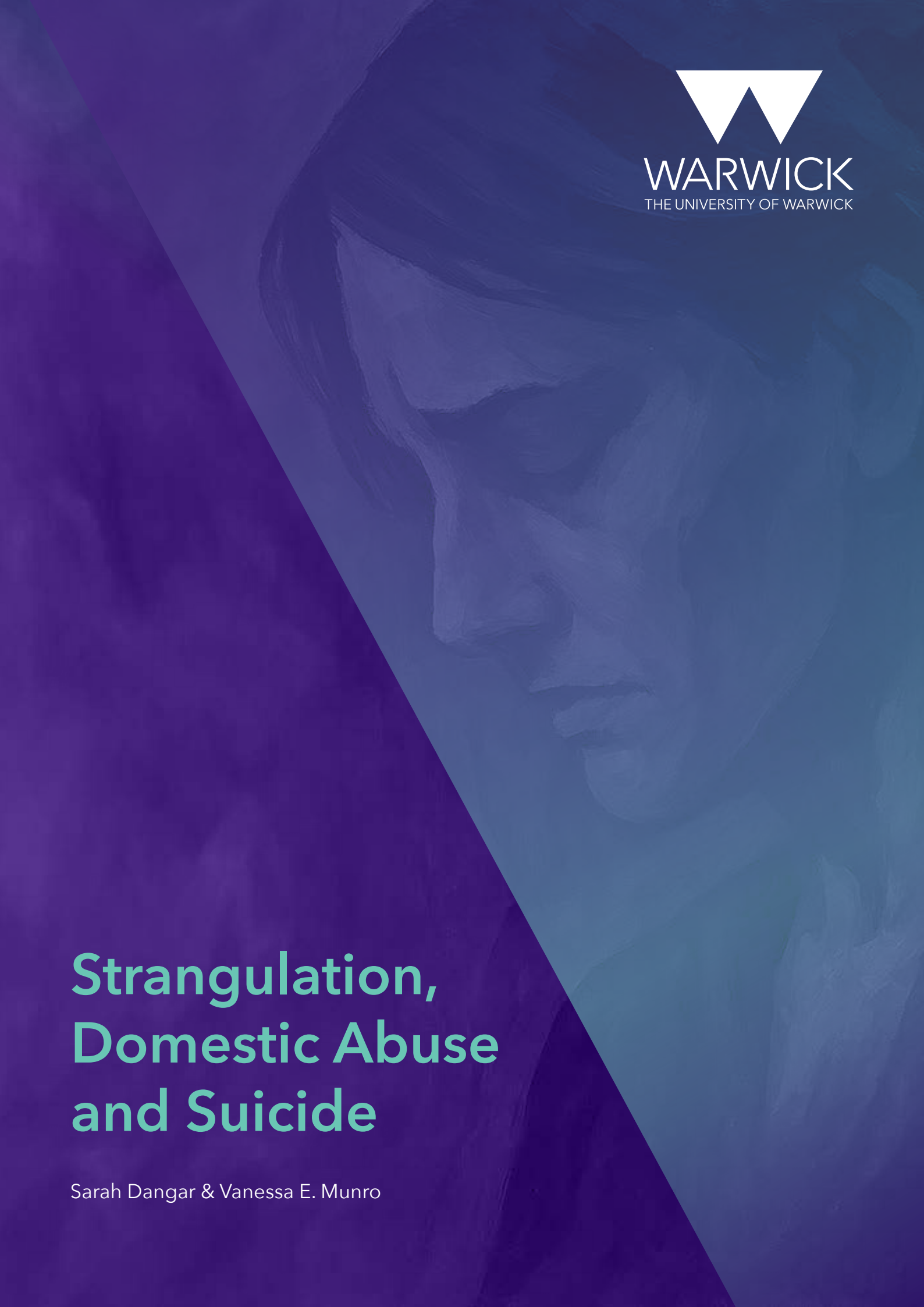

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Strangulation, Domestic Abuse and Suicide

Sarah Dangar & Vanessa E. Munro

At international and domestic levels, the incidence of non-fatal strangulation or suffocation in intimate partner relationships has been well-documented (Zilkens et al, 2016; Pritchard et al, 2017; White et al, 2021; Brainkind, 2024), with it suggested to be particularly prevalent in abusive relationships that involve coercive or controlling behaviour (Stanfield & Williams, 2021; Hoeger et al, 2024).

Equally, behaviours such as 'choking' or 'breath play' have become increasingly normalised, particularly amongst young people (Herbenick et al, 2022; Sharman et al, 2024). This is often framed as an expression of sexual autonomy, sometimes even where it occurs in more broadly coercive or violent relationships (Douglas & Fitzgerald, 2020; Douglas et al, 2024).

The risks associated with this behaviour are significant. Prior experience of non-fatal strangulation is a reliable predictor of future fatality amongst victims of abuse (Glass et al, 2008; Websdale, 2019; McGowan, 2024). Though it does not always result in visible physical injuries (Strack et al, 2001: Zilkens et al, 2016; White et al, 2021), other impacts include bruising around the site of pressure, incontinence or loss of consciousness. Longer-term difficulties in swallowing and breathing, and an increased propensity to haemorrhaging or strokes have also been identified. It can cause hypoxia, resulting in brain injuries that manifest in headaches, anxiety, Post Traumatic Stress Disorder, depression or difficulties with memory, concentration and rational processing (Bichard et al, 2022; Foley, 2015; Funk & Schuppel, 2003; Brainkind, 2024).

Research has begun to explore the adequacy of responses to non-fatal strangulation, including in terms of professional identification, risk-assessment, and safety planning, as well as criminal justice interventions. In England and Wales, attention has focused on the improvement, if any, following the introduction of bespoke offences in June 2022.[1]

Though this has brought some progress (Bows & Herring, 2024), concern remains regarding statutory and voluntary sector responses. Analysis of learning reviews conducted following a domestic abuse-related death has highlighted shortcomings in professionals' triage and treatment of victims who experienced non-fatal strangulation (McGowan, 2024). Meanwhile, of the nearly 24,000 offences recorded by police between June 2022 and June 2023, only 13% resulted in a charge or summons, with evidential difficulties being deemed to preclude prosecution in 67% of cases (Smailes, 2024).

Much existing work has focussed on whether non-fatal strangulation or suffocation is identified and responded to with a degree of urgency and concern that reflects the homicidal risk posed by perpetrators. Despite growing recognition of an increased risk of suicidality amongst victims, there has been less attention afforded to the adequacy of professional understanding of this impact and the extent to which it is, or can be, accommodated in safety planning or support interventions. By looking specifically at the incidence and impacts of experiencing non-fatal strangulation, reflected in reviews of domestic abuse-related deaths by suicide in England and Wales, this study was designed to provide a more evidence-based framework for evaluating agency responses and identifying how practitioners could be better equipped to support victims (for further detail regarding our aims, methods and key findings, see Munro & Dangar, 2025).

1 s. 75A Serious Crime Act 2015, as amended by s.70(1) Domestic Abuse Act.

What Did We Do?

From May to July 2024, we collated two datasets.

First, a sample of reviews - formerly Domestic Homicide Reviews (DHRs) and recently renamed as Domestic Abuse Related Death Reviews (DARDRs) - completed in England and Wales in cases where a victim of domestic abuse died by suicide. These, by definition, represent only a proportion of suicides that occur in this context, but they provide useful and – sometimes, detailed – insight into domestic abuse histories and agency interactions.

From a dataset of 70 reviews, which captures at least a significant proportion of publicly available DHRs/DARDRs completed in suicide cases to date, we extracted a subset of 32 in which non-fatal strangulation or suffocation was identified in the abuse history.

Our second dataset was comprised of semi-structured interviews with professionals (n=20) across a range of sectors, all of whom had familiarity with the identification, handling and impacts of non-fatal strangulation or suffocation. We also conducted one interview with a family member bereaved by suicide in the context of a domestically abusive relationship that involved non-fatal strangulation.

That participant was recruited via Advocacy After Fatal Domestic Abuse (AAFDA) as an intermediary to ensure appropriate specialist support. All interviews were conducted online and recorded for subsequent transcription and analysis by the researchers.

Professional Role	Participant Numbers (21)
DHR/DARDR Chair	6
Other DHR/DARDR/CSP Professional	3
Specialist DA Professional/Advocate	6
Healthcare Professional	2
Justice Professional	3
Bereaved Family Member	1

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(Institute for Addressing Strangulation, 2024)

What Did We Find?

Prevalence and Contexts of Non-Fatal Strangulation

All our interviewees agreed that non-fatal strangulation was being more frequently encountered in their professional practice. Estimates varied, but it was said to be common in DHRs/DARDRs, featuring in 30%-50% of cases, regardless of whether death was by homicide or suicide.

> This correlates to our review sample, where **46%** (n=32) involved recorded incidents of non-fatal strangulation.

The gendered nature of non-fatal strangulation within abusive relationships was highlighted. Across our sample, in all cases where the deceased was female (n=28 of 32), strangulation was perpetrated by a male partner. In those cases where the relationship between the parties at the time of death was documented, 6 were married, 6 were cohabiting, and 8 had separated. In only one case (DHR20) did strangulation occur outside of an intimate partner relationship, involving abuse perpetrated by the deceased's brother. In some instances, strangulation was presented as an isolated incident, whilst in others it was recognised as a repeated occurrence. Men's greater physical strength often appeared to assist them in executing acts of strangulation or suffocation which involved, variously, holding down by or grabbing at the throat; use of a belt, rope or cable around the neck; pulling clothing over the mouth and throat; pushing the head into carpet or under water; or applying pillows over the face. In 13 of the 32 reviews, the deceased's partner had previously been reported, investigated or convicted in relation to criminality, often including domestic abuse, stalking or harassment, with reports of prior non-fatal strangulation.

Interviewees underscored that there is no 'template' for the occurrence of non-fatal strangulation. In some cases, it can be a routinised experience in relationships marked by systematic abuse and violence. In DHR10, for example, the deceased disclosed constant arguments and violence in her relationship, which also involved psychological control and financial abuse. In the panel's report, it was noted that she disclosed that her partner "physically assaulted her by grabbing her around her throat to strangle her on a few occasions."

Meanwhile, in DHR09, it was noted that "there were 26 disclosures relating to suspected or reported domestic violence, most of which were of significant harm, including strangulation to the point where [she] lost consciousness."

This violence involved punching and kicking, hitting her with a metal object, and making threats to her life. Though, when asked, the deceased had maintained that the strangulation was consented to, her diary stated: "one night during sex I felt his hands around my neck … Progressively sex got rougher and the more I fight back the more he enjoys it."

At the same time, professionals emphasised that non-fatal strangulation can be deployed as a tactic to establish control early in a relationship, unrepeated until an abuser feels that control is imperilled; or can reflect a sudden shift in behaviour in response to a lack of control. P1 (DA Professional) explained: "there's two experiences that I've seen. One where strangulation is something that is a form of violence being used alongside other forms of violence. Not that it becomes normalised but it's often that people have experienced it more than once … The other is where there's been no prior physical abuse. And it is a really big jump, a really big escalation in violence. The things that I've noticed about those experiences in the second group is the perpetrator's loss of control over the situation." In DHR19, for example, the (female) deceased described her (male) partner's behaviour as "controlling and psychologically abusive, but not violent." Nonetheless, the review reported that, on the day of her suicide, he had "come up behind her, put his hands around her throat and said 'I can tighten'." This suggested a deliberate tactic, if not to remind her of a prior experience of strangulation, then to underscore her vulnerability to it.

Disclosure and Professional Identification

Interviewees highlighted ongoing, and often substantial, barriers to disclosure amongst victims. One barrier thought to be particularly significant was the absence of visible, corroborating injuries. As P4 (DHR/DARDR Chair) put it, "if you've got physical signs and bruising … being able to take that to the police or another agency might be easier." Likewise, others highlighted that loss of oxygen to the brain can diminish victims' ability to form memories, making "the cognitive impacts a huge barrier" (P7: DA Professional). P21 (Family Member) reflected on the implications of this. She reported that, following an attack during which she was strangled to the point of unconsciousness, her daughter called the police, but the attending officer was "quite disbelieving," commenting that "she hasn't got much marks around her neck" and describing the report as "a bit wishy-washy." As a result, she felt they failed to conduct a thorough investigation.

Some interviewees suggested there can be a sense of "shame," "humiliation" or "embarrassment" (P8: DA Professional), whilst others highlighted that, for some victims, strangulation is "so tied up with other acts of violence that they actually don't themselves distinguish that this is something of real severity" (P15: DA Professional). This was reflected in the language used by victims during disclosures, which could be vague, minimising or euphemistic. P2 (DHR/DARDR Chair) reported that, even when directly asked if they had been strangled or suffocated in risk assessments, victims often provided equivocal responses:

> "more of a, well, no, not really, but sometimes he holds me up against the wall and puts his hands over my mouth or puts a pillow over my face when he doesn't want me to talk."

In DHR08 in our sample, in making a complaint of rape to police, the deceased simply intimated that "the relationship was not right." On further questioning, though, it was noted that she "stated that [partner] had never physically hurt her but went very quiet when further prompted and disclosed that he had put his hands around her neck on two occasions but 'not for long though and he did not squeeze my throat'."

Interviewees emphasised the importance of professional curiosity:

> "it comes down to … hav[ing] the courage and wherewithal to ask the questions because if [the victim] isn't asked the question, she probably won't tell you" *(P17 (DHR/DARDR Chair)).*

But several worried that it could be "overwhelming for practitioners" to "hear someone talk about fearing for their life" (P18 (Healthcare Professional)), and so "professionals shy away from it" (P13 (DA Professional)). Interviewees also highlighted that the spaces and places in which victims are expected to disclose - for example, hospital A&E departments or GP surgeries - are often profoundly ill-suited.

Siloed Responses and System Failures

A siloed approach to service provision and justice responses across domestic and sexual abuse was identified as a particular challenge, posing the risk that "because strangulation overarches both, it tends to fall through the gaps" (P13: DA Professional).

More broadly, interviewees worried that professionals – particularly amidst substantial resourcing challenges – might be disinclined, or unable, to work with women navigating complex needs to elicit and respond to disclosures. P5 (DHR/DARDR Chair) highlighted cases where agencies positioned victims as 'difficult to engage' or not desiring support when they developed "coping mechanisms," including use of drugs and alcohol or tactics of acquiescence to manage partners' volatility. P21 (Family Member) was clear that her daughter's use of alcohol to cope with the trauma arising from abuse had significantly impacted on professionals' treatment of her prior to her death: "they were very judgmental."

> Across our sample, we found evidence of victim mental ill-health diagnoses in 26 of the 32 reviews, drug or alcohol dependency in 22, and financial or housing precarity in 20. There was evidence of prior suicide attempts and suicidality on the part of the deceased in 17 cases, accompanied in 13 reviews by other forms of self-harm, and in over one-third of cases (n=11), the deceased was concerned about social services interventions or otherwise losing custody of children. In 14 cases, there was evidence indicating they had been subject to domestic abuse by previous partners, and in 10 cases there were reports of them experiencing abuse or trauma during their childhood.

Despite this prevalence of complex needs and vulnerabilities, there were several examples of agencies failing to engage empathetically with victims – for example, in DHR06, where the deceased was described as "deliberately evasive" and "often difficult" when she ceased cooperating with a criminal investigation after police and social services took action to remove her children from her custody. Though it is clearly important to ensure the safety of children at risk, there was little evidence of recognition amongst professionals here of the ways in which this might reduce the deceased's ability and willingness to disclose information regarding abuse.

Professionals' Risk Assessment and Safety Planning

Some interviewees felt there had recently been an "enormous shift" (P20: Justice Professional) in terms of identifying strangulation as a risk factor, while others remained unconvinced about the extent to which this was consistently taken on board. P15 (DA Professional) reflected that, in their experience,

> "this is still largely not on professionals' awareness" and that "it is quite startling actually how few people recognise [non-fatal strangulation] as a serious risk indicator."

A tendency to trivialise the risk involved by relying on minimising language was often highlighted. P21 (Family Member) recounted being "shocked" to discover that police described incidents reported by her daughter as "[partner] had his hands around her neck while forcing himself upon her," which she felt was a "polite, non-committal" sanitisation of the brutal reality that "he was trying to strangle her while raping her."

We identified several cases in our sample where such language was relied upon, and rarely challenged. In DHR16, police repeatedly used the phrase "grabbed her by the throat" and referred to the perpetrator's "attempted choking". In DHR15, a series of reports were made to police, which included the deceased's partner breaching bail conditions that required him not to contact her. Nonetheless, in recording one such incident, the police simply said: "[partner] had kicked the door in and put his hands around [victim's] throat."

Understanding the Range and Severity of Impact

Interviewees reflected that the myriad physical, cognitive and psychological impacts of non-fatal strangulation were often still poorly understood.

Across our review sample, there was little consideration of longer-term physical impacts, for example, heightened risk of stroke or paralysis, or brain injury. Likewise, in a context in which strangulation could be a particularly "scary" or "significant" moment for victims (P1: DA Professional), there was a lack of reflection among professionals about the risks this might provoke in terms of emotional and mental health.

The ways in which, in a space of anxiety and trauma, the cognitive implications of brain injury resulting from strangulation might have a compounding impact on victims' reactions were also not well-acknowledged. P12 (Healthcare Professional) highlighted that the parts of the brain most vulnerable to damage play a key role in "emotional regulation, judgment, decision-making, and sort of social cognition and navigating relationships," which are "all the things you need in order to think your way out" of abusive situations. Thus, the "sense of being trapped, and the hopelessness of the situation" (P12) may be increasingly pronounced, in a context in which research has shown that - though trajectories to suicide are complex - feelings of isolation, entrapment, and hopelessness can be clear indicators of heightened risk (Munro & Aitken, 2020).

Though not surprising perhaps given our focus on suicide reviews, it is notable that in over **60%** of the cases in our sample (n=20 of 32) there was **documented evidence of suicidal ideation or prior suicide attempts.**

In DHR04, the deceased made a complaint against her ex-partner who attended her home and assaulted her, including by "holding his hands to her throat."

> Though arrested, he was released on bail, which provoked such acute fear that she said "it was like the magistrate had signed her death warrant." Shortly thereafter, she took her life.

That the strangulation was a significant moment in the wider chronology of abuse, after which the victim could not tolerate the risk posed by the perpetrator, was not reflected upon by the review panel.

There is much work yet to be done in understanding these connections, but what our analysis suggests is that, even to the extent that there may now be growing appreciation amongst professionals about non-fatal strangulation or suffocation indicating a heightened risk of homicide or physical injury, the potential for such experiences to also substantially increase victims' risk of self-harm or suicidality is not being recognised in delivering service responses.

What Can You Do?

Despite growing awareness of non-fatal strangulation in terms of its prevalence and risks, there is still inconsistency of practice that diminishes the prospects for identification and effective support.

A tendency for professionals to deploy euphemistic or minimising language in documenting incidents tends towards trivialising the potential impacts involved. A focus on physical injury and the risk of domestic homicide has also left too little space for reflection around emotional, cognitive and mental health impacts, which increase the likelihood of suicide.

A whole system approach which recognises that responding to non-fatal strangulation will often require multi-agency communication and cooperation is key.

This includes across both specialist domestic abuse and sexual violence services. All professionals should be curious in how they conduct risk-assessments, criminal justice investigations and medical examinations. They should cultivate environments and relationships of trust that will be conducive to disclosure, and ensure that data relating to the incidence and impacts of non-fatal strangulation is robustly captured. At the organisational level, patterns of victim attrition must be scrutinised to inform and improve support provision.

Further investment in training and service capacity is needed to assist professionals in these regards, and to empower them to identify and respond to the range of impacts and needs that experiencing non-fatal strangulation or suffocation might generate.

By taking these steps, it is hoped that suicides can be prevented. But **where death occurs, it is crucial that opportunities for learning and improvement are not missed**.

DHR/DARDR chairs and panel members have a vital role to play. P17 (DHR/DARDR Chair) noted that there can still be "a massive gap" in the detail provided "from the police and other domestic abuse agencies" in relation to strangulation. Chairs giving explicit direction to agencies, as part of setting terms of reference, to consider the existence and impact of strangulation in abuse histories can assist with this. More involvement of experts and a bolder approach to panel recommendations in this context would be beneficial.

> **Across our sample, the existence of, and professional responses to, NFS typically received cursory treatment in DHR/DARDR reports, and recommendations made by panels in this respect were often limited, vague or non-existent.**

In DHR06, for example, the panel concluded that the handling of the deceased's disclosures by police "showed good awareness and practice of their domestic abuse policy," despite their risk assessment only identifying her as at 'medium risk' when the police and review panel alike had previously acknowledged that the presence of non-fatal strangulation in her abuse chronology ought to have positioned her as high risk.

If domestic abuse-related death reviews are to provide meaningful 'learning legacies,' they must provide clear, specific, measurable and achievable recommendations for change in this context.

About the Authors

Sarah Dangar is an Independent Consultant with extensive experience in the domestic abuse sector. Having worked as Deputy CEO at Advocacy After Fatal Domestic Abuse, she is now conducting a PhD at City St George's, University of London on domestic abuse related suicide.

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