had previously complained of domestic abuse. Problematically, Case 5 is lacking in considerable detail and it is difficult to gain any sense of the victim. However, there was a domestic incident reported to police in which the homicide victim is documented as the victim.

The perpetrator later complained to his GP that he was in fact the victim, but this was not accepted by the judge during the murder trial. As noted above, inadequately explored in this DHR is the fact that the victim was a Thai national and unable to read or write English. She was not in employment and no Thai family is reported as living nearby. Her mother described her daughter as receiving 'a small amount of education'. The DHR does not report her immigration status but concluded that the 'diversity issues' did not 'have a link to domestic abuse or the death of [the victim]'. Whether the victim's immigration status, cultural, national or educational background created any hurdles to escaping an abusive relationship is not explored.

In Case 2, the victim had reported domestic abuse to friends but not to any agency. She had also experienced some mental health difficulties and a year before the murder had complained to her GP about thoughts of self-harm.

In Case 3, the victim had no particular vulnerabilities. However, she had complained to police about a belief that someone was accessing her property when she was out. She had also received malicious communications and underwear had been sent to her through the post. With regards to her notifying the police about this, the DHR highlights that "insufficient weight was given to the complaint" (p.42). The victim had also been involved in a domestic abuse incident between her and two of the perpetrators.

Vulnerabilities largely related to physical and mental health issues

In this age category is also a 23 year old man. He had a complex history of substance misuse and mental health problems, including four suicide attempts. His family had previously complained to the police about his behaviour but always retracted their statements. At the time of the homicide, the family had a restraining order against the victim which prohibited him from entering the family home. This is an unusual case in which the victim of the homicide was the perpetrator of the previous domestic abuse against his wider family.

Adults aged 60+

In Cases 1, 4, 6, 7, 8, 11, 12 and 14, the victims were aged over 60. It is important to note that in all these cases, the victim was very vulnerable. In five cases (Cases 1, 4, 6, 7 and 11), the victim had been diagnosed with dementia. This raises questions around dementia support for families. Four victims had mobility issues (Cases 1, 7, 8 and 11) with the latter two completely bedbound. In Case 14, the victim had terminal cancer and in Case 12, the victim's medical records indicated some history of anxiety and depression.

It is unknown whether victims of domestic homicide who are aged 60+ and are subjected to modes of killing other than suffocation and smothering are likely to be vulnerable in the ways demonstrated in this cohort. It is worth exploring whether suffocation domestic homicides are more frequently carried out on older vulnerable people than other forms of homicide (for example death by beating). It is also worth exploring whether diagnoses such as dementia statistically make older people more vulnerable to suffocation domestic homicide. These questions cannot be answered in this review, but are important considerations for further research endeavours.

Vulnerabilities of perpetrators

The main issue that arose for perpetrators was related to mental health. Cases 1, 4, 5, 7, 8, 10, 12, 14 and 15 explore to some extent the mental health problems of the perpetrators. These largely relate to anxiety and depression. This includes one case in which the perpetrator had previously reported suicidal thoughts (Case 1) and two further cases in which the suspect had attempted suicide in the past (Cases 14 and 15).

Often the DHRs are lacking in detail regarding the status of a perpetrator's mental health. This may be due to the lack of detail the panel received from the various agencies. In Case 13 for example, the family had private health care and their private hospital refused to engage. Consequently, any vulnerabilities of the perpetrator are unknown. Further, in Case 5 a practice nurse had previously noted that the perpetrator was of 'low mood' but had not adequately reported the interaction in the medical notes. Later, the perpetrator did not turn up to a GP referral the practice nurse had made regarding his 'low mood'. Whether poor mental health is related to the homicide is unknown as the DHR is generally lacking in considerable detail. A lack of detail regarding mental health is also apparent in Cases 6 and 11. In the former report there is mention of the Mental Health Team visiting the couple, and in the latter, the DHR quotes the trial judge as commenting on the perpetrator's depression. In both reports, these circumstances are not expanded upon.

Specific concern was raised with regards to the child perpetrators in Case 9. One of the 14 year old perpetrators had previously attempted suicide. It was acknowledged that both had previously lived in homes with extreme domestic abuse. Both children also had difficult relationships with their father and had spent time in care.

Perpetrator 2's mother had died when he was young and at the time of the homicide, he lived with his aunt.

There appears to have been complex dynamics between the perpetrators in Case 9 and their parents. Perpetrator 1 had been hit by her mother in the past and removed into foster care as a result. Before the murder, she had complained of being hit a second time, but this was not pursued by authorities.

Perpetrator 2's father had been in prison for abusing his ex-wife. When he was released, no parenting assessment was made. Agencies later considered Perpetrator 2's father as unable to provide 'adequate supervision' to his children. Despite this, he was allowed to take them on a boating holiday from which Perpetrator 2 ran away and was returned to his aunt. As a result, the difficult homelives of the two teenage perpetrators could be seen to contribute to their vulnerabilities.

Some issues arose in Cases 7 and 9 regarding services that are provided for diagnosed mental health issues compared to situations when someone has psychological problems. In the latter situation, these support services were lacking. Similar conclusions were drawn with regards to mental health, psychological and social support for young adults. This was particularly apparent in Case 9 regarding the perpetrators and Case 10 regarding Becky the victim.

In Cases 2 and 3 there is note that the perpetrators had convictions related to alcohol. After the homicide in Case 2, defence evidence suggested the perpetrator had an alcohol and drug problem. In Case 4, the DHR states that the GP practice was aware that the perpetrator was drinking more alcohol than he should, but this was not explored in the DHR as any form of addiction.

In Case 8, there is mention of the perpetrator living at a friend's house at some point. The friend asked the perpetrator to leave after finding alcohol and drugs behind the sofa. Beyond these instances, there is no indication in the DHRs that perpetrators had any significant alcohol or drug dependencies.

Generally, little detail is provided on the perpetrators' childhoods. However, the perpetrators in Cases 2, 9 and 10 had previously been in care (four in total). Further, Perpetrator 2 in Case 10 had previously complained of rape as a teenager whilst in care. However, at the time, police did not pursue the allegation.

Relationships between victims and perpetrators

The relationships between perpetrator(s) and victim varied. Nine perpetrators were intimate partners of the victims, with six of those being husbands of the deceased. In the cases of married couples, 5 DHRs provided information regarding the duration of the marriage: 8 years (Case 5), 'Over 50 years' (Case 4), 69 years (Case 11), 51 years (Case 12) and 55 years (Case 14).

In two cases where the victim was killed by more than one person, the accomplice was the partner of the victim's sibling (Cases 9 and 10). In the third case where there was more than one perpetrator (Case 3), there is some evidence to suggest that the female accomplice may also have been in a relationship with the victim's intimate partner.

In two cases, the perpetrator was the victim's daughter and in two cases, the perpetrator was the victim's father.

Table 4. Perpetrator Relationship to Victim.

Case	Perpetrator(s) relationship to victim
1	Daughter
2	Intimate Partner
3	1 Intimate Partner & 2 Acquaintances
4	Intimate Partner (Husband)
5	Intimate Partner (Husband)
6	Intimate Partner (Husband)
7	Step-Grandson
8	Daughter
9	Sister & Acquaintance (Partner of Perpetrator 1)
10	Step-Brother & Acquaintance (Partner of Perpetrator 1)
11	Intimate Partner (Husband)
12	Intimate Partner (Husband)
13	Father
14	Intimate Partner (Husband)
15	Intimate Partner
16	Father

Perpetrator as a carer

One of the most worrying findings from this study is the number of homicides in which people are left to care for loved ones who have significant health problems and this ends in tragedy.

This is demonstrated in Cases 1, 4, 6 and 8. In others the perpetrator informally supported and/or cared for the victim. This is most apparent in Cases 11 and 14 and possibly Case 12. In the latter case, post-homicide, the relationship was deemed likely to be one of coercive control. The wife wrote in her diary about unbearable pain and wanting to end her life. Her husband however, was her only support as the couple lived extremely isolated lives.

In some cases, the perpetrator took on an official role as carer.

9/16 perpetrators were intimate partners of the victims

When vulnerable adults with significant health problems are killed by people who are either their official carers or who are in some way providing unofficial care or support, it raises significant questions around adult social care. This is particularly important with regards to older couples who would appear dedicated to each other. In these cases (4, 6, 11 and 14), loyalty and desperation appear to have played a role in the homicide. Whilst it is concerning that older people – some in their eighties and nineties - are left responsible for the care of their very vulnerable partners, it should be noted that in Cases 4, 6 and 14 it was highlighted that the couples were reluctant to accept professional help. In the relevant DHRs there was no meaningful conclusion on how this could be overcome in future cases.

It is notable that in the two cases where daughters killed a parent they were caring for (Cases 1 and 8), no carer's assessment had been made. In Case 14, the panel also noted the lack of carer's assessment.

Turning specifically to Case 8 as an example, the victim originally had professional carers who had raised concerns about the condition of the home he shared with his daughter – particularly how unhygienic it was - but these had not been pursued by more senior management. As the victim was bedbound, his daughter was responsible for looking after his pets and providing some of his care (later and at the time of his death, she provided all of it). Some of the concerns raised by carers resulted in the RSPCA removing pets from the house due to 'inadequate care.' Perhaps surprisingly, the home environment and care provided by the daughter was not suitable for animals, but was considered suitable for the victim. In this DHR the panel noted that the victim may not have suffered a violent death if, amongst other things, a robust carer's assessment had been made and he had been provided with better living conditions.

Whilst in Case 13, the perpetrator was not a 'carer' for the victim in the sense applicable to the above mentioned cases, he was her father. As such, he was responsible for her care and wellbeing.

The parallels between this case and those above relate to the vulnerability of the victim and the trust typically inherent in the child-parent relationship. Such trust may exacerbate the child's vulnerability and make her more susceptible to being physically overpowered during the act of suffocation.

History of previous abuse between the parties

With the exception of the cases in which the victim was aged between 20 and 40, there is typically no pattern of behaviour between the parties that is investigated, documented and confirmed as domestic abuse. In other words, in the cases involving victims aged 16 and under, and those involving people aged 60+, there was no formal pre-homicide recognition within agencies that there was domestic abuse between the parties concerned. However, this did not always mean that no domestic abuse existed within the family setting; rather that professionals were not always exercising professional curiosity or acknowledging the myriad ways in which it can manifest.

In Cases 4, 6, 11 and 14, there was no previously reported domestic abuse of any kind, nor did the suspects/perpetrators have any criminal record or history of violent behaviour.

In Cases 1 and 8, whilst there was no evidence of previous domestic abuse per se, the DHRs mentioned issues that could have been more closely considered by professionals. For example, before his death, a complaint had been made to the police about the daughter in Case 8 financially abusing her father, and in Case 1, the mother had been to hospital several times with injuries following falls, yet no falls assessment was made. Although the exact circumstances of these incidents remain unknown, the point is that a demonstration of more professional curiosity may have helped eliminate any post-homicide questions around previous domestic abuse.

With regards to Cases 7, 10, 12 and 13, agencies had not specifically noted nor investigated any claims of domestic abuse between the parties. However, within the DHRs there is evidence of domestic abuse, but it had not been considered nor explored as such by agencies. For example:

- In **Case 7**, the perpetrator had previously threatened to kill his brother and confronted him with a knife.
- In **Case 10**, the second perpetrator was in care and was only 15 when she began a relationship with the first perpetrator, who was 22 at the time. Agencies noted the controlling behaviour of the first perpetrator towards the second, particularly when she became a mother in her teenage years, yet no action was taken.
- In **Case 12**, prior to the homicide, the adult son had made a complaint to the police about his father regarding non-recent physical and emotional abuse. Although he did not pursue the allegation, there seems to have been no action taken by police. The son described his father as a 'monster' and the DHR panel considered the husband was likely to have been coercively controlling his wife.
- In **Case 13**, the daughter's parents had previously been involved in a domestic incident and the police were called. However, attending officers did not query whether a child was in the home, nor did they consider whether the incident would impact the child's welfare.
- In **Case 9**, both perpetrators had grown up in families which had been subjected to considerable domestic abuse. The DHR highlights the impact of this on the perpetrators as children had not been fully explored prior to the homicides. Further, Perpetrator 2 lived with his aunt and agencies were aware that she struggled with his behaviour. He was known to direct his frustrations towards her and his siblings and had been violent in the home, for example by "smashing a door with a cricket bat." The DHR notes that agencies did not recognise or explore this as a potential form of domestic abuse even though the aunt did at times request professional support.

In the cases where the victim was aged between 20 and 40 (Cases 2, 3, 5 and 16) there had been previous domestic abuse.

In Case 2, the victim had not reported it to police, however, the perpetrator did have a history of violence towards others, including a former partner. The latter situation included a complaint to the police for non-fatal strangulation, categorised in the DASH as 'medium risk' and not pursued as the ex-partner had left the relationship.

In Case 3, there was one incident in which Perpetrator 1 was suspected of abusing both the victim and Perpetrator 2 during the same event. This included Perpetrator 1 grabbing Perpetrator 2 by the throat and threatening to kill her. This was categorised in the DASH as 'medium risk'. Despite both women retracting their statements, the police pursued the case to trial and it resulted in a restraining order.

It is worth noting here that it is questionable whether non-fatal strangulation incidents should ever be categorised as only 'medium risk.' Such acts demonstrate the perpetrator's propensity for extreme violence and the vulnerability of their victim to being immobilised and physically overpowered. Whether agencies take non-fatal strangulation seriously enough when completing the DASH risk assessment is a subject worthy of further exploration.

Previous non-fatal suffocation between the victim and perpetrator

What is notable in these DHRs is the lack of previously reported non-fatal suffocation between the victim and perpetrator.

In this cohort, there is no indication that the method of killing was a form of violence used by the perpetrator (non-fatally) in any other circumstance.

Even when violence did exist previously between the parties, it was not noted in any of the DHRs that non-fatal suffocation formed any role. In other words, in this cohort, there is no indication in the DHRs that based on previous behaviour, suffocation is the mode of killing the perpetrators would adopt.

Victims and perpetrators declining support

As has been touched on above, although many of the parties subjected to the DHRs had various issues or vulnerabilities in their lives, people were not always open to accepting support and some actively refused it. It is undoubtably difficult for professionals if vulnerable people to do not accept help when they need it. However, in the relevant DHRs, no suggestion was made as to how this may be overcome and no recommendation was made on how to best support vulnerable people – and staff – in these situations.

Further, when people did not turn up to scheduled medical appointments they were often discharged from the service. In Case 8 for example, the victim had frequent urinary tract problems due to the use of a catheter. When he did not turn up to his medical consultations, no attempt was made to discover the reason. This was despite the fact that he was bedbound and completely reliant on his daughter to inform him of the appointment and take him to the hospital. In such situations this again raises the issue of a lack of professional curiosity and systemic capacity to respond to individual needs.

Outcome for perpetrators

Eight perpetrators were convicted of murder, five of manslaughter, five took their own life, one was unfit to stand trial and therefore a trial of facts was conducted, and one person was released without charge.

In four of the five cases in which the perpetrators took their own lives, the circumstances of the offences were very similar. In Cases 4, 6, 12 and 14 the perpetrators were all in the 60+ age category (in three cases the perpetrators were in their eighties) and had killed their long term wives. In Cases 6 and 12 the suicides had taken place shortly after the homicides.

In Cases 4 and 14, the husbands' initial suicide attempt failed, but they took their own lives at a later date. In Case 13, the husband had fled the country after killing his wife and daughter before taking his own life at a friend's house.

It is unknown whether homicide-suicide is more prevalent in cases of suffocation as opposed to other forms of killing. Similarly, it is unclear whether it appears more frequently when perpetrators have certain demographics, for example they are male, or from a certain age group. The consequences for perpetrators varied along the spectrum of possible outcomes. On one end were Cases 3 and 10 in which perpetrators received prison sentences of 32 and 33 years respectively. This likely reflected the very cruel and pre-meditated circumstances of the murders. On the opposing end, was one person who was released without charge. Of interest is Case 8, in which a murder conviction resulted in a short sentence of four years. This may be linked to the judge's acceptance that he believed the murder was an 'act of mercy.' Notably three perpetrators received hospital orders (including one with restrictions) indicating very serious mental health difficulties.

The variation in sentences reflects the sensitivity of the law to the complex circumstances that can often surround domestic suffocation homicides. It demonstrates how some of these homicides can incorporate brutality but others are acts of desperation. When people experience serious mental health problems (Cases 1, 7 and 15) or are left to support/care for loved ones (Cases 4, 6, 12 and 14) and professional support services are lacking, this cohort indicates that the circumstances may lead to tragedy.

Table 5. Outcomes for perpetrators.

Case	Outcome/conviction	Sentence
1	Pleaded guilty to manslaughter	Indefinite hospital order
2	Pleaded guilty to murder	17.5 years imprisonment
3	All 3 perpetrators convicted of murder	All 3 perpetrators sentenced to 32 years imprisonment each
4	Suspect took own life	N/A
5	Convicted of murder	12 years imprisonment
6	Suspect took own life	N/A
7	Pleaded guilty to manslaughter	Hospital order with restrictions
8	Convicted of murder	4 years imprisonment
9	2 perpetrators convicted of murder	2 perpetrators sentenced to 20 years imprisonment each
10	Perpetrator 1 convicted of murder/Perpetrator 2 convicted of manslaughter	33 years imprisonment/ 17 years imprisonment respectively
11	Convicted of manslaughter	1 year imprisonment suspended for 2 years
12	Suspect took own life	N/A
13	Suspect took own life	N/A
14	Suspect took own life	N/A
15	Trial of facts* (not criminal trial) in which the jury agreed the suspect had carried out the relevant act	Hospital order
16	Released without charge	N/A

** A trial of facts takes place when the defendant is unfit to stand trial due to a relevant disability. It is not a criminal trial in which the person is found guilty or not guilty. Instead it is a determination of the facts and the jury decide whether the person carried out the alleged acts.*

Missed opportunities, learning lessons and recommendations

Within the DHRs analysed there was no uniform way in which relevant missed opportunities, lessons or recommendations are presented. Sometimes missed opportunities are discussed, in other reports they are combined with a general discussion. In some DHRs there is a table in which the recommendations are presented, which can aid clarity. Nevertheless, it is generally difficult to extract this information from a DHR. Even if a DHR clearly presents recommendations, there is typically no indication in the document as to whether those recommendations have been acted upon. Consequently, any impact of the DHR on domestic abuse/homicide remains unquantifiable.

The quality of detail regarding missed opportunities, lessons learned and recommendations varies. Case 7 for example, details the perpetrator's mental health problems, the attempts his mother had made when he was a child to secure support and his continual disengagement with services.

On remand for the murder, the perpetrator put another prisoner into a permanent vegetative state, was subsequently diagnosed with paranoid schizophrenia and was finally sentenced to a hospital order with restrictions. The judge specifically stated that it is possible the perpetrator may never leave the hospital. However, there were no lessons learned or recommendations suggested with regards to mental health agencies.

Instead the DHR focused on the behaviour of care home staff on the day of the homicide and suggested a public health awareness campaign to spread awareness about, and to destigmatise, paranoid schizophrenia.

Consequently, it is difficult to reconcile the facts of the case with the lessons learned and recommendations.

Improved record keeping is a factor that appeared in Cases 2, 4, 5, 8, 10 and 15. This is symptomatic of some of the wider issues that DHRs are unable to challenge. For example, failure to record interactions adequately may be linked to understaffing, stretched resources and thus inadequate funding from local and national government.

However, these are not issues raised in the DHRs in this cohort. Instead frontline staff and services are often pinpointed as requiring improvement. Whilst undoubtably there may be instances where frontline staff could do better, these recommendations are never in the context of much wider societal problems.

'Lack of professional curiosity' is a phrase that emerges in three of the reviews (Case 8, 10 and 14). Similarly a lack of carer's assessments was noted in Cases 1, 8, 9 and 14. This resulted in vulnerable adults being cared for by people who had their own difficulties. Given that the earliest of these DHRs was published in 2017, it is questionable whether lessons are being disseminated appropriately.

It is worth considering whether the focus of DHR panels and the framework in which they work operates successfully. For example, in Case 11, the focus of the review was to understand whether "there had been evidence of abuse in the relationship and what barriers there were to reporting such abuse". Invariably, this colours the lessons learned and the recommendations. Given that the couple appeared completely dedicated to each other and there had been no evidence of abuse, it meant that opportunities to explore other factors were not taken. Notably, the homicide appears to have been triggered by an upcoming move for the couple into a care home. Whether they wanted to enter the care home is unexplored as is whether they were happy with the choice of home selected. Equally, it is not understood whether the couple would need to be separated in the home or whether they would continue to share a room.

Such issues are unconnected to domestic abuse and relate more to the way in which society supports (or not) older people in a major life transition.

Quality and Consistency of Reviews

As has already been noted, the quality of the reviews varied considerably. Case 10 is just an executive summary. Cases 5, 6 and 11 have scant details. More specifically, Case 6 appeared to include a Learning Event for the panel and staff involved in the case. As a result, the DHR is lacking in detail as it seems the sharing of learning took place beyond the pages of the DHR.

The lack of demographic detail within DHRs is concerning. There should be a requirement that this information is included in a DHR. This would enable a better understanding of whether ethnicity and cultural background contributed to the homicide, and importantly whether it hindered the people involved in the case from seeking help and support. Whilst DHRs are not written for the purposes of researchers, collectively they provide a body of data that is useful in understanding trends and patterns. Failing to document basic demographic data hinders this and thus undermines the chance of learning lessons from such a large body of publicly available reviews.

The use of pseudonyms was not uniform in the reviews. In Case 14, it was unclear if the victim and perpetrator had even been anonymised. Whilst it may be understandable that there will be some concern over protecting the identities of the parties, domestic homicide is so shocking that these cases are typically reported in the press.

'Lack of professional curiosity'

As a result, anonymising the victim and perpetrator becomes futile. More frequently, this only serves to confuse the reader of the DHR if terms such as 'Adult A' are scattered throughout the document. It also makes it difficult to report any analyses of DHRs as there is no consistent approach to the naming of the parties involved.

It is interesting that in eight cases, the Independent Chair was a former police officer. None of these Chairs reported ever having previous contact with the parties involved or the homicide investigation, and there is no suggestion that they lacked independence in any way. However careful consideration should be given about former police officers investigating and judging the decision making of other officers. This is particularly important in DHRs where the Chair is considering the behaviour of former colleagues from the police force in which they had previously been employed.

Four families declined to be involved in the DHR of their relative (Cases 11, 12, 13 and 16). When families decline to be involved in a DHR it raises questions around the general process of the review, the perception families have of that process and why that would be the case. It may be that families predict the process will be retraumatising and it is questionable as to what support is provided to families who do engage. The involvement of the perpetrator may also be perceived as problematic by the family or it may be that families are sceptical of the impact a DHR will have on wider practice. Whatever the reasoning, better understanding of why families disengage may assist in improving the DHR process for all those involved.

Summary and key recommendations

DHRs are not written for research purposes. However, their overall objective is to share learning and prevent future domestic homicides. Ideally therefore, DHRs should be consistent, uniform, easily accessible and of a high quality. Lessons cannot be learned if reviews lack detail, are poorly written or the public and professionals are unable to locate them. Perhaps surprisingly, although the Home Office has recently begun a library of DHRs, IFAS has found no database in which all DHRs are listed or housed. Worryingly, it is unknown how many have even been carried out.

The DHRs in this report indicate that suffocation is a phenomenon that may be different to other forms of homicide. Although some cases reflected the cold blooded brutality of typical forms of domestic abuse, there were also examples of desperate husbands struggling to support and/or live apart from their vulnerable and unwell wives. However, given that there were no cases in this analysis of older women killing their vulnerable husbands in this way questions must be raised around differences in men and women's ability to cope with caring responsibilities and the potential contributing factors to this. These examples reflect problems in adult social care and do not represent the typical pattern or understanding of domestic abuse.

Based on this report, IFAS has made the following recommendations:

The DHR system must be greatly improved.

DHRs must contain clear information on victim and perpetrator demographics, particularly age and ethnic/cultural background.
Information must be given on the lead up to and the circumstances of the homicide.

Consideration must be given as to whether the 6 month timeframe for the completion of a DHR is realistic. Consideration must be given to the appointment of former police officers to act as Chair of a DHR, particularly when they are required to analyse the behaviour of officers in their former force.

Questions arise when families refuse to engage with a DHR and this warrants further general exploration.
It is questionable whether the anonymisation of DHRs continues to serve any useful purpose. Cases are typically reported in the media thus undermining any attempts at maintaining the anonymity of those involved.

The phenomenon of suffocation domestic homicide must be better understood.

Our analysis indicates that suffocation domestic homicides incorporate specific nuances that may not be apparent in other forms of homicide. This includes older adult victims who may have terminal illnesses, dementia or other vulnerabilities. Our analysis also suggests that there is a cohort of older perpetrators of suffocation domestic homicide. It is questionable whether this is reflected in other modes of killing. These points require further investigation.

This report demonstrates that often suffocation domestic homicides do not reflect the typical pattern of domestic violence. So called 'mercy killings' may be symptomatic of poor adult social care services and a failure of society to fully support families caring for relatives.

Mental health issues feature in many of the DHRs in this review.

Government must ensure adequate resources for mental health support, particularly for young adults.

One issue that arose in this review was the refusal of people to engage with support and/or health services.

Whilst it is understood that in many circumstances people do have the right to decline care and support, research enquiring into this phenomenon would assist in creating guidelines and support for staff confronted with this issue.

In this cohort there were two examples of non-fatal strangulation being categorised as 'medium risk' on the DASH questionnaire.

At IFAS our view is that NFS incidents warrant a high risk categorisation regardless of the score on formal risk assessments. Further, those conducting risk assessments should use their professional judgement to refer to MARAC (multi-agency risk assessment conference) and ensure the relevant agencies are involved.

It is notable that in none of the cases in this review had there been earlier reports of non-fatal suffocation.

In this cohort, the mode of killing did not reflect the previous behaviour of perpetrators, even when their history included violence.

This report offers an insight into suffocation domestic homicides. It has revealed that this form of killing often includes both vulnerable victims and perpetrators. Our analysis serves to highlight inadequacies in mental health services and adult social care, in addition to flaws in the DHR process and final publication. Our report is a starting point for further research on the phenomenon of suffocation homicide and seeks to better understand and challenge homicide caused by domestic abuse.

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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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