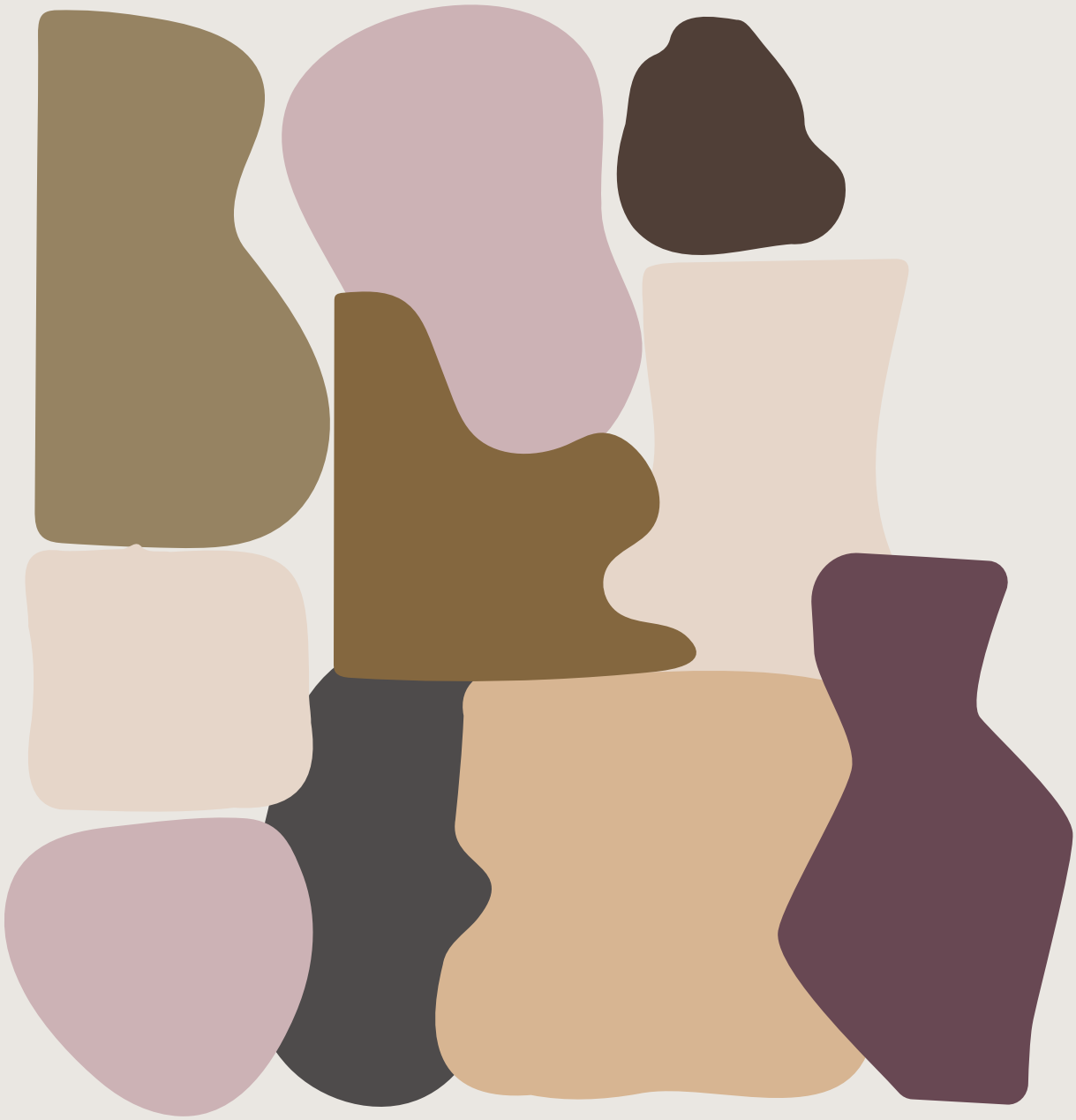
Family violence and women's deaths by suicide:

A Victorian study



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We acknowledge the lives of women who have experienced family violence and died by suicide, their family members, friends, and communities. It is our hope that this work can play a role in building the evidence base needed to prevent such deaths and advance the national conversation about the multifaceted nature of violence against women, its impacts, and fatal consequences.

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Contents

Acronyms

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and other drugs
CCoV	Coroners Court of Victoria
CI	Coroner's investigator
CIP	Central Information Point
CPU	Coroners Prevention Unit
DHR	Domestic Homicide Review
DFSV	Domestic, family, and sexual violence
FVISS	Family violence information sharing scheme
GP	General practitioners
SOCIT	Sexual Offences and Child Abuse Investigation Team
RCFV	Royal Commission into Family Violence
UK	United Kingdom
VSR	Victorian Suicide Register
VSRFVD	Victorian Systemic Review of Family Violence Deaths
WA	Western Australia

Executive Summary

Women's deaths by suicide in the context of family violence victimisation represent an important but often overlooked dimension of gender-based violence. Coroners and researchers in Australia and internationally are increasingly drawing attention to the intersection between women's lived experiences of family violence and their heightened risk of suicide. Currently, suicides related to family violence, including women's death by suicide in this context, are inconsistently counted in national statistics, obscuring the scale of the issue and limiting opportunities for targeted prevention and intervention.

In recent years, the Victorian coronial investigation process has revealed compelling evidence of the impact of family violence victimisation, in its myriad forms, on women's mental health and wellbeing generally and suicidality specifically. Drawing on the views of a small group of experts, this report aims to offer insights to inform better understandings of the risk of suicide among women who have experienced family violence victimisation and opportunities to support investigative processes to account for the relationship between family violence and women's deaths by suicide in Victoria. It also illuminates some of the opportunities for enhanced intervention and system responses across the family violence, mental health and justice systems.

Research design

This exploratory study used a qualitative research design to examine investigation processes relating to histories of family violence following women's deaths by suicide in Victoria, Australia. We conducted a background review of 12 published coronial investigations into women's suicides released between 2019 to 2024 where a history of family violence was identified or where this violence was suspected in the lead up to the death. This background review offered insights into the range of circumstances within which family violence was recognised in the context of women's deaths by suicide. This review also supported the approach to the interviews undertaken for this study, which are the focus of this report. Specifically, data collection involved in-depth interviews with 20 participants working in various roles across the family violence, health, and justice sectors, including professionals from Victoria and the UK. The exploratory design of this study has enabled us to identify key issues emerging in this area. It does not constitute a formal evaluation of current systems or processes, but the insights drawn from participants from a range of expert perspectives highlight critical considerations for policy, practice and resourcing. Specifically, the report illuminates a range of systemic challenges – as well as opportunities – for identifying and responding to women at risk of suicide, along with the issues that can arise in recognising the role and impacts of family violence prior to women's deaths by suicide.

Key Findings

The findings of this study aim to advance discussions about the connection between family violence victimisation and women's death by suicide, and to further conversations about the strengthening of systemic responses to women at risk of suicide. Our findings include:

The need to enhance understandings of the circumstances within which women with a history of family violence victimisation die by suicide.

Participants in this study recognised the profound impact of family violence victimisation – including coercive and controlling behaviours – on women's risk of suicide. There was an emphasis on the need for greater recognition of specific forms of intimate partner violence, including coercion to suicide, and the ways perpetrators may manipulate a woman's suicidality or identity as part of a pattern of control. The interviews also revealed the diverse contexts and pathways through which family violence victimisation may contribute to suicide risk, including feelings of entrapment, fear of the perpetrator, lack of help-seeking options, and the cumulative effects of violence – both during and after a relationship. Precipitating events, such as a perpetrator's release from prison, were noted by some participants, alongside the long-term impacts of family violence victimisation. Participants also identified that the connection between family violence and suicide may be missed because other presenting factors, such as drug and/or alcohol dependencies, are foregrounded as immediate and/or contributing factors.

Our findings point to the importance of sustained healing and recovery supports and underline the need for further research to deepen understandings of the complex and varied circumstances surrounding women's deaths by suicide. Interrogating the history and impacts of family violence victimisation through the coronial investigation process was positioned as a key avenue to continue to build evidence-based insights to inform early intervention and prevention practice.

The importance of continuing to explore the relationship between family violence victimisation and suicide within coronial processes.

Our findings in relation to how coronial investigations engage with histories of family violence victimisation in suicide cases identify some key challenges, including the underreporting of family violence victimisation. Some participants also raised questions regarding the way both proximity of circumstances and the cumulative impacts of victimisation over time are understood in the coronial investigation process. Our findings suggest that there may be opportunities to enhance evidence-gathering practices – such as through improved police training and information-sharing – and emphasise the value of drawing on a wide range of sources, including input from family members and friends, while acknowledging the complexities these engagements may involve.

The importance of improving risk assessment and management practices to more effectively prevent family violence-related suicides.

Our findings reflect the understanding that suicide risk for family violence victims is shaped by a complex interplay of individual, relational, systemic, and temporal factors, and that understanding the context of a woman's experience is central to providing effective and indeed lifesaving supports. Despite growing awareness of the mental health impacts of family violence victimisation, many participants drew attention to the need to better understand and respond to risk of suicide among women who present to the family violence service system. A key consideration raised was the importance of suicide risk indicators within family violence risk assessment and management processes, including the Victorian Multi-Agency Risk Assessment and Management (MARAM) framework to better support practitioners across the family violence, mental health, and justice sectors to recognise and respond to risks. Several participants suggested there may be opportunities to enhance risk assessment processes to more fully account for the cumulative impacts of coercive control, trauma, and the intersecting vulnerabilities that may elevate women's risk of suicide during and following family violence victimisation.

The need to strengthen cross-sector integration to improve suicide prevention efforts.

Our findings highlight the need for the family violence, justice, health, and suicide prevention sectors to be better supported to work together to ensure women at risk of suicide receive appropriate and timely intervention(s). Participants recognised the importance of viewing and responding to family violence victimisation, mental health, and suicidality as intersecting rather than separate issues; they also often highlighted the need for effective responses to family violence to be a core component of suicide prevention strategies. This requires further development with stakeholders across these service systems to map opportunities for greater integration and coordination of services and system responses. Strengthening cross-sector collaboration and data-sharing could also support more comprehensive understandings of women's risk pathways, facilitating earlier intervention and more effective support provision. There may also be opportunities to better utilise the coronial investigation process and its resulting recommendations to inform cross-sector collaboration and build evidence-based understandings of how risk identification, assessment, and management processes across sectors can prevent women's deaths by suicide. Systematic tracking of coronial investigation findings and recommendations and monitoring of their uptake presents an opportunity for further action in this area.

The need to address housing insecurity for family violence victim-survivors.

The lack of secure housing for family violence victim-survivors remains a significant issue in Victoria and emerged as a key issue in this study. Women and children escaping family violence in Victoria who seek emergency accommodation can be placed in motels, an option identified by participants as often unsuitable and unsafe for victims seeking crisis support, and as particularly harmful for those who may already be experiencing suicidal ideation. The urgent need for long-term, sustainable housing solutions was emphasised by Victorian participants interviewed, alongside the need to move away from a reliance on emergency motel accommodation.

The importance of prioritising early intervention for children and young people.

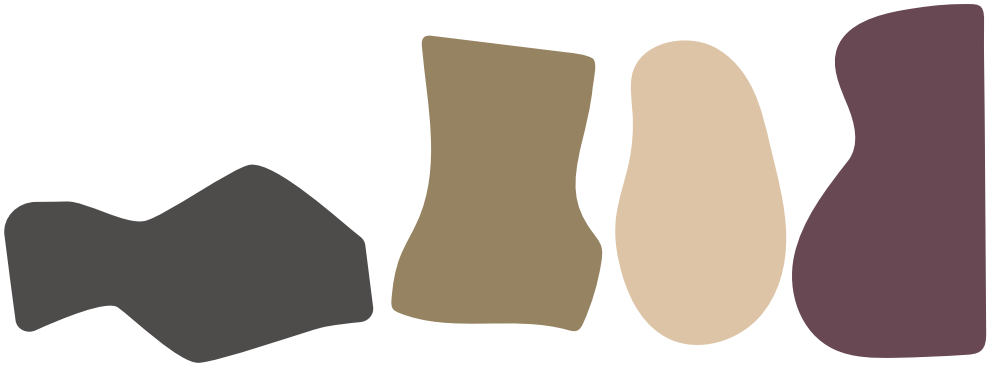
While this study focused explicitly on deaths by suicide among adult women victims of family violence, suicide is the leading cause of death among young Australians (AIHW 2022). During the interviews some participants highlighted the importance of better understanding and investigating how children's experiences of family violence intersect with risk of suicide. The need to embed these understandings into early intervention strategies and age-appropriate trauma-informed support services was emphasised.

Exploring opportunities to enhance perpetrator accountability.

A consistent issue raised throughout the interviews was that perpetrator accountability remains a critical yet unresolved challenge in family violence-related suicides. Unlike other family violence-related deaths, suicides have not prompted the same level of scrutiny regarding perpetrator responsibility. Our findings point to the potential for the coronial process to play a more active role in recognising and documenting the patterns of coercive control that may contribute to higher risk of suicide among family violence victims. As legal and policy discussions evolve, it is important for responses to family violence-related suicides to balance two needs: first, to hold individual perpetrators to account where possible; and second, to critically interrogate system failings with a view to preventing future deaths.

Conclusion

In 2024, the Australian Government's Rapid Review of Prevention Approaches (Campbell et al. 2024) recommended that improving understandings of and responses to family violence-related suicides must become a state and national priority. Delivering on this recommendation requires sustained investment in prevention, better data collection, and long-term support for systems change. Critically, it also requires a detailed analysis of current practices in each state and territory jurisdiction. This report offers timely insights into the operation of specialist response and coronial investigation processes in Victoria in the context of deaths by suicide of women who have experienced family violence victimisation. It lays the ground for a better understanding of how support service responses, suicide risk assessment, and coronial investigations are operating, and it highlights the critical need for continued comprehensive investigation into these processes and the circumstances surrounding women's deaths by suicide.



Introduction

In December 2024, following an investigation into the 2021 suicide of a young mother in Melbourne (Victoria, Australia), Victorian State Coroner Judge John Cain emphasised the importance of giving greater attention to the relationship between family violence and women's deaths by suicide (Cain 2024). Judge Cain acknowledged that suicides related to family violence are currently excluded from national homicide statistics:

> despite evidence suggesting that suicides related to DFSV [domestic, family and sexual violence] victimisation potentially account for at least three times the number of female homicide deaths (Cain 2024: 11).

In his findings, Judge Cain stated that the victim's "experiences of family violence from [the perpetrator] and other people intersected with and contributed to other key stressors in her life, proximate to the fatal incident" (Cain 2024: 10). Media reporting following the release of the coronial findings in this case highlighted community concerns about the potential scale of family violence-related suicides and how many of these relate to situations where women with lived experience of violence are "taking their lives in order to escape their abuser's torment and control" (Simonis 2024: para 7). Increasingly, Victorian coroners have highlighted the connection between the lived experience of family violence victimisation and women's deaths by suicide in their findings (e.g., Jamieson 2019), and have noted the importance of prevention efforts in addressing these links (e.g., Giles 2024). Calls for greater understanding of deaths by suicide among family violence victims are increasing among advocates and other stakeholders, reflecting growing concerns about the need to improve understandings of the interactions between the lived experience of family violence and death by suicide, and the need to fully account for all women's deaths resulting from family violence (see, among others, Campbell et al. 2024; Fitz-Gibbon and Walklate 2025; Walklate et al. 2020).

Recent figures from the Australian Bureau of Statistics (ABS 2023) indicate that an estimated 4.2 million Australian adults (21% of the population) have experienced intimate partner violence since the age of 15 years, including 17 per cent of women and 5.5 per cent of men (ABS 2023). Beyond the focus on intimate partner violence specifically, a broader focus on family violence – a term encompassing a wide range of familial relationships and abusive behaviours, such as social isolation, emotional, economic, physical and verbal abuse, sexual violence, technology-facilitated abuse, and coercive control – reveals that women and children are disproportionately impacted as victims (RCFV 2016).[1] The effects of family violence at the level of the individual, family, community, and society are well documented, as are the economic costs to health and social services and the criminal justice system (RCFV 2016). The need to account for the health, social, and economic impact of family violence has received considerable attention among policy makers, and research has documented a range of long-term impacts for victim-survivors. For example, family violence has been shown to have an adverse impact on the mental health of victim-survivors, resulting in effects, such as emotional and psychological trauma; depression, anxiety, and self-harm; and issues with drug and alcohol use (e.g., ANROWS 2020; Lagdon, Armour and Stringer 2014; Webster 2016).

1 Our focus in this study is on intimate partner violence as the most prevalent form of family violence. We recognise that experiences of suicidality are also impacted by violence that occurs between other family members – an issue which requires further exploration. In this project we have primarily focused on the lived experiences of adults and, in particular, adult women who are disproportionately impacted by family violence. We acknowledge the broader context within which family violence occurs and how this influences the ways that suicidality manifests for specific cohorts, including children and young people (see, e.g., Commission for Children and Young People 2019). In this report, we often use the term "family violence" as this is the predominant term used in the Victorian policy and legislative context, however, where we refer to studies conducted by other researchers, government bodies or organisations, we use their preferred terminology.

Across research, advocacy, and policy settings, there has been growing recognition of the need to better understand the intersection between family violence victimisation and women's deaths by suicide (see, among others, Campbell et al. 2024; Dangar et al. 2022; Hoeger et al. 2024; Keynejad et al. 2022; WA Ombudsman 2022a). Increasingly, intimate partner violence is recognised as a risk factor for suicide (see, among others, Devries et al. 2011; MacIsaac et al. 2018; McManus et al. 2022). However, exploring the relationship between risk factors, stressors, and causal links in understanding what leads to a woman's death by suicide where there is a history – whether formally reported or not – of family violence victimisation, remains complex. Understanding this is critical to informing improvements in the ways in which current systems, including response systems and coronial investigation processes, operate.

This report offers insights into the relationship between family violence victimisation and women's deaths by suicide. The research was undertaken with a view to inform more comprehensive understandings of current investigative practices, and to identify opportunities to better understand and improve responses to women's death by suicide and the intersection with family violence victimisation.

Background

In this section we provide a brief overview of current knowledge on the relationship between family violence victimisation and women's deaths by suicide, followed by an explanation of the role of the coronial investigation process in Victoria, including how it currently operates to investigate deaths by suicide – specifically in cases where there is a history of family violence victimisation.

Research on the intersection between family violence and women's deaths by suicide

International research has begun to evidence the association between family violence and risk of suicide. Globally, the study by Devries et al. (2011) found that one of the most consistent risk factors for suicide attempts (after adjusting for mental health disorders) was intimate partner violence. Similar trends have been evidenced at the country level. In England, for example, McManus et al. (2022) reported that nearly half of individuals who attempted suicide in the past year had at some time experienced intimate partner violence. Within this sample, close to 35 per cent of women who had attempted suicide had also experienced intimate partner violence (McManus et al. 2022; for further discussion, see Bates et al. 2021, 2022; Hoeger et al. 2024). Further research from England found that women who had experienced intimate partner violence over their lifetime were three times more likely to have attempted suicide in the past year compared to those who had not experienced such abuse (Agenda Alliance 2023). They were also three times more likely to have self-harmed without suicidal intent, and more than twice as likely to have had suicidal thoughts in the past year (Agenda Alliance 2023). The study evidenced that intimate partner violence often occurred in a context of poverty and multiple unmet needs, which can lead to the entrapment of women who have fewer resources (Agenda Alliance 2023).

English-based research with service-level data has also contributed to better understanding the association between domestic abuse and suicide. Aitken and Munro (2018) reported that almost a quarter of victims who sought help from Refuge (an England-based domestic abuse service) reported that they felt suicidal at one time or another. Among this group, 3.1 per cent had made at least one suicide attempt, 18 per cent had made plans to end their life and 96 per cent reported feeling despair and hopelessness. Findings also indicated that there was strong evidence for psychological distress among the sample (Aitken and Munro 2018).

In Australia, evidence on the link between family violence victimisation and suicide risk is building. The Australian Institute of Health and Welfare (AIHW 2024) has documented the role that intimate partner violence plays in women's risk of suicide and self-harm, reporting that for women aged 15 years and over, this violence was the second greatest contributor to years of healthy life lost due to suicide and self-inflicted injuries. An investigation into family and domestic violence and suicide was recently undertaken by the Western Australian (WA) Ombudsman, drawing from a review of existing research and data on deaths by suicide (WA Ombudsman 2022a). The review found that in 2017, 56 per cent of women and children who died by suicide in WA had been identified as victims of family and domestic violence by authorities prior to their death (WA Ombudsman 2022a, 2022c). Challenges to understanding the nature of the association and the scale of the relationship between family violence and deaths by suicide were also identified, including the significant underreporting of family violence in the community (WA Ombudsman 2022a, 2022b). The investigation also noted the impact of gaps in data and changing data, and the time it takes for retrospective examinations into the circumstances surrounding a death to be undertaken (WA Ombudsman 2022b).

The 2024 data from the Coroners Court's Victorian Suicide Register (VSR) provides the most recent Victorian-specific insights on this issue (CCoV 2024). For all recorded suicides in Victoria over the period 2009 to 2016, there was evidence that family violence was present in 24.5 per cent of cases. Of these deaths, females formed part of the victim-only group in 62.1 per cent of cases. Significantly more males (65%) than females (16%) were recorded as family violence perpetrators. A higher proportion of males (22.1%) who died by suicide than females (10.2%) had perpetrated family violence against numerous people, including a partner and at least one other family member. The data also show that female victims of family violence who died by suicide were more likely to have experienced family violence by their intimate partner. Prior to the release of this data, a study conducted by MacIsaac et al. (2018) identified the prevalence and characteristics of interpersonal violence among people dying from suicide in Victoria. The authors identified that over the period 2009 to 2012, there were 2,153 suicides (1,636 involving males and 517 involving females). Again, highlighting the gendered nature of the association, they found that 42 per cent of women who died from suicide had a history of interpersonal violence, including physical violence (23%), psychological violence (18%), and sexual abuse (16%).[2]

The VSR (CCoV 2024) data also indicates that the experience of family violence and suicide was often experienced alongside other factors, including diagnosed mental illness, financial constraints, substance misuse, and financial and legal stressors. This aligns with prior findings that suicide "results from a complex mix of social risk factors, population characteristics, interdependencies (i.e., co-occurring conditions such as mental illness and substance abuse), and multilevel causality" (Brown and Seals 2019: 53). In their 2019 study, for example, Clapperton et al. (2019) sought to better understand the risk of suicide following exposure to recent stressors among Victorian adults in the 12 months preceding a death. Drawing on VSR data, they found that suicide risk increased among females who experienced "mental illness, removal of children, alcohol and/or other drug problems, abuse/violence, trouble with the police and divorce/relationship separation" (Clapperton et al. 2019: 256). Taken together, the growing evidence base highlights the need for a nuanced understanding of how experiences of family violence victimisation intersect with suicide risk, and the social, psychological, economic, and legal challenges that can converge to entrap women in cycles of violence and act as barriers to effective support and long-term recovery.

The purpose and legislative function of the Coroners Court in suicide cases

A key role of the Coroners Court of Victoria (CCoV) is to monitor and release statewide data regarding deaths by suicide.[3] As part of this monitoring function, the VSR also produces data on suicide and family violence.[4] In 2024, the VSR released its first data summary documenting the experience of family violence among people who died by suicide in Victoria between 2009 and 2016. The report indicates that among the 4,790 recorded Victorian suicides, there was evidence of family violence in 24.5 per cent of these cases (n=1,172) (CCoV 2024).[5] The coding of suicide deaths and their connection to family violence following 2017 is underway at the time of this report's completion. The VSR has noted that the resource-intensive nature of this process presents challenges to timely completion (CCoV 2024: 5).

2 In the systematic review conducted by MacIsaac, Bugeja and Jelinek (2017), the findings affirmed an association between intimate partner violence victimisation and suicide, however, the authors noted that further investigation is required. For example, they point out that the influence of "temporal proximity of exposure to IPV on suicide risk" is under researched and that while efforts have been made in a small group of studies to define the period within which women experience violence prior to their death this as yet does not provide sufficient evidence of its impact on suicide risk (MacIsaac, Bugeja and Jelinek 2017: 67).

3 Surveillance data for suicides in Victoria is recorded by the Coroners Prevention Unit (CPU). The CPU "captures information about every death reported to the CCoV and records this in a surveillance database" (VSRFVD 2024: 2). If a death is identified as a suicide it is then added to the VSR. The VSR is comprised of a *core* and *enhanced* dataset. The core dataset "includes basic information on all suicides reported to the Court between 2000 and the present" (CCoV 2024: 2). The enhanced dataset "includes more detailed information about the contexts in which the suicides occurred" (CCoV 2024: 2).

4 The VSR's enhanced dataset draws on information from the coronial brief of evidence and other information requested by the coroner. It captures binary, categorical, and free-text information across nine key areas. One of these areas is "interpersonal stressors", which includes the "experience of interpersonal violence" (CCoV 2024: 5).

5 The relationship to family violence among these cases of suicide varied and included perpetrators (who had only ever perpetrated family violence and had not been a victim), victims only, and deaths where the deceased was identified as both a victim and perpetrator (CCoV 2024: 7).

In addition to overseeing these databases, the CCoV undertakes investigations into reportable deaths – which can include any *unexpected*, *unnatural*, or *violent* death that resulted either directly or indirectly from an accident or injury.[6] Death by suicide is encompassed within this definition. The purpose of the coronial investigation process is to independently investigate and ascertain, if possible:

- the identity of the person who has died,
- the cause of death (referring to the medical cause of death)
- the circumstances in which the death occurred, and
- any other prescribed particulars.[7]

For coronial purposes, surrounding circumstances are those that are "sufficiently proximate" and "causally related" to the death (see, among others, Cain 2024: 2). As such, not all circumstances which might form part of a narrative surrounding a person's death will be included within an investigation.

The broader purpose of the coronial investigation process is to contribute to a reduction in the number of preventable deaths across Victoria. This is primarily achieved through the publication of investigation findings and the specific recommendations within them.[8] In line with the Act, a coroner has scope to "comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice".[9] There are limitations on what can be reported in a coroner's findings, including any statements that indicate whether a person is or may be guilty of an offence.[10] There are also several factors to consider in line with the purposes of the Act, such as timeliness, respect for cultural differences, that family members be kept informed of the progress of an investigation, and the public interest.[11]

The Victorian Systemic Review of Family Violence Deaths

First established in 2009, the Victorian Systemic Review of Family Violence Deaths (VSRFVD) is a specialist unit across the CCoV, led by the State Coroner (VSRFVD 2024). The VSRFVD is comprised of a team of specialists, including family violence case investigators, lawyers, court registrars, the Yirramboi Murrup Unit, family liaison officers, and data specialists (VSRFVD 2024). The VSRFVD offers expertise to support the investigation of deaths that may be *family violence-related*. The VSRFVD has a variety of functions, including:

- to examine deaths suspected to have resulted from family violence,
- to identify risks and contributory factors associated with deaths resulting from family violence,
- to identify trends and patterns in deaths resulting from family violence,
- to identify trends and patterns in responses to family violence, and
- to provide coroners with information obtained through the exercise of the above functions.[12]

When it was first established, the VSRFVD's remit was family violence homicides specifically. However, since 2018, the VSRFVD can review a broader range of family violence-related deaths, including family violence-related suicides where the death involves a victim or perpetrator of family violence.[13]

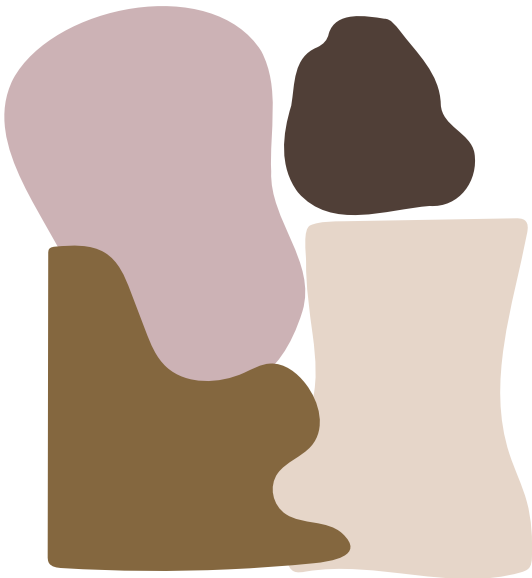
6 *Coroners Act 2008* (Vic) s 4(2A).
7 *Coroners Act 2008* (Vic) s 67(1).
8 A coroner may make recommendations to any Minister, public statutory authority or entity on any matter relating to the reportable death. These stakeholders are required to provide a written response following the receipt of these recommendations, including any action that has, is currently, or will be taken in relation to these (*Coroners Act 2008* (Vic), s 72).
9 *Coroners Act 2008* (Vic) s 67(3).
10 Ibid s 69(1).
11 Ibid s 8.
12 Ibid s 102W.
13 In addition to homicides and suicides, the VSRFVD can also review bystander deaths, third party deaths, as well as any other family violence-related deaths as directed by a coroner (VSRFVD 2024).

Since the expansion of its criteria in 2018, the VSRFVD (2024) has prioritised the investigation of suicides of victims of family violence where:

- the deceased identified family violence as one of the reasons for the suicide, or
- a family violence incident occurred in the six weeks prior to the death by suicide.[14]

The coronial investigation process for suicides in Victoria (and for any other family violence-related deaths investigated by the VSRFVD) is unlike other death review processes in international jurisdictions, which involve a separate body and/or independent chair who oversees the review (see Dangar, Munro and Andrade 2023). A central feature of the Victorian process is that the coroner holds discretionary power over the process.[15] In its current form, the VSRFVD does not have the power to request information or investigate individual matters without the authority and direction of the coroner (VSRFVD 2024). However, since 2024, the VSRFVD has had mechanisms in place to monitor all deaths that meet the criteria and proactively raise these with the coroner (VSRFVD 2024).

The process for investigating deaths by suicide usually commences 24 hours following the report to the coroner. They are typically reported by a Victoria Police member via the submission of a Police Report of Death to the Coroner (often referred to as a Form 83) (see CCoV 2024).[16] If a police member is aware of the presence of family violence, they should document this in the form; however, the presence of family violence – including in situations of unreported violence – may not be identifiable until the coronial brief is prepared (VSRFVD 2024). Following this a coronial brief is compiled by the coroner's investigator (CI), who is usually the reporting police member and assists the coroner in their investigation (VSRFVD 2024). The CI will undertake enquiries and gather evidence at the coroner's discretion (VSRFVD 2024). The coronial brief of evidence should contain all information the coroner requires to undertake their investigation. Although there is a range of matters that require a mandated inquest, suicides do not fall within this category. Our understanding at the time of finalising this report is that in Victoria they do not proceed to an inquest very often.



14 These criteria "were determined after consideration of data available within the VSR at the time the criteria were expanded, literature on the prevalence of suicide in the context of family violence, and in consideration of resources available at CCoV" (VSRFVD 2024: 2).
15 More specifically, "referral to the VSRFVD is at the discretion of the investigating coroner, who directs the course of the investigation and has broad discretion in doing so" (VSRFVD 2024: 1).
16 The Form 83 contains "high level" information relating to the death (VSRFVD 2024: 1). The information that is collated by the reporting police member is based on "available witnesses and available information at the time" (VSRFVD 2024: 1).

Research Design

This report presents findings from a Victorian-specific exploratory study which aimed:

- to examine the intersection between experiences of family violence victimisation and suicide, including the circumstances within which Victorian women die by suicide and the histories and role of family violence in these deaths,
- to better understand the Victorian coronial investigation process for suicides and how family violence histories are examined as part of this process, and
- to inform improved response and investigation processes to better prevent women's deaths by suicide following experiences of family violence victimisation.

To achieve these aims, we first conducted a background review of published Victorian coronial findings between 2014-2024 in cases of women's death by suicide where there was an identified or suspected history of family violence victimisation (n=12 reports). Data collection then involved in-depth interviews with Victorian and international stakeholders with knowledge of family violence and suicide and investigative processes. This report presents findings from these interviews.

Qualitative interviews

We completed 20 in-depth, qualitative interviews with Australian (n=15) and United Kingdom (UK) (n=5) stakeholders and received one written response (in place of an interview) from the VSRFVD.[17] The participants worked in a variety of roles within and across the family violence, health, and justice systems, including as practitioners in the intersecting fields of family violence, mental health, and suicide prevention, and as academics and policy stakeholders. Given the small sample size and the Victorian-specific focus of the study, throughout this report we do not specify the exact roles of participants interviewed to maintain confidentiality. For this reason, we have assigned general pseudonyms, including family violence stakeholder, justice practitioner, domestic homicide review (DHR) stakeholder, and expert stakeholder. We also specify in the pseudonym used where the interview participant was located (i.e., in Victoria or the UK) at the time of the interview.

Although the primary focus of this project was the state of Victoria, a smaller number of interviews were undertaken with UK stakeholders and experts with knowledge of:

1. the association between suicide and family violence victimisation, and
2. the death review process for family violence-related suicides in comparative international jurisdictions, including England and Wales.

These interviews provided valuable insights from a comparative international perspective. In contrast to Australia, the issue of domestic abuse victim suicides in England and Wales has been the subject of considerable attention in research, policy, and practice in recent years. Interviews with UK experts helped to illuminate the challenges of responding to deaths by suicide of domestic abuse victims in comparative processes; it also helped to better understand the contributory role of family violence in these deaths. The interviews commenced with the international participants, which provided a useful foundation to better understand how the death review process in England and Wales contrasts with the coronial investigation process in Victoria. While the report remains primarily Victorian-focused, where relevant we explore internationally comparative issues and opportunities.

Stakeholders were recruited through the research team's networks and a sampling strategy that combined

17 Ethics approval for this research design was obtained through the Australian Catholic University Human Research Ethics Committee (2024-3587E).

targeted and snowball sampling. Stakeholders were initially contacted about the project and then were sent follow-up information in the form of the participant information statement. If they agreed to participate, a time was set up for an interview via Teams/Zoom or in person. In total, 18 interviews were conducted online and two interviews were conducted in person. All interviews were audio recorded. The interviews were semi-structured according to key themes, including:

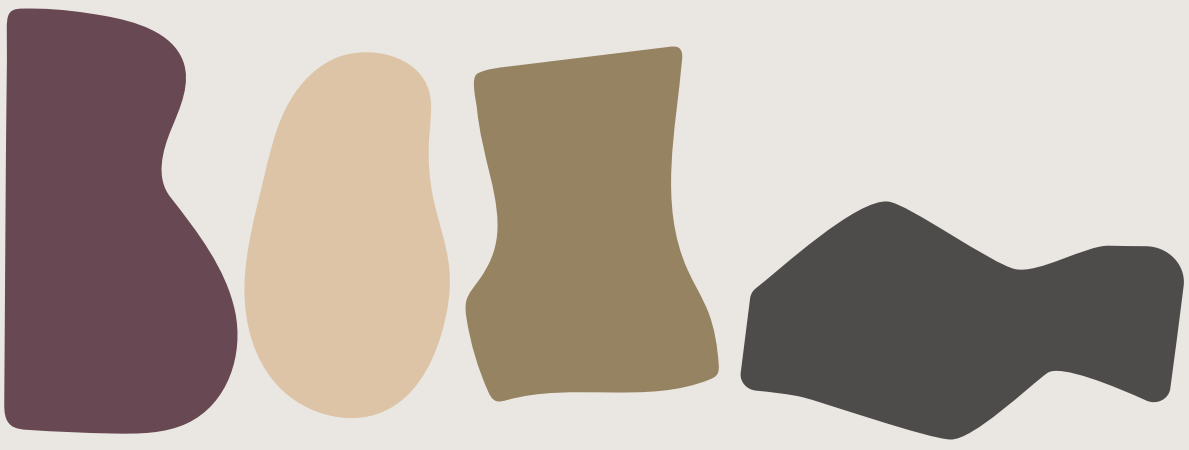
- the role of family violence victimisation as a contributory factor prior to women's suicides,
- risk identification and response,
- the coronial investigation process, including the role of family members and the next of kin,
- criminal justice system responses, and
- prevention and early intervention efforts.

All interviews were transcribed and de-identified. The transcripts were uploaded into NVivo qualitative analysis software to support thematic analysis. Braun and Clarke's (2006) approach to thematic analysis was adopted to identify key themes. Following the initial thematic coding of the interview data, the NVivo file was exported and the research team met to discuss emerging themes and key findings.

Project limitations

While this project represents the first qualitative study in Victoria to explore the intersection between women's deaths by suicide and experiences of family violence victimisation, we recognise its limitations. The interview sample that informs our analysis reflects the timeframe and scope of this exploratory study. The research is not a formal evaluation of any current systems or services: we cannot and do not seek to make claims about specific processes in Victoria and how they are working. Rather, the exploratory design has enabled us to highlight critical issues that were brought to our attention. In acknowledging this we note that our analysis reflects the views of a small group of experts – there are experiences and issues that sit beyond the findings of this research and are not canvassed here. Despite this, the report seeks to contribute to a growing conversation by examining this complex and underexplored issue. Our findings underscore the need for more extensive research to deepen current understandings of the circumstances surrounding Victorian women's deaths by suicide, inform meaningful prevention efforts, and support the delivery of more effective system responses in this area.

Findings



PART 1:
Exploring the context of family violence victimisation and women's deaths by suicide

In this section we present the findings from our interviews with Victorian and UK participants on the context of family violence victimisation and women's deaths by suicide.

1. Coercive control and the cumulative impact of family violence

Across the interviews, participants acknowledged the cumulative impacts of family violence victimisation in women's lives prior to their death by suicide. Recognising both the immediate and long-term psychological harm and distress of family violence and its relationship to women's risk of suicide, three Victorian participants explained:

> *I would have to say that family violence is a crucial factor contributing to the woman's decision of suicide. ... sometimes it's the feeling of going through ongoing abuse and the impact of the abuse even after the separation [that] led the woman to the feeling of hopelessness, isolation, and sometimes despair.* (Family violence stakeholder 1, Victoria)

> *So that is the thing about suicide in – where there's family violence, that the women feel like it's emotional abuse that is so difficult to work through. It damages their self-esteem, self-image, their confidence, their ability to see the world, their judgement. And that's what drives suicidality.* (Expert stakeholder 1, Victoria)

> *In this role and in my previous role, which is child protection, family violence was a major contributing factor to suicide. And it was the issue around a cumulative trauma that people experience when they're experiencing domestic or family violence. And when they're processing that trauma, it can often lead to suicidal ideations.* (Family violence stakeholder 2, Victoria)

Relatedly, it was also recognised that understanding women's risk of suicide requires giving consideration to the context within which their experience of abuse occurs. That is, for example, where some victim-survivors may have complex histories of violence perpetrated by multiple abusers over their lives, including experiences of violence in childhood.

Some participants reflected on the role of coercive and controlling behaviours specifically and how they viewed this form of abuse and its impact as important considerations in understanding women's risk of suicide. The concept of coercive control has been used to enhance understandings of domestic, family, and sexual violence by emphasising the range and pattern of abusive tactics employed by a perpetrator to limit a victim-survivor's agency and sense of freedom (see, among others, Barlow and Walklate 2022; Stark 2007). Participants described the impact of abusive practices, such as put-downs and threats, and the extent of the everyday control that perpetrators can wield over women's daily lives, choices, and interactions. These important but often unseen aspects of women's experiences may be less easily identified as experiences of violence proximate to a death by suicide, in part due to factors such as underreporting. One participant shared her experiences working with women who have experienced coercive and controlling behaviours and who use alcohol and other drugs, and their intersection with suicide risk and death:

> *Also fear of – that there may be images. This is a recent one – images of someone – of you using substances being disclosed to your family or to your work or to Child Protection ... So there've been overdose attempts as a result of that, suicide attempts as a result of that. We had a completed suicide as a result of that. Death in the AOD sector is actually really common.* (Family violence stakeholder 3, Victoria)

A small number of participants specifically discussed the impact of experiences of isolation, a tactic often employed within a coercive and controlling relationship. Specifically, for migrant women who may not have high levels of English language proficiency and arrive with limited social connections and may be unaware of available supports, two Victorian participants described:

> *... when women arrive, they don't know who to talk to, where to go. And that is definitely a factor that the women are told not to talk to anyone, not to go to any organisations that are – you know, like when we do lots of educational programs out in the community, these are the kind of women who don't turn up, where there is coercive control. And they are the ones who need to come. ... So, there is definitely an issue of isolation and control. And because there is domestic abuse going on in the house, they don't want to talk to any strangers and anyone else at all, to share this information. So, it is very difficult to support – figure out how to assist.* (Expert stakeholder 1, Victoria)

> *So, there is a degree of desperation over there, coping mechanisms, it impacts their mental health, trauma, they feel helpless. Language, a barrier. Ability to travel is a barrier. They're left home alone with children. Financial abuse. They go through lots of barriers, some of these women.* (Expert stakeholder 2, Victoria)

The second participant went on to describe this in greater detail, highlighting the nature of isolating and controlling tactics:

> *They don't speak the language, they're not allowed to get out of the house, they don't mingle, they don't socialise. They're quite isolated. In fact, I had a few women who were not allowed to socialise, they didn't speak the language, they had no finances, all they were doing was they got married, they came into the house, they did the housework, they weren't allowed to go out, weren't allowed to speak to anyone, and then I said, well, how did you find me? ... It is about being isolated socially, lack of finances, no access to finances. Being controlled. Some of these women have mentioned that ... cameras have been put inside the house to monitor them. So, they've been tracked on their phones to monitor them ... So there's no way to access services for these women ... there is a degree of desperation ... There's a degree of [wanting] the violence to stop, there's a degree, a level of tolerance, there's a threshold of tolerance.* (Expert stakeholder 2, Victoria)

While not all migrant women will experience violence in such a context, these stakeholders pointed to the ways that experiences of isolation can be compounded by perpetrators via the denial of social interactions, access to resources, and to community-based services and supports, which work to ensure that women are highly dependent and controlled (see Jamieson 2020; McCulloch et al. 2016; Segrave 2017). These findings resonate with extensive work on the specific links between migration status and family violence (see Segrave 2017, 2021; Segrave and Vasil 2025; Vasil 2024) and point to the importance of examining how such impacts manifest in the context of migrant women's deaths by suicide.

More broadly, the sense of being "trapped" in an abusive intimate partner relationship and having limited options was positioned by some participants as important to understanding the impact of family violence victimisation on women's decision-making regarding suicide. These participants explained that some women can feel caught in a situation they can't escape, and they reflected that this may lead to a sense of helplessness or hopelessness. As two stakeholders described:

> *The sort of family violence they endure for the long term, or for a period of time, particularly when women have children also, they find that they're absolutely cornered and they just don't know what next, how can they get out of it, out of that situation.* (Expert stakeholder 2, Victoria)

> *But they had absolutely no choice. So, they are trapped, they get a slap here and [t]here, they get put down, they get abused, they get diminished, humiliated, and there is no escape.* (Expert stakeholder 1, Victoria)

Participants also reflected on women's limited options to exercise free will and their understanding that suicide was one pathway out of violence or a way to exercise control over an otherwise uncontrollable situation (see also Abraham 2005). For example, one stakeholder explained:

> *[Suicide is about being] in control of your own demise, your own death rather than waiting for someone else to do it. So, when you're in control, when you're injecting or when you're drinking yourself to death it's because you've been emotionally abused, belittled and your self-worth is so low.* (Family violence stakeholder 3, Victoria)

Such reflections highlight the long-term impacts of family violence and raise important questions about the proximity of violence to the death by suicide, as explored later in the report. Some participants also identified that the point of relationship separation can be a time of heightened risk of suicide among victims of intimate partner violence. This was attributed to several reasons – or "triggering events" – including women returning to live with the perpetrator after a period of separation. One stakeholder shared the story of a woman they had worked with who died by suicide:

> *A young lady [was] assaulted [and was in] hospital whilst away on holiday, and then, you know, utilised our crisis accommodation and then has gone [with a] full [safety] plan going back, back to her normal place. And then [she] was found deceased [resulting from suicide] the next day.* (Family violence stakeholder 4, Victoria)

Another stakeholder reflected on the challenges that women can face following their exit from an abusive relationship, and the cumulative impact of abuse alongside the challenges of survival:

> *The other thing that I think comes up for people – victim-survivors who are escaping violence – is, "Where am I going to live? When am I ever going to feel safe again? How am I ever going to gain stability?" Often people have children. They have no financial security. They have no home security. All those things are very – if you think about someone's mental stress of that, on top of the chronic trauma that they've experienced … and the coercive control and the lack of coping mechanisms, and the living in survival mode and not being able to think about the future, and the future looks very dark to them still – and one of the things you have to try to build, with any process, is that sense of future and hope and healing.* (Family violence stakeholder 2, Victoria)

This stakeholder also shared reflections on how abuse can extend beyond the end of the relationship and exiting the shared home; they highlighted through one woman's story how women's safety and mental wellbeing can continue to deteriorate in the post-separation period:

> *I remember there was one trigger for one young person. She was 19 and had been really severely assaulted and abused for a period of time, and had an 18-month-old, and the trigger was the perpetrator of violence – because she was actually in safe accommodation – was releasing images and videos of her onto the internet. So he found a new way to perpetrate abuse. And then that just – she just made an immediate decision to overdose on sleeping tablets, and called family, because her 18-month-old was with her at the time as well. So very – it was an impulsive reaction to a form of violence – technical abuse, or whatever you want to call it. But it was just a continuation of the perpetrator traumatising the victim.* (Family violence stakeholder 2, Victoria)

This participant also emphasised that the process of notifying associated victims of a perpetrator's release from prison requires a family violence and suicide risk-informed approach. Recounting another woman's story, the participant highlighted why the imminent release of the perpetrator, a man who had "really, severely assaulted her, to the point where she had to act dead to survive, in that house. And he had broken through the door and a screen", was perceived as a contributory factor to her death. They explained:

> *So, within four hours, I think, of her being notified that he was being released from prison, she committed suicide. And we were going to bring her into service, probably the next day … So, that's something else that I think we need to look at. Because the imminent risk is not there if they're in prison. They can't get to them [but] even if it's three days out, even if it's a week – that fear starts to manifest … the psychological unsafety.* (Family violence stakeholder 2, Victoria)

Two participants shared this story, and both drew a direct link between the perpetrator's release and the woman's unassailable fear that he would find her. One described:

> *... she took her own life because the person who had assaulted her was leaving jail and it was a contemporaneous thing with a note where she had told people it was really obvious that she was in fear of her life from this person finding her.* (Family violence stakeholder 5, Victoria)

The account of this woman's story speaks to the ways that women's perceptions of perpetrator dangerousness and/or their fear of being killed by an intimate partner can drive suicidality. This was further reflected in an example of another client who had attempted to die by suicide:

> *I had a victim-survivor who was hospitalised for a very real suicide attempt, where it was a very real, significant overdose. ... had a hugely violent perpetrator – and this was a young girl as well – very violent perpetrator. [He] had access to all sorts of weapons. He was involved in gangs. And was making threats along the lines of, "Check your car. You're going to die", and things like that. So, was making very real threats to her. Had a gun. Had held the gun up at his own head. Had held the gun up at her.* (Family violence stakeholder 2, Victoria)

Offering another perspective, a small group of stakeholders with AOD expertise recognised how this fear can manifest for victims who use substances, which may be exacerbated by a lack of perceived or accessible support options. For example, one Victorian participant reflected:

> *... because the police aren't a safe option, many, many clients that I've supported have actually overdosed as a result of their fear that they're going to be killed in order to get an emergency services response that's not the police.* (Family violence stakeholder 3, Victoria)

This recognition that an overdose may be a pathway into services for victims who experience barriers to support requires careful consideration, as this participant argued:

> *I think that amplifying the visibility around people that are coerced to overdose and that use overdose as a mechanism to access support is [needed] ... I think if people attempt suicide there are support systems that are visible and available for them. If people attempt to overdose, there aren't visible support systems available. [There is] availability in alcohol and other drugs, but it's still seen as a very insular issue.* (Family violence stakeholder 3, Victoria)

A final consideration which emerged was coercion to suicide, where perpetrators denigrated women and encouraged them to harm themselves and to see their lives as worthless. One stakeholder explained:

> *And you don't know how much impact someone has on someone's mind or is instructing them – how much coercive control someone might have over other another person's behaviours. So, we need to – I feel like we need to understand so much more about this from a legal perspective – from a coronial inquest perspective. ... Because for me, I think sometimes, if someone says, "Check your car, I'm planting a bomb", and then they complete suicide, those two things are not unrelated.* (Family violence stakeholder 2, Victoria)

This stakeholder further reflected on the possible impact of perpetrator tactics in this context:

> *That, on top of – and this happens quite a lot of – perpetrators telling them, "just go die" or, "just -" – making threats of killing them, or making them – telling them to just go kill themselves. When you hear that enough through the abusive process, self-worth and value and a whole range of things – your ability, your coping mechanisms, all those sorts of things, are really depleted. And when it accumulates at a really critical time – or there could be just one little trigger.* (Family violence stakeholder 2, Victoria)

Coercion to suicide was also noted during the interviews as an emerging issue in the UK. On this specifically, stakeholders with AOD expertise identified that perpetrators may draw on a range of tactics to coerce women to overdose. As one participant explained:

> *... one of the things that we've been exploring ... [is] really identifying those nuanced tactics that exist when you're exploiting a particular element of someone's identity such as substance use, mental health.*
> (Family violence stakeholder 3, Victoria)

This intersects with the recognition that perpetrators can encourage women to self-harm, make an attempt on their life, or suicide as part of their abusive behaviour. To date there has been limited research in Australia and elsewhere on coercion to suicide as a form of intimate partner violence, including the ways in which perpetrators manipulate and utilise a victim's suicidality as part of their pattern of coercive control. Resultingly, this is a hidden aspect of coercive control that may not be readily identified and responded to by support services, including through current risk assessment and management practices in Victoria specifically, and elsewhere.

CHILDREN AND YOUNG PEOPLE

While this study is focused specifically on adult women's deaths by suicide in the context of family violence, throughout the interviews numerous participants raised the importance of enhancing understandings and awareness of the circumstances within which children and young people die by suicide following family violence victimisation (on this, see Meyer et al. 2023). There is growing recognition that understanding and responding to children and young people's experience of family violence in their own right is critical (see, among others, Department of Social Services 2022; Meyer and Fitz-Gibbon 2022). A number of participants interviewed emphasised the importance of better understanding how risk for children and young people may be identified in the context of suicide and family violence:

> *I think ... there's probably a far higher rate of teen suicide as a result of family violence and especially for, you know, [children who are or have been] in the child protection system, I've been involved with [a] number of cases of girls [who] have been sexually exploited by older men. I think that's severely under reported and I think everyone's just tick it off as that client had depression, anxiety for issues at school and not looking into the family violence aspects.*
> (Family violence stakeholder 4, Victoria)

Mirroring some of the concerns raised here, another Victorian participant raised significant concerns surrounding the inadequacies in current system responses to children and young people who have experienced family violence and are at risk of suicide. They remarked:

> *Then there are the questions for children and young people who are a bit older and they are engaging in high-risk behaviours or they're having suicidal ideation. They are getting closer in their lives to being at that crisis point themselves ... So the young person is then seen as a young person who's engaging in high-risk behaviours or getting in trouble with police or using violence themselves against an adult family member or a girlfriend or a boyfriend or whoever or who has significant mental health issues. So, then there's a service response to that out of context of that child's experiences of [being a] victim of family violence. So, again these are big – pretty big and systemic changes but there is something about the need to get a wraparound coordinated response to a young person who is at risk of suicide or self-harm that understands and responds to their experience of victimisation as well as wraps around and coordinates whatever other supports and services they need ... Those service systems are very reliant on the young person being prepared to engage and able to engage and there's just – there's not – there's generally not the flexibility or the wraparound intensity to meet the needs of those young people at that point.* (Expert stakeholder 3, Victoria)

Given that suicide is the leading cause of death among young Australians (AIHW 2022; see also Hill et al. 2021), there is a critical need to improve early intervention and crisis system responses for children and young people at risk of suicide who have experienced family violence. This is crucial to delivering improved practice across the spectrum of prevention, early intervention, response, and recovery.

PART 2:
Responding to women's risk of suicide

In this part we examine potential opportunities to enhance early intervention and responses to women's risk of suicide in the context of family violence victimisation. We focus on findings that highlight the importance of recognising family violence victimisation as a risk factor for suicide, the challenges of identifying and responding to suicide risk, and participant reflections on ways to enhance system responsiveness to better support women's needs and help-seeking.

1. Risk identification and assessment practices

In this section we analyse participant views on system responsiveness, in particular risk assessment practices, the challenges of identifying and interpreting suicide risk, and the importance of risk-informed practice across sectors.

IDENTIFYING AND ASSESSING RISK OF SUICIDE USING THE MARAM

Since the Victorian Royal Commission into Family Violence (RCFV) reported in 2016, and over the course of the subsequent eight-year whole-of-system reform agenda, family violence risk identification, assessment and management practices in Victoria have been substantially reformed. The resulting framework, the Multiagency Risk Assessment and Management Framework (known as the MARAM), aims to provide a consistent and collaborative approach for practitioners across the service system to use when identifying, assessing, and managing family violence-related risk. The continual updating of the MARAM has sought to improve Victorian practitioners' shared understandings of risk, to enhance coordination within and across services, and to improve service responsiveness to victim-survivor risk and safety. However, the degree to which these reforms have effectively embedded a consideration of suicide risk in the context of family violence victimisation was the subject of considerable discussion across the interviews.

Victorian stakeholders who work across the family violence system spoke positively about the MARAM. They described it as a useful tool and resource for practitioners working with victim-survivors to identify the nature of their experiences, undertake risk assessment, and respond in ways that support women's safety. As one participant noted, the MARAM framework assists with the identification of indicators of family violence risk:

> *Well fundamentally the MARAM framework does provide us with a comprehensive approach to understand and assess the risk in family violence cases and it encourages us to – practitioners to consider a wide range of practices that impact the safety and wellbeing of the woman and her children.* (Family violence stakeholder 1, Victoria)

However, there was a mixed response among Victorian participants on the effectiveness of the MARAM in identifying and assessing women's risk of suicide in the context of family violence victimisation. Some positioned the MARAM as one way to identify risk of suicide among other factors. In doing so, they referenced questions that relate specifically to mental ill health, noting that these can be used to help identify suicide risk experienced by victim-survivors. Some participants reflected that the MARAM can capture "red flags", assisting support workers to identify known risks, including with respect to suicide. Two stakeholders commented:

> *... we have our MARAMS and we have our high risk factors which gives us some some idea [about] which clients might be a bit more susceptible to to try and escape their family violence through through dying by suicide.*
> (Family violence stakeholder 4, Victoria)

> *MARAM identifies risk. It's comprehensive. It looks at a person very holistically. It understands – it red flags suicidation [suicidal ideation]. It unpacks that a little bit in terms of – tries to get a degree of risk associated with that suicidation [suicidal ideation].* (Family violence stakeholder 2, Victoria)

Other participants were less familiar with or certain about the framework's capacity to identify suicide-related risks, or the degree to which they are currently included in the MARAM. Two family violence stakeholders remarked:

> *I think the MARAM does have it in the framework around suicide I don't know though – it's definitely in the framework. I don't know how it features in the tool.* (Family violence stakeholder 6, Victoria)

> *I mean, it does ask about that. I mean it has fields for asking around suicidality, so that's good it triggers the question, but it's one of many, many questions.* (Family violence stakeholder 5, Victoria)

Some participants noted that there could be further scope for risk of suicide to be more clearly identified in the MARAM. Questions were raised about the extent to which the existing framework encourages discussion about mental health beyond one or two questions, and about the type of guidance provided to practitioners on this topic. One participant commented:

> *So yeah, definitely MARAM considers the issue of suicide and I think, but I do wonder whether or not that can be strengthened. You know, once we sort of understand more about what is happening, is there an opportunity to strengthen some of that, narrow the guidance, not so much the framework, but the guidance in using the tool.* (Family violence stakeholder 6, Victoria)

Building on this, two Victorian stakeholders reflected on how limited existing approaches to asking about risk of suicide are:

> *I have to say that the MARAM does not really provide any specific questions for us to assess the risk of suicide and it really depends on the practitioner's awareness and skills in assessing the woman's mental health situation at the time we carry out the MARAM assessment and during the service engagement.* (Family violence stakeholder 1, Victoria)

> *I think the level that we'd look into mental health suicide risks when completing MARAMS with victims is very limited. I mean from – I don't do MARAMS anymore, but I think there's maybe two questions out of like 50 questions on, around the suicide risk. ... without that training, I don't think practitioners know what to do with that when it is there ... to put that information in there in their rationale to provide to ongoing case management services or whoever's taking that case.* (Family violence stakeholder 4, Victoria)

Some participants commented on the need to re-frame how risk of suicide is conceptualised in existing family violence risk assessment frameworks so that the impact on victims is clearer. Within this, the need to move beyond looking at risk of suicide from a perpetrator-only perspective was identified. Some participants noted there is limited focus on the harms that victim-survivors can inflict upon themselves and that efforts could be taken to ensure that behaviours that operate as a precursor to suicide are more clearly identified. For example, one Victorian stakeholder explained:

> *There is one specific question in the MARAM where it asks about the perpetrator's risk of suicide, mental health situation but there's no question in the MARAM where we can ask about the victim survivor's mental health, history of mental health situation and suicidal ideation, I would have to say. There's only one part in the need assessment that we talk about mental health and it's just one single like very short ... and then it depends on the practitioners to explore that with the victim-survivors.* (Family violence stakeholder 1, Victoria)

These observations were not unique to Victoria. Throughout our interviews with UK stakeholders, similar reflections were made on the perpetrator-focused nature of risk within risk assessment practices. As one participant commented:

> *Because all of our entire domestic abuse industry, sector, profession – whatever you call it – is set up to protect the survivor from being physically harmed – well, not physically harmed – being harmed in any way by their perpetrator. It is all – 99% of it is being set up to protect that person, that individual, from the risk that the perpetrator poses. However, nationally we now know that there is a greater risk of that person causing themselves harm, and killing themselves, than actually being murdered by the perpetrator. And don't get me wrong, it's not an either/or. I'm not saying, "stop all the work that's being done protecting them from the perpetrator". It's a, yes, brilliant, keep doing that. But we need to add on more things now to keep the person safe from themselves as well.* (DHR stakeholder 1, England and Wales)

Connected to this, some participants from Victoria and the UK reflected that identifying suicide risk can be challenging and suggested that existing risk screening and assessment tools may benefit from greater specificity. This might include, for example, incorporating questions about prior suicide attempts or plans (for further discussion see Woodhouse 2025).

Participants also discussed the potential for the MARAM to more effectively account for self-harm risks that might be associated with perpetrators coercing victims to harm or kill themselves. Although several stakeholders emphasised that this greater specificity could help to enhance the MARAM framework and practice guides, there was also recognition of the limits of these tools to capture suicide risk fully and effectively. More specifically, some participants expressed concern that the process of undertaking risk assessment can, in and of itself, be risky and fear-inducing for victims of family violence. As one explained:

> *So the MARAM is a critical tool for us, but it takes a long time to do it. It takes a really long time to do it properly, and you're disclosing an enormous amount of information, and in this day and age, when we're concerned about what we tell people and who can access it, what I also say is that that process in and of itself causes anxiety. So what if the perpetrator gets it? What if their lawyers get it, and even though we go to some trouble to redact information and remove third party information and phone numbers and addresses and things like that, it's still a level of anxiety. So I think in a way, even the process contributes to a sense of lack of control and for some people, depending on their circumstances, I think that's, you know, it's all part of this thing around, well, what creates an environment where suicide is seen as a good option?* (Family violence stakeholder 5, Victoria)

As we examine in the following sub-section, participants also recognised that while the MARAM framework supports identification of critical information relating to safety and risk, the challenge is in understanding suicide risk in a family violence context to support prevention.

UNDERSTANDING RISK OF SUICIDE IN A FAMILY VIOLENCE CONTEXT

Many participants noted that the assessment of risk itself is one part of a broader process of understanding and responding to women's experiences of family violence victimisation and suicidality. As one participant from the UK noted:

> *There's been a lack of ability of services to make that connection between suicide and domestic abuse. Necessarily, there's been concerns about the ability of services to then identify those most at risk. And also … there's a tendency for risk management approaches to be short term. So having short term risk management approach is inadequate, usually to address – well, not only to facilitate disclosure, but also to address suicidality. So if somebody's asking about, you know, at the first point of contact with a woman for example, and going through a risk assessment process, which can be really formulaic, … it's very difficult for somebody particularly in diverse communities or having experienced a range of different forms of abuse to disclose their feelings that they want to take their own life.*
> (DHR stakeholder 2, England and Wales)

This participant, and others, emphasised how important it is for victim-survivors to have the opportunity to disclose their experiences – for example, of self-harm, suicidal ideation, a previous suicide attempt, or coercive behaviours by the perpetrator involving suicide – and that this may take time. Reflecting on UK practice, the participant went on to explain:

> *There is that limitation of existing tools I think to assess risk of harm, particularly risk of harm to herself over a broad time frame and also particularly risks of perpetrators' coercive control involving pressure or force or threats for her to harm herself or take her own life. I was involved in a review where that happened really regularly as part of the abuse, but agencies never asked about it, so she never told. She disclosed domestic violence but never told them that he was forcing her to kill herself or threatening ... that was a constant part of the abuse and as part of the coercive control. So, unless you kind of make that connection and ask about it, it's not necessarily going to going to come up.* (DHR stakeholder 2, England and Wales)

Connected to the challenge of managing disclosures around suicide was the recognition among Victorian stakeholders of the ways that some support services can be limited by the information that victim-survivors are willing to disclose about their experiences. One participant working in crisis response noted:

> *Everything, certainly for [our organisation] is self-reported, there is no request for evidence. There's no linking to other services unless we have permission to do so. It's a very passive process. So it's a little bit like someone going into ED, you know they can present [and] give a false name. ... you just don't know what the person's background is, you don't know people's medical history or any of that background. You're just dealing with what you have in front of you and what the person is able to tell you, or if you're lucky to have third party support that provide information – you just accept it at face value.* (Family violence stakeholder 5, Victoria)

Although there was recognition among participants that some victim-survivors who die by suicide may not have had previous interactions with the service system – or may not have disclosed their experiences where there was prior contact – there was also recognition that some victim-survivors who experience suicidal ideation do seek help and may do so more than once. For example, one participant reflected:

> *One of the things that I've found really interesting, and quite compelling, is that actually, when victim-survivors have suicidal ideation, I find that they do a lot of help-seeking. I find that they keep telling us, "Hey, I'm scared. I fear for my life. He's going to kill me". I find at lots of points in time, where a service can intervene and prevent the completed suicide.* (Family violence stakeholder 2, Victoria)

A related issue raised by a UK participant is the recognition that in some cases women may disclose to multiple parties – but there is limited action or intervention following these disclosures. They explained:

> *I think the DHRs give you the opportunity to identify all of the abuse, so ... when you start to see the chronologies come together from all the different agencies, and they're combined, you start to see this real pattern of like disclosure here, disclosure there, disclosure here, disclosure there, and you realise how much disclosure actually there was, or how much people knew.* (DHR stakeholder 3, England and Wales)

A Victorian participant similarly reflected, noting the need for wraparound responses in high-risk cases:

> *And I just think the whole sector needs to take more responsibility, that when someone's crying out for help like that, we need to respond in a commensurate way. It's not about putting band-aids on someone who's experiencing chronic domestic violence and sending them back out into the community to try and survive. It's actually about wraparound services that they need, right there at the time of their need. ... I think we have to look at our practice, all along the way. I don't think it's at any one interval. I think all of us have to work really hard sometimes, to keep people alive. The biggest risk for them at any one time is themselves.* (Family violence stakeholder 2, Victoria)

In recognition of the intersecting forms of family violence that victim-survivors might be subjected to, this stakeholder suggested that there is scope to be more attentive to the cumulative nature of risk. They explained:

> *What we probably need to do better is understand the cumulative risk and understand how the cumulation of that risk increases the risk of completing suicide. So, when we went in to look at the people within our service who had high risk for suicide ideation – so they were expressing that they wanted to commit suicide … A few of them said they had been strangled, so strangulation. Coercive control was another one. Fear was another one. They were just endlessly fearful. They feared for their life.* (Family violence stakeholder 2, Victoria)

Within these discussions, participants highlighted that risk of suicide is not linear, and that there is a need to consider not just immediate risk but also the need for a longer-term focus on risk mitigation as part of existing support models. Many also stressed the need for risk assessment practices to take account of the dynamic nature of risk.

Participants also recognised the complexity of assessing risk of suicide for family violence victims. One such challenge identified was how to effectively manage information that is obtained through the process of conducting a risk assessment, and how it can be used to generate an accurate account of the likelihood that women are at risk of harming themselves. On this, two participants commented:

> *And I think one of the things we struggle [with] within the family violence sector is sometimes you get two sets of similar circumstances and two sets of similar risk factors, but one will result one thing … it's really a hard predictive area to be in.* (Family violence stakeholder 6, Victoria)

> *There've been a few other people who've told me multiple times saying, "this is the last message" or "I'm not going to be able to speak to you anymore, I've had enough of the world", things like that. I never take anything lightly. I continue to support them but sometimes I also know that that person is reaching out for that kind of immediate support because they know that if they use those words – I'm just assuming again – but they might get that immediate support. It's a whole load of variations there.* (Expert stakeholder 4, Victoria)

This participant went on to emphasise the multifaceted nature of risk:

> *Because there's so many things, it could be a whole range of risk factors and so they have to look at the risk factors and that could be at the systems level, the familial level, the community level, the cultural level, the personal level, all of those things so it's multifaceted and we have to address every one of those risk factors if we are going to prevent that family violence and any kind of further risk to the individual.* (Expert stakeholder 4, Victoria)

Although emphasis is given to what is said by a victim-survivor – and any other available information that a practitioner may have available – risk assessment also relies on professional judgment: "experience and knowledge – assessing those words and things" (Expert stakeholder 4, Victoria) which forms part of safety planning practice and classification of risk. One family violence stakeholder explained:

> *So you do this as a normal part of the practice anyway, but you try to understand: is there intent? Is there means? Have they got a plan? All these things come into play. Because if someone [says], "Oh, I feel like dying", you know? But if someone says, "I'm going to die. I'm going to overdose. I'm going to take 50 Valiums. I'm going to do it tomorrow. I've got the bottle", you know what I mean? You know that they're serious about it. So, there's all sorts of practice implications about you using the MARAM. And then you have your clinical thinking that goes behind that as well. And your judgment – your clinical judgment. The MARAM can only go so far.* (Family violence stakeholder 2, Victoria)

Connected to this, some Victorian participants spoke about the importance of providing opportunities to build that professional experience, alongside the importance of developing trust with victim-survivors over time. Participants working in frontline service delivery also noted that the process of interpreting suicide risk is often enhanced when there is a strong handover from a previous support service, supporting continuity of care and risk management. Mindful of the strategies utilised by practitioners to identify and respond to risk of suicide among victim-survivors, participants also reflected on the importance of training in this area, with one describing:

> *I don't think they [practitioners] really know what to do with that information. And because [they] don't understand that with that lack of mental health awareness and their work ... because I guess the MARAM training is really around the risk level, not around how to support them through that risk.* (Family violence stakeholder 4, Victoria)

While the MARAM framework has been in place for over five years in Victoria now, the iterative process of improvement and expansion of the MARAM practice guidance and training packages presents an opportunity on this topic. Reiterating the importance of dynamic and ongoing risk-sensitive engagement with victim-survivors, several participants also discussed the need for victim support workers to be able to assist women through that risk to explore the possibility of harm (see, e.g., Aitken and Munro 2018).

THE IMPORTANCE OF RISK-INFORMED PRACTICE ACROSS SECTORS

Numerous participants expressed that, despite years of targeted reforms stemming from the Royal Commission into Family Violence (2016), there continues to be siloing across the family violence and related sectors that victim-survivors interact with. Participants believed this can have implications for identifying and responding to women's risk of suicide. In particular, they discussed the impact of non-family violence experts missing the broader context of violence within which women's experiences of mental ill health and suicidality take place. Similar reflections emerged in discussions with English participants:

> *[In] two of those cases – [where women had died by suicide] what has been really interesting is the level of mental health involvement and mental health just apparently not getting it. And so extraordinarily, it's the domestic abuse they're not getting. ... [they] didn't connect the kind of cumulative of impact of isolation and coercive controls in whatever that might be, and that sense that that victim was in a profound place of hopelessness and had been for some time, but didn't really seem to go, "Well, what does that mean in domestic abuse and then what's that mean about their own risk?" And just didn't see that, and I find that really troubling obviously.* (DHR stakeholder 4, England and Wales)

One Victorian stakeholder with a background in family violence and mental health also raised a concern that some services and organisations are supporting key groups of women that have limited mental health expertise. A commonly raised view among participants was that there may be value in promoting greater consistency between the practices employed by specialist family violence and mental health practitioners in identifying suicide risk where there is a history of family violence victimisation. As the following participant highlighted:

> *... knowledge of the crossover between the need for mental health skills and family violence skills for practitioners ... just understanding [those] underlying sort of issues and red flags ... that mental health practitioners use would be really important for all staff I think ... obviously a death by suicide is our worst case scenario in those cases but ... every victim [who] come[s] through our door has some form of mental health so whether it's a diagnosis whether it's you know PTSD whether it's cumulative harm. ... I think they're seeing it as very different sectors when they are very connected.* (Family violence stakeholder 4, Victoria)

Participants pointed to the importance of interdisciplinarity, highlighting the need for suicide prevention training for frontline family violence practitioners and family violence training for mental health professionals. One described:

> *I don't know how many people are trained well enough to actually conduct such risk assessments. For example, psychologists may not have that specific training but also I don't know about family violence practitioners. I know of course they use the MARAM and the use of all of the other risk assessment tools but it's also about what then? What next? How well can they identify and do they have the tools and resources at their disposal even if they do identify immediate risk?* (Expert stakeholder 1, Victoria)

Participants from England and Wales also noted a similar issue, emphasising the importance of training across the intersecting areas of family violence and mental health. Two commented:

> *We're sort of looking at mental health in a very medical way of looking at suicide, and then we're looking at drugs and alcohol, and we're not looking at the why, and these deaths are just sort of being written off. So, I think it's really important for us to understand domestic abuse, but for us to understand suicide, and suicide prevention too.* (DHR stakeholder 3, England and Wales)

> *Mental health clinicians knowing about domestic abuse, and domestic abuse staff knowing about mental health. That's just a basic training thing. ... in terms of DHRs, ... every DHR report [recommends] training for domestic abuse staff in mental health issues, and better training for domestic abuse issues for mental health staff, and ... vice versa ... it is a need. It's a must.* (DHR stakeholder 1, England and Wales)

Beyond training, some participants also spoke to the benefits of a stable workforce, one for whom ongoing learning and professional development are prioritised. One participant emphasised the importance of retaining skilled practitioners in the sector, explaining that:

> *You've got to be alive to the new and ongoing progressive understanding that is emerging all the time and there is a lot of professional judgment that practitioners build over time ... [that] helps them apply our tools and guidance ... when I first started in this [field] some time ago there were very long-term experience practitioners in the specialist family violence sector. Now, there are still some of those, but we've had a lot of turnover and increasingly we're seeing more and more turnover. ... newer practitioners are coming through, dealing in a much more highly regulated environment with more specific tools and guidance. How do you build that capability enough to be able to have a combination of directed guidance, but also professional judgment that's built by years of experience? Because those tools have been also built on years of experience.* (Family violence stakeholder 6, Victoria)

There was clear recognition among participants that risk is dynamic, and that effective risk assessment requires the collection and sharing of new information over time. A few participants interviewed expressed the view that while the introduction of the FVISS has undoubtedly improved practice, they have encountered cases where information pertaining to a victim-survivor's mental health was not readily shared between different services. One participant noted that there may be opportunities to strengthen current practices to better support agencies in recognising and responding to risk when working with victim-survivors; they shared the following case reflection:

> *I'm not saying it never happens but a child is a subject of report to Child Protection because of family violence. Now sometimes we're better at providing the supports to the nonviolent parent, sometimes but often not in a way that really meets her needs. So it might be a referral to Child First [Orange Door]. Child Protection gets the case, makes the assessment [that it's] family violence but there's no – it's not at the threshold of risk that they see a place for statutory intervention. They refer the family to Child First [Orange Door] [who] tries making three calls then closes. That's the pattern ... So I don't think we've got a service response that actually means that children might get some therapeutic supports when they're living in the context of violence and I don't think we've really worked out what the service response should mean for the whole family that provides some supportive intervention to mitigate the risks and the harm to the child but without punishing the nonviolent parent.* (Expert stakeholder 3, Victoria)

Connected to these issues, some Victorian participants reflected on the importance of ensuring effective system responses to support women when they seek help. This was considered central to (rather than separate from) efforts to reduce women's risk of suicide. For example, one family violence stakeholder reflected on the siloed nature of the family violence system and how – in their view – this can exacerbate risk:

> *So, it's access to services, it's the way that people are responded to, it's the way the system is broken up into pieces, into silos, that clearly shows that lack of understanding and leads to really fragmented, not just responses, but supports … And that's where you get things like suicide attempts, people dying by suicide, and having significant impacts on families and communities … There's a flow-on effect.* (Family violence stakeholder 7, Victoria)

Another family violence stakeholder highlighted the possible impact of service delays and waiting times on suicide risk:

> *Although I would have to say that Victoria is doing a much better job in responding to family violence with all the services and funding in place, that I cannot deny but … in the system that we respond to family violence – well I would have to say that they assume lots of gaps and the waiting time is also an issue. … Yeah and there's also things like – I understand the services, they have criteria for support but in some cases when the woman cannot meet that criteria, let's say not at that level of imminent risk, she probably [receives] advice to just go home and wait for the referral. Then during the time, that waiting time, things could escalate and some distrust of the service may already be there in the client. That will really escalate the situation and result in much worse outcomes.* (Family violence stakeholder 1, Victoria)

On the issue of the impact of waiting times to access support, this participant drew on a specific example from their own professional experience. They recounted:

> *… the decision that the client took was very soon in the early stage of my engagement with the client and she already went through the whole interaction with Child Protection in the system and everything. I came in for a session, initial appointment, just getting to know her and then before we had our next conversation she made the decision to end her life. So it was – if the response time, the referral and then response time could be shortened I think there would be more support in place to support the woman through that point of time. That's the first thing.*
> (Family violence stakeholder 1, Victoria)

Relatedly, stakeholders with AOD expertise and practice experience noted that victim-survivors may experience fragmented support, particularly when seeking help for substance use – including in situations where perpetrators are exerting control over their use of substances. It was noted that when substance use is addressed in isolation, it may become more difficult for women victim-survivors to access appropriate support for their experiences of family violence. One participant expressed the view that perceptions of women who use substances within the system can shape how support is provided and accessed; they noted that substance use is sometimes used to justify limited intervention or support:

> *You can certainly guarantee safety from family violence which is one of the identified risks and you can connect in with an AOD worker to support safety around overdose or withdrawal or whatever risk it is they believe they've identified but they have a common set of language and it's the same in homelessness and it's the same in mental health. Everyone has a common set of language which ensures they are justified in not supporting people who use substances.*
> (Family violence stakeholder 3, Victoria)

This same participant reflected on one woman's experience, noting the barriers she faced when seeking access to family violence support, which led to a greater reliance on the AOD sector. They explained:

> *So really it was just the AOD sector that was able to offer her some support and safety with no resourcing. There's no resourcing in AOD. In family violence you've got access to private rental brokerage, you've got transitional houses, you've got crisis properties, you've got a high priority through Office of Housing applications. You've got family violence flexible support packages which have to be approved by the family violence sector. You've got leaving home brokerage, you've got a whole bunch of money available [that is not available] in AOD ... So it's just hard, it's just difficult work because you know that this client would have better outcomes with an integrated support team and that she's worthy of an integrated support team. But then you become a part of the problem by attempting those referrals because you know it's the right thing to do and it ends up causing her harm. It's really challenging.*
> (Family violence stakeholder 3, Victoria)

These reflections offer an insight into practitioners' views on the ways service responses can inadvertently exacerbate women's risk of suicide where comorbidities are present.

Participants also emphasised the importance of health professionals, including hospital practitioners and GPs, in identifying the association between family violence and suicide, and providing a risk-informed response in health settings. Some participants reflected on cases they were aware of where women had died by suicide following their release from hospital – a setting where there are opportunities to ask about the experience of family violence. This viewpoint was not unique to Victoria. During our UK interviews one participant provided a lengthy reflection on the importance of integrated hospital responses to de-escalate risk of suicide:

> *There's a disconnect between the health response and the criminal justice response, and whether they take somebody who's really in crisis and threatening to take their own life and whether they take them to a place of safety and provide them with intensive support at that point of crisis. Some women I know have taken their own lives because the decision has been, "oh well, she can go home". You know, they've not actually taken her to a place of safety, and the family have said as part of the review process. If somebody would have done something at that point of crisis, she was obviously in distress. She was obviously in crisis. They didn't assess the whole context of the abuse. They just looked at that immediate presenting issue and then they determined that actually she's okay to go and then she took her own life the next day. In hindsight, had they taken her to, you know, a place of safety, then more intensive support could have been put in place ... they hadn't taken into consideration not only the crisis being presented, but the history of abuse that she'd experienced as cumulative. You know, threats or pressure from the abuser to take her own life, for example. All of those issues and the impacts of psychological harm. So, they haven't kind of seen the whole picture. They just looked at the presenting issue and not safeguarded accordingly.* (DHR stakeholder 2, England and Wales)

Likewise, some Victorian participants perceived that longer-term support provided in a hospital setting may mitigate risk of self-harm or death in some cases. For example, one participant reflected on a case which involved the death of a victim of family violence following a short stay in hospital:

> *She was out within three days, because she was saying to the hospital, "I feel good. I'm really good now. I'm really positive". We also experienced that when this client came back into service – her positivity. We wrapped really significant services around her. Then she was transferred to a refuge. The discharge plan read, "Discharge to [organisation]". We advocated really strongly for her to stay in hospital. We advocated for her to get her mental health stabilised. She wasn't taking medication – she was using drugs: ice. The perpetrator was still looming around as well – a very, extremely vulnerable person – she was extremely vulnerable. And she was at a really significant risk. If he had found her, he probably would have killed her, just based on past behaviours. ... She also went to a police station and said she wants to die. She also told a family friend that she doesn't want to live – she wants to unlive her life. So what that tells me is that there were opportunities. They might have been miniscule at the time, and they might not have seemed as much, but if the hospital had to have kept her in and put her into an acute care facility and looked after her mental health, and actually done a more in-depth assessment, she'd still be alive.* (Family violence stakeholder 2, Victoria)

Mirroring a growing body of work in Australia and elsewhere which has identified GPs as a key point of intervention for victim-survivors (see, among others, Lynch, Stone and Victoire 2022; Taft, Broom and Legge 2004), some participants spoke to the need to ensure GPs are trained to effectively identify the likelihood of future harm to self in the context of family violence victimisation. One participant explained:

> *[Women who had died by suicide] had had regular contact with their doctors, that's a lot of opportunity for intervention … again it's like these are massive opportunities to be asking about self-harm and suicide, and we're just not. So, relatively small changes could have some really significant results, just in our practice.* (DHR stakeholder 3, England and Wales)

Recognition of the range of professionals and services that may have visibility of a victim-survivor's risk led some participants to also reflect on the need to embed clear handover practices and protocols between support services and intervention points – including where women are moving geographical locations. Ensuring information sharing across services was identified as central to supporting effective future risk assessment and management practice. Alongside the FVISS and MARAM, the central information point (CIP) was also noted as a core component of the reforms across Victoria that have sought to improve information sharing practices within and across systems. Future examinations of these key Victorian reforms should be cognisant of the need to identify opportunities to support cross-sectoral collaboration and risk-informed practice between the specialist family violence, health, child protection, policing, and suicide prevention sectors.

2. Supporting women's help-seeking: Family violence, access to housing, and risk of suicide

The issue of women's deaths by suicide in emergency accommodation has been the subject of recent attention and advocacy in Victoria (see, e.g., Tuohy 2024). Recommendation 18 of the RCFV (2016) identified the need to remove barriers to accessing refuge and crisis accommodation, including by ensuring that women and children are not accommodated in motels and other forms of ad hoc accommodation. Despite the acquittal of all RCFV recommendations (on this, see Fitz-Gibbon and Buys 2023), the utilisation of motels and ad hoc crisis accommodation for victim-survivors of family violence continues in Victoria. This has led to ongoing concern among specialist practitioners and advocates that this form of emergency accommodation contributes to women's sense of isolation and feelings of helplessness and may exacerbate the psychological impact of family violence and risk of suicide (Tuohy 2024). These concerns were reflected through the interviews, where several Victorian participants noted the inadequacy of crisis housing responses and the importance of taking women's safety into account when allocating emergency supports. Some participants discussed the risks associated with housing women who have experienced family violence victimisation in motels:

> *I would never put someone with suicidal ideations into a motel, which you know is where the overflow of victim survivors go. I just don't think it's safe, and I think it's negligent on our part if we do that. I think they need to go into some sort or form of supported accommodation. That's probably it. Yeah. I think motels are – they add to the stress and risk.* (Family violence stakeholder 2, Victoria).

This participant also reflected on how exiting a relationship and being moved into crisis/emergency accommodation, particularly without support, can be a significant risk for women:

> *For us, the most significant risk and the most significant presenting factor is someone's suicidation [suicidal ideation]. It's actually not the perpetrator. So once we get them into safe care, it's actually the suicidation [suicidal ideation] that is presenting the most significant risk of homicidal death. … what are we doing about those aspects? It's once someone's in care, generally, when we understand and see this playing out. And I think from a practice perspective and from a trauma-informed perspective, I think that they've been surviving and living in survival mode for so long, that once they get into safety it's actually a bit of a – it's a trauma shock to them.* (Family violence stakeholder 2, Victoria)

Although there was broad agreement that housing women with active suicidality in a motel was not a safe option, participants provided other examples where this may happen because a woman's risk of suicide has not been identified. For example, one stakeholder explained:

> *So, I've also had women in my care that I was directly supporting who attempted suicide when they were in emergency accommodation through coercion by their ex-partner that they'd just left. There was one woman in particular that I remember. So I have direct experience with that.* (Family violence stakeholder 3, Victoria)

Some participants also noted that women leaving situations of family violence and seeking crisis accommodation may experience fear, a loss of control, and uncertainty – factors that could contribute to an increased risk of suicidality. In relation to this, one participant highlighted the importance of providing regular support, which was perceived as not possible for women who are placed in motel accommodation. They explained:

> *Most people who are in that space require some level of monitoring … motels are just like putting someone in a box and leaving them to dwell on their own in their own head … and just reiterate all the problems … it's just hard being on your own …* (Family violence stakeholder 5, Victoria)

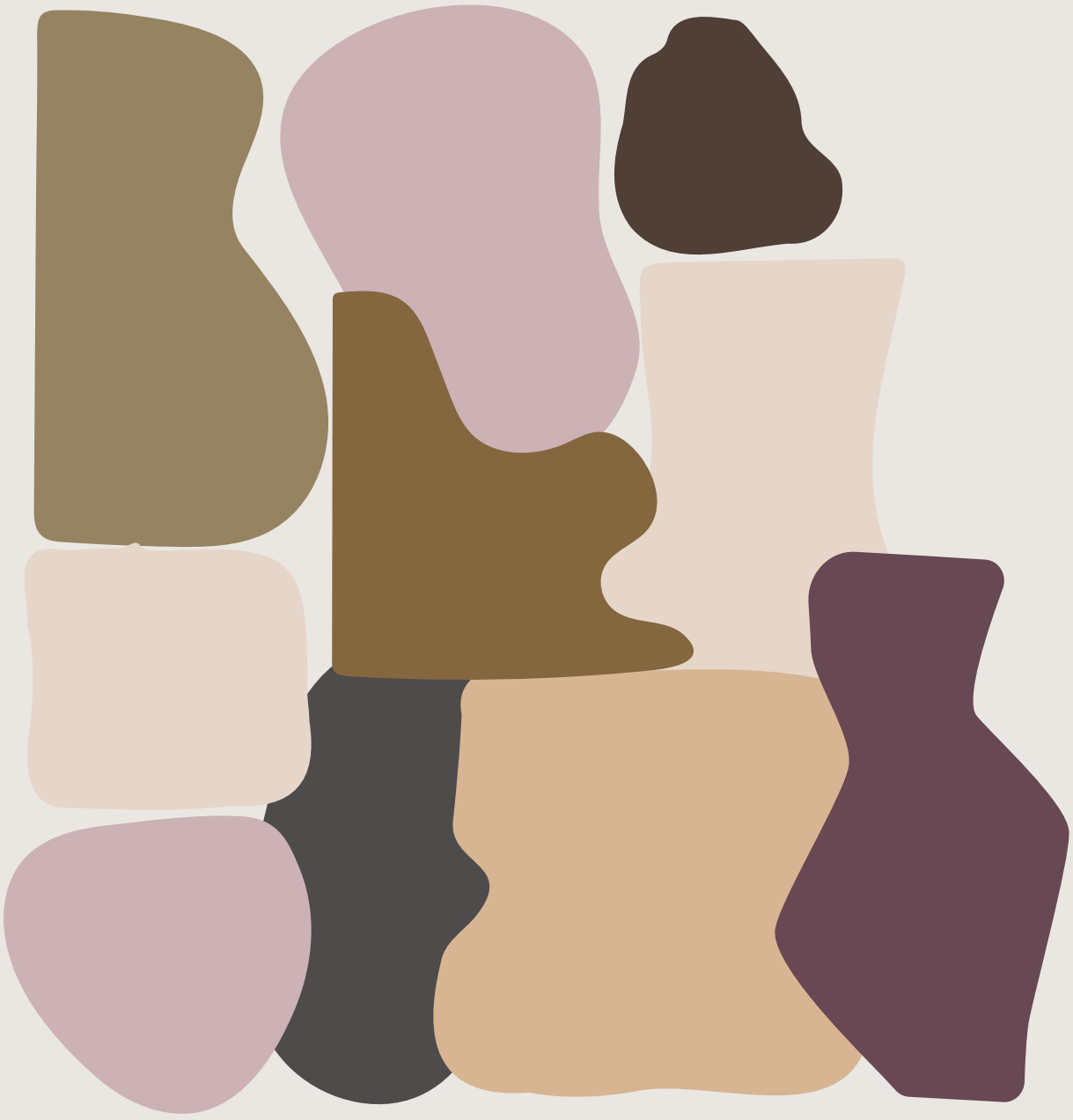
Building on this, some participants contrasted the types of supports available to victim-survivors who use motels with what is currently available through the refuge system and other forms of supported crisis accommodation. Two stakeholders described:

> *[Motels are] the worst place to put someone at risk of suicide obviously, because there are no supports when people are in motels, so it's not like the refuge model and I think this is a really important part of understanding who needs to go where.* (Family violence stakeholder 6, Victoria)

> *Once they were in a motel, then we would sort of move on to the next one because we [do] their risk assessment, do their initial intake, get them into the motel, do the application for housing, do all this stuff … and sometimes like they, they didn't even want to be there because Child Protection would say if you don't go there then you know, we'll take the kids. So, they often they weren't there because they wanted to be there.* (Family violence stakeholder 8, Victoria)

Recognising that the reliance on motels is partly a symptom of a broader housing crisis in Victoria, these findings echo the broader call for the Victorian family violence system to be better resourced by government to move away from using motel accommodation as a crisis housing option (see, e.g., Safe Steps 2024; Tuohy 2024).

PART 3:
Investigating women's deaths by suicide in the context of family violence



Examining the nature and impact of family violence victimisation within the coronial investigation process is complicated by a range of factors, including the underreporting of family violence, the intensive nature of these investigations, and resourcing considerations. In this part we examine participant views on the coronial investigation process and the evidence that comes to the attention of police and the legal systems through these investigations. We then explore issues related to accountability and perpetrator visibility, with a focus on recent criminal prosecutions in England and Wales. We note that these perspectives offer important insights into practices in this area, however, we do not seek to make broad claims or generalisations about processes in Victoria. Rather, our intention is to highlight critical issues that were brought to our attention.

1. Investigating women's deaths: What comes to the attention of police and legal systems

In this section we examine some of the recognised challenges of identifying family violence through the coronial investigation process, including the complexity of women's lived experiences of violence, and how the coronial process investigates the contributory role of family violence in deaths by suicide. We also focus on two central aspects of this process: the role of family members, including next of kin, and the role of the police.[18]

IDENTIFYING FAMILY VIOLENCE THROUGH THE CORONIAL INVESTIGATION PROCESS

The coronial investigation process following a death by suicide where there may be a history of family violence is neither straightforward nor easily understood. We acknowledge the complexities of determining which suicides are investigated as family violence-related deaths and the extent of that investigation. Throughout the interviews, we asked participants to share their views on how family violence is examined within the coronial investigation process.

Some participants identified the underreported nature of family violence and the challenges this can present for investigations following a death by suicide. Our interview with a justice practitioner also reflected the challenge of investigating suicides where there may be suspicions of family violence but no official record. That practitioner remarked:

> *It's just not always that clear, I think that's the problem. As you'd be well aware women can be subjected to family violence but never make a report. When there's an absence of a police report or an active intervention order then it is very difficult to act upon the assertions of another family member, best friend, child, whatever it is.*
> (Justice practitioner 1, Victoria)

The way evidence is gathered following a death was also described as a factor that can influence the type of information that comes to the attention of the coroner, as the following excerpts indicate:

> *[There is] a pretty stock-standard request that goes out for a brief, in a suicide case; that doesn't mean the coroners can't, and don't, ask specific questions. But they will only do so if they're alerted to that possibility. So normally, the starting point … is what is called a Form 83, which is the report that the police use … And that can range enormously in quality, from really basic to really quite good. So, it's an A4 document, it might have this much free text, or it might run to several pages if someone's done a lot of work, generally at the scene. So this captures the basic demographic information, usually people – senior next of kin, who their doctor is if they know that, where the death occurred, that sort of basic stuff. … And it'll only be as good as whoever is at the scene.* (Justice practitioner 2, Victoria)

18 There was variation among interviewees' understanding of the coronial investigation process, which reflected their differing roles and levels of direct involvement. This is important to acknowledge, given that at times the issues raised in interviews reflected different understandings of what happens in practice across different cases and why. However, in the sections that follow we share key issues raised by participants that point to important considerations in any review of the Victorian system.

> *If [the coroner has] been given information of a history of family violence, [they will] explore that further. This is the – critical for [them] … is what information is provided … in the investigation? When [the coroner] make[s] a request for a brief to be prepared … by Victoria Police, [they] always ask them to address where there is any history of family violence. Whether [they] get that or not is another thing. If there's any indication in any of the material that [they] get back, [for example a] statement, even just a throwaway line from Mum for example … [they'll] go back to [the] investigating officer and ask them to do a LEAP search on any reports of family violence from that unit. If [they] don't get anything [they] don't know and that's where the big gap is …* (Justice practitioner 1, Victoria)

This participant went on to explain how a referral to the VSRFVD team may be made and to discuss the potential scope of their subsequent investigation:

> *… if [the coroner has] a clear indication of a contemporaneous situation of family violence then [they] can explore that further and that's when [they] would go to [the] Family Violence Unit … and ask those workers to tell [them] what agencies or where supports that that person was engaging with. Was it active? How many have there been? Were there breaches? All that sort of thing becomes very relevant to the story.* (Justice practitioner 1, Victoria)

It is not necessary for an incident(s) to have been reported to the police prior to the victim's death for a death by suicide to be investigated by the VSRFVD team (VSRFVD 2024). Rather, any evidence of family violence can be sought or received, including, for example, statements by family, friends, and/or employers; phone messages; references to family violence within a suicide note; service interactions and records, including prior risk assessments (VSRFVD 2024). Given the high levels of underreporting and the oft-invisibility of family violence victimisation in official records, the ability to look beyond reported incidents of family violence is an important feature of the present VSRFVD criteria. This enables information about family violence victimisation to be provided to the court from a variety of sources, including friends and family.[19] This was explained by one family violence stakeholder:

> *Domestic and family violence is not always reported to authorities, right? And the information sharing protocol don't [sic] always go into the courts, for confidentiality reasons. So, it's almost like when they start looking at doing an inquiry – a coronial inquiry into a young woman or a person who's committed suicide out of nowhere, it's really about them making sure that they understand, holistically, the full situation that person was in.*
> (Family violence stakeholder 2, Victoria)

While seeking information from alternative sources may permit histories of family violence victimisation that have not come to the attention of the criminal justice system to be investigated as part of the coronial process, access to this information may be limited by other factors. As an example, some Victorian and UK participants interviewed cited the reluctance of some family members to put themselves in view of state systems. Participants also identified the impact of shame and stigma, with some family members not wanting to speak about what may have taken place within a loved one's intimate partner relationship. On this point participants expressed differing views; one participant, for example, argued that concerns surrounding possible stigma can be "overplayed" and that there is a desire within specific communities for "the truth to come out" (Expert stakeholder 1, Victoria). Such reflections highlight the importance of nuanced rather than blanket views on various populations in the community.

Some participants interviewed suggested that there could be ways to enhance information sharing practices to ensure that information that may not always come to the attention of the criminal justice system (for example, whether a MARAM assessment has been conducted or not) can be readily accessed. One family violence stakeholder believed this would enable more consistent identification of prior family violence victimisation:

> *… at some point in this person's journey towards an active suicide and then at least somebody has documented a risk assessment … there's lots of people who can document it, but it isn't held in a central place and I think that's a really problematic thing* (Family violence stakeholder 5, Victoria)

19 The VSRFVD (2024: 3) notes that "[v]arious parties can raise concerns with, or provide information to, the CCoV about matters relevant to someone's death, in addition to what is requested by the coroner when they request a brief of evidence to be compiled by the CI [coroner's investigator]". If the "coroner receives information that family violence contributed to a suicide, the coroner may direct further examination of the circumstances by the VSRFVD" (VSRFVD 2024: 3).

This was identified as important in cases where there may not be any other reported history of family violence surrounding the woman's death by suicide. While reforms stemming from the Royal Commission into Family Violence (RCFV 2016), including the legislated family violence information sharing scheme (FVISS) and the central information point (CIP), have sought to improve data sharing and risk visibility, participant reflections suggest there may be room for further progress in this area.

Beyond the underreported nature of family violence victimisation specifically, some participants reflected on the complexity of women's lives prior to a death by suicide. They noted that in some cases, there may be a range of evidenced system interactions, including and extending beyond the family violence system. Related to this, one Victorian family violence stakeholder shared their understanding that:

> *It's very difficult to associate domestic violence with a completed suicide, when there are so many other factors that impact on the victim survivor's life. And it might be other factors like alcohol and other drug use; it might be mental health diagnosis; it might be a disability; it might be childhood trauma. There's so many things.* (Family violence stakeholder 2, Victoria)

This same stakeholder emphasised the importance of understanding the impact of trauma:

> *What we were advocating for is that if you unpack that trauma that someone's experienced, and you unpack the behavioural manifestations, it all comes back to that underlying trauma of domestic and family violence – the chronic trauma that someone's experienced.* (Family violence stakeholder 2, Victoria)

These experiences were shared with a view to considering how the coronial investigation can capture the full breadth of women's lives and specifically the insidious impacts of victimisation, including over time. Relatedly, some participants noted that the multitude of factors presenting in a case may act as a veil to identifying the impact of family violence victimisation. One participant explained that:

> *What's not clear is – ... that unless there's some indication in a suicide, [or] reports from other people that family violence was a contributing factor, then they don't know to go and ask. Lack of money, lack of purpose, addictions. ... being unsafe, not having access to housing like they're the root of all evil, kind of wicked problems that are triggers and then of course you know mental health specifically ... diagnosed conditions.* (Family violence stakeholder 5, Victoria)

A justice practitioner reflected on the challenges in attributing causation:

> *I have a particular issue with people making findings about what the main stressor was in someone's life. And there are cases where people have lots of stuff going on: they've lost their job, they've lost their relationship, they've been sick ... even a person who says in a note, "Look, I've had enough, I can't do this anymore; this relationship – let's say – he's driving me nuts". Do [they] accept that at face value, that that's all that's going on? ... There may be something that bothers one person more than anything else in their life, but there's generally a lot going wrong, ... they [sic] may be women who were in violent relationships, but other things are also happening to them that probably contribute, or possibly contribute.* (Justice practitioner 2, Victoria)

This stakeholder was not suggesting that the investigative process does not uncover clear evidence of the role of family violence prior to a woman's death. They clarified:

> *You can't take a scalpel to it and just kind of find the bit that suggests that the relationship was crucial ... It depends. There are some women who clearly have issues, they do go to the police, they're in and out of intervention orders, they're estranged from their family, they're isolated, all of that; that's a certain kind of picture. But the picture is not always as clear as that.* (Justice practitioner 2, Victoria)

When considering the challenges arising from the investigation process, it is important to acknowledge the undeniable challenge that the victim is deceased. This was recognised by the VSRFVD team, who noted:

> *Coronial investigations rely on secondary sources, such as what other people know about the deceased, and what has been recorded in documents. These secondary sources are an inadequate substitute for what people can tell us about their experiences of violence, and any contribution of the family violence to a decision to suicide.* (VSRFVD 2024: 3)

This highlights the difficulty that can be associated with retrospective examinations of women's lives to understand how family violence may have contributed to their risk of suicide.

THE IMPACT OF PROXIMITY OF FAMILY VIOLENCE IN INVESTIGATIONS

Within the coronial investigation process, the question of the proximity of circumstances can be important. As overviewed in the report background, the Victorian coronial investigation process takes into consideration those circumstances that are "sufficiently proximate" and "causally related" to the death. Questions surrounding what is considered proximate to a death were raised by several participants. In our interviews, Victorian justice practitioners identified proximity as important in determining the relevance of evidence drawn upon to better understand a death by suicide. One justice practitioner explained:

> *Well, because of the sheer volume of cases, you've got to have something to alert you … When [the coroner is in their] formal role, [they] need to be evaluating the evidence. And that sounds kind of cold, but that's the reality … unless there's something in the material to sort of confirm that it's happened – and not only that, but to confirm that it's happened close to/proximate to death, and is causally relevant to it – then [they are] not going to be able to say very much about it.* (Justice practitioner 2, Victoria)

Another justice practitioner explained the constraints around the degree to which life histories of family violence can be considered within the scope of an investigation:

> *It is very complex and being subjected to any form of abuse from childhood or in a domestic relationship, of course absolutely literature supports, research supports the long-lasting effects of that in many ways, whether that's taking to alcohol or drugs or other means to get through the day. But [the coroner is] constrained if you like in what [they] can look at and so the Supreme Court has said … that [the coroner is] not supposed to enter into a wide-ranging inquiry into family violence per se but [is] supposed to be investigating a particular death and what are the circumstances and what are the immediate surrounding circumstances? So [they've] just got to be careful on that.* (Justice practitioner 1, Victoria)

What emerged in the interviews was that there was support for investigation in cases where a death by suicide is clearly associated with family violence victimisation (e.g., where an intervention order has been sought or where a woman has kept a diary, left a suicide note, or has corresponded with friends and family in the weeks leading up to the suicide), but also some important reflections about whether and how to pursue investigations where the proximate link is less evident. Connecting questions of proximity with causality, one participant reflected:

> *To what degree did the family violence contribute? I guess if the person for example was in emergency accommodation and killed themselves then I think that you can make a — that's absolutely attributable to what was going on there immediately and their lives. So, if it's happening whilst in the system … I think it's a lot … easier for a coronial inquiry, … how far removed does violence have to be? That's when the other contextual issues come in, like witnesses about what was happening for that person at the time. Were they triggered at that particular point? … was it also their experience of some of those other risk factors, alcohol and drugs? Childhood trauma? You know how much do you take that into account?* (Family violence stakeholder 6, Victoria)

A number of participants talked about how experiences of family violence victimisation over the course of a lifetime, and their impacts, are considered within the coronial investigation process; they noted that family violence experienced at any point in an individual's life may be an important factor in understanding their death by suicide. The participant offering the preceding quote also succinctly expressed this point, stating that:

> *How far down the track do you count that experience [of violence] null and void? You can't. I don't think you can ever disassociate it; [because] things trigger at different times in your age.* (Family violence stakeholder 6, Victoria)

While not speaking specifically about family violence, one justice practitioner interviewed emphasised the importance of a longitudinal gaze in understanding a person's death:

> *To look at the end you've sometimes got to look at the past. How did they get to that point? That person finally couldn't take it anymore or made that conscious decision that they were going to take their own [life].*
> (Justice practitioner 1, Victoria)

Reflecting specifically on investigations involving children impacted by family violence, a family violence stakeholder remarked:

> *I don't know that I've seen the process interrogate an experience of family violence and responses to that family violence in the way that I think increasingly the evidence suggests we should ... often the coronial investigations that I've seen are predominantly focused on what's occurred in the period of time immediately prior to the death by suicide.*
> (Expert stakeholder 3, Victoria)

Some participants suggested that there may be value in further interrogating how the impact of family violence and its relationship to suicide are considered within the coronial process. For example, one justice practitioner commented:

> *I personally would like to see greater interrogation of suicides that – where there's even a hint of family violence. I think that then we get down to resources ...* (Justice practitioner 1, Victoria)

The need for further investment and resourcing was identified as key to any ability to further examine the presence and impact of family violence victimisation in suicide cases.[20] There was little description from participants in relation to how to broaden the scope to recognise family violence. However, as in the case of the participant below, emphasis was placed on the importance of getting the right information to better understand the circumstances of the suicide in order to inform prevention efforts and other interventions:

> *Because if [the coroner] doesn't get the right information we don't have the right data and we don't have enough focus or other people can't assess that as being – that we need more focus on or more resources put into prevention. So, everything gets skewed because [the coroner's] not getting the information to help [them] put that down to – in place. So yes, we definitely need a better means of interrogating the suicide circumstances, particularly when it's women. I mean they're outnumbered as being the victims and so I want to know why they've done that and if we're not always asking the question is there a history, does it smell like there's a history we're not giving it enough attention.*
> (Justice practitioner 1, Victoria)

The issue of the timeliness of investigations and subsequent findings was also noted by participants. Some identified that findings and resultant recommendations can be released some time after the death has occurred, potentially affecting their relevance and usefulness for practice, given the pace of recent system reform.

20 As noted in the Background to the report, one of the two criteria that the VSRFVD review team uses to prioritise cases for investigation is that a family violence incident has occurred in the six weeks leading up to the death by suicide. Although this is one of the guidelines for investigation by the VSRFVD team, it is not stringently applied in all cases and does not automatically exclude other cases from review in practice. In this context we note that the VSRFVD expanded its criteria beyond family violence homicides in 2018 and received a boost in resources at that time; however, it has not received any additional resources since.

EVIDENCE GATHERING AND THE ROLE OF THE NEXT OF KIN

Coroners Court of Victoria (CCoV) guidance provides that throughout any investigation the senior next of kin serves as the court's prior contact, noting that this is usually the deceased's intimate partner. During our interviews, one justice practitioner explained the type of questions put to the next of kin and, importantly, what happens where there is a suspicion that the next of kin has previously perpetrated violence against the deceased:

> *A person that [the court] need[s] to deal with early on to ask questions like, "Do you want an autopsy? Do you object to autopsy? Are there cultural constraints around that? Are you going to bury the body? Are you the person to whom we release the body?" That's something [the court] have to take into account, their attitude … That's the person to whom [there is] a legal obligation to provide information. If [the court is] concerned that they're a perpetrator of violence or somehow implicated, [they] can be a bit circumspect in how [they] give that. But [they] can also provide information … to, say, family. If a mother or father comes forward and says, "I'd like to know what's happening with this investigation, because he's not telling me anything, and I don't trust him, by the way", [they] would just communicate with several people on the same file. Now, it's a logistical nightmare … but [they] do it.* (Justice practitioner 2, Victoria)

Throughout our interviews, particularly those conducted with UK stakeholders, there was shared acknowledgement of the challenges that arise from requirements in the domestic homicide review (DHR) investigation process to engage the next of kin when a suicide has followed a history of family violence victimisation – and where the next of kin may be the perpetrator of that abuse. As one UK participant explained:

> *The next of kin issue's tricky, because it could be the perpetrator, so that's where the guidance is unhelpful, and that's where there's more clarity needed … the next of kin issue is just really thorny, and accessing their records, is really, really difficult, and that's just where we need this clear guidance. So, that I think people are doing their own thing, and they're trying to do the best they can, and they're navigating it, but I think that leads to inconsistency in practice.* (DHR stakeholder 3, England and Wales).

In Victoria, one justice practitioner also noted the problems associated with the reliance on senior next of kin evidence in death by suicide coronial investigations.[21] They remarked:

> *It can be awkward because sometimes – when the deceased person comes to [the coroner], [they] know immediately, [they're] being told by police there's an active order in place, intervention order in place … He's the senior next of kin because they're married. So, the role of the senior next of kin for [the court] particularly in those – in the initial stages of [the] investigation is that [they] talk to them about the coronial process and they're the – seen to be the decisionmaker, they're seen to be the decisionmaker about whether [there is] an autopsy or not.* (Justice practitioner 1, Victoria)

This practitioner shared various anecdotal strategies on how the involvement of a "perpetrator" next of kin may be minimised during the investigative process. While acknowledging that this was not part of the formal process, these anecdotes provide valuable insights into how investigations may be carried out under these circumstances. For example:

> *… If [the court is] talking to the senior next of kin who is also – [they] know [is] – a perpetrator of family violence then that's difficult because they might have a reason to say "no, I don't want you to do an autopsy" … [the coroner] can't just say well [they] can't on hearsay [say]"we're going to exclude you to be the senior next of kin", there's got to be something that really [they] can stand on … often by then Mum's rung in or someone else has rung in and said "don't talk to him, he's the bastard that did it", and the coroner might make a decision that [they're] going to sideline him and take the mum as senior next of kin.* (Justice practitioner 1, Victoria)

21 We note that in Victoria, "there is a process where another family member can request to be the senior next of kin, which is sometimes used in family violence related deaths" (VSRFVD 2024: 4). In addition, "[t]he VSRFVD has a dedicated Family Liaison Officer (FLO) role" and these officers "assist coroners with investigations where families and witnesses require additional support during the coronial process" (VSRFVD 2024: 4). This can involve "delivering sensitive information on behalf of coroners and other stakeholders, helping families understand information contained within a coronial brief of evidence and providing support during court proceedings when needed" (VSRFVD 2024: 4). Additionally, officers "ensure families are aware of how to raise any concerns relating to the death with the coroner" (VSRFVD 2024: 4).

Several participants stressed the importance of obtaining a breadth of evidence as a strategy to overcome the problems potentially associated with engaging the next of kin in cases involving a history of family violence victimisation. One specialist family violence stakeholder explained:

> *I think that the information-sharing needs to be an accountable process, and the coroner needs to be made aware when their suicide – the person that completes suicide has experienced domestic and family violence. So there has to be some clear communication pathways there, so they get the complete and full picture. If they're talking to the perpetrator, they're obviously going to get a very different picture. And I don't see how it's going to be informative or useful for a coronial inquest into the death of someone, apart from them saying, "I had nothing to do with it. I was over here".*
> (Family violence stakeholder 2, Victoria)

Beyond questions relating specifically to the involvement of a next of kin, numerous UK and Victorian participants interviewed also recognised the importance of broader engagement with family and friends during the investigation process to better understand the contributing circumstances to a woman's death by suicide. One participant described engagement with family and friends as "really important" (DHR stakeholder 4, England and Wales), while another UK participant explained:

> *I think that family testimony, and the testimony of friends in the community, and work colleagues, is so critical, because there's just so much. When we did our research, we found that there was all this agency engagement, there was also all this other stuff that nobody knew about that predates all the agency involvement, all of these disclosures. Or, maybe even just how the victim was struggling to manage multiple appointments, and multiple different agencies, when there's been an incident ... And that's what family can give ... it's all the stuff that the victim hasn't told the agencies too.*
> (DHR stakeholder 3, England and Wales)

Another UK participant commented, "There's also incidents where the victim had not reported anything but the family was aware of incredible amounts of abuse" (DHR stakeholder 4, England and Wales). This, of course, connects back to the investigative challenges stemming from the underreporting of family violence – yet it also offers engagement strategies through which information gathering barriers can be partially overcome. Such clear recognition in the UK of the value of family and friends to inform investigations into a woman's death by suicide in the context of domestic abuse is unsurprising, given that a heavy emphasis is placed on the families' involvement through the DHR process (see further, Mullane 2017; Rowlands and Cook 2022).

Several Victorian participants interviewed recognised the opportunity to support the proactive involvement of family and friends during the investigation process.[22] One family violence stakeholder commented:

> *I think there is more to be done with friends and family in this area too. Who knew what at the time? Because very often it's not the system. Very often it's someone who knew that this person was extremely isolated, suffering something.*
> (Family violence stakeholder 6, Victoria)

In discussing the role of family and friends throughout the coronial investigations process, some participants interviewed cautioned about giving too much emphasis to the evidence provided by family members (including immediate family), who could be involved in the perpetration of coercive control against victims who later died by suicide. In such situations, and particularly in the context of multi-perpetrator abuse, these participants highlighted the importance of exercising caution when engaging with family members during the investigation process. These reflections speak to the complexity of such investigations, whereby the question of the various motives for family to support or to impede an investigation is not necessarily straightforward.

22 At the time of writing, the VSRFVD (2024: 4) is exploring the potential of a project to "more systemically involve families in investigations", however, this initiative – informed by restorative justice principles – "is not currently progressing due to lack of resources".

THE ROLE OF THE POLICE

This study did not seek to examine police responses in family violence-related deaths by suicide specifically, nor to explore in any detail the adequacy of police investigations. However, throughout the interviews participants raised the role of police, including in relation to the challenges of investigating experiences of family violence victimisation following a death by suicide. In particular, these discussions focused on two challenges – the well-documented underreporting of family violence (see, among others, Duncan et al. 2021; Ellsberg et al. 2001) and the value of specialist family violence training. Specific to training, one justice practitioner interviewed noted the obvious benefits of having a specialist officer (such as a Family Violence Command or SOCIT police officer) conduct the initial investigation into the death by suicide. They explained:

> *They're kind of better at it than the average police officer, obviously, because they have specialist training in terms of domestic violence, but also in dealing with children. So … that can be very helpful.* (Justice practitioner 2, Victoria)

Another justice practitioner expressed a view that there is not enough police training to specifically support officers in the identification of family violence-related suicides, and that more may be needed to ensure that the circumstances surrounding women's deaths are effectively interrogated. They stated:

> *Unfortunately, the police aren't suspicious, they just go "oh what we see, what we're told". So, I feel pretty comfortable to say we miss a lot of it, I think we miss a lot of that family violence. So, it can only get better at us finding these if [the] police are more responsive and more diligent as being the eyes and ears for the coroner in the first instance.* (Justice practitioner 1, Victoria)

This view on what may be missed during the investigation, particularly where there is no documented evidence of prior family violence, was shared by some family violence stakeholders, who noted that the result otherwise could be a mis-categorisation of the death, for example, as an accidental overdose. For example, one family violence stakeholder reflected:

> *… unless there's sort of documented evidence of the family violence, it could just be seen as an accidental overdose. And it still might be so even for the coroner to be able to draw a conclusion between an overdose … It's not always clear that there is a link. Now I know that the coroners court now has a team of people … who are specifically looking at how that evidence can be strengthened.* (Family violence stakeholder 5, Victoria)

Some participants noted that close interrogation of the circumstances surrounding substance-abuse-related deaths is needed in order to explore the potential influence of family violence victimisation, and, in some cases, the possibility of coercive behaviour by a perpetrator as a contributing factor.

In the UK, while deaths by suicide in the context of domestic abuse victimisation have received substantially more attention in recent years (see, among others, McManus et al. 2022; Rowlands and Dangar 2024), participants interviewed shared similar reflections on the challenges arising from the role of police investigations following women's deaths by suicide. For example, one participant described police investigations following a death by suicide as "superficial and inadequate in the main" (DHR stakeholder 3, England and Wales). Another UK stakeholder detailed what such inadequacies can look like in practice:

> *I'm not sure a junior police officer attending at 11:00 o'clock at night has any idea what to do. I think he might hear depression, and go, "Okay", and sort of think lots of people are depressed. But I don't think he's going to go, "Oh, suicidality, what do I need to do with that?"* (DHR stakeholder 3, England and Wales)

In England and Wales there is Police Guidance for investigations following "Sudden and Unexpected" and "Sudden Unexplained Deaths", which includes guidance on what is required of police when investigating a death by suicide (see further, Home Office 2024). This guidance was, however, identified as inadequate by some participants interviewed, one of whom explained:

> *We've always said it's inadequate, because it doesn't tell them that you have to check whether there's a domestic abuse history on police records, to check with family, and so on.* (Justice practitioner 3, England and Wales)

Another UK-based participant similarly identified problems arising from the current scoping of the guidance:

> *All it does is define [domestic abuse] as a cause for concern when there's been a death by suicide, and then gives the example for coercive control. That tells you nothing … then the rest of the guidance doesn't really then address the very specific different practice implications of a death by suicide when it comes to review.* (DHR stakeholder 4, England and Wales)

At the time of conducting interviews for this study the police guidance in England was being reviewed and was in the process of being updated.

Beyond the specifics of the police guidance in England and Wales, the importance of a thorough police investigation prior to a coronial court investigation was flagged as integral to ensuring the full context of the abuse experienced is brought to light. As one participant explained:

> *In order to get a meaningful inquest, if you don't have a proper police investigation, there's nothing for the coroner to go on. Because the coroner can't do their own investigation, they don't have the resources for that, so they're reliant on other organisations … So, the coroner doesn't have their own resources to go around collecting witness statements, I mean they might do a tiny little bit, but nothing really significant.* (Justice practitioner 3, England and Wales)

While the context and specifics of the English and Victorian processes differ, this quote captures commonalities relating to the importance of thorough police investigations, and it suggests that there may be an opportunity for a more comprehensive examination of current police investigative practices in both jurisdictions.

2. Culpability: The invisibility of perpetrators and the question of accountability

Since the Victorian Royal Commission into Family Violence (RCFV 2016) released its findings and recommendations, there has been a strong focus in Victoria – and indeed across Australia – on the need to improve perpetrator accountability across the family violence response system. This has led to significant reform in policy and practice, including the expansion of men's behaviour change programs as a central feature of the suite of perpetrator interventions offered (on this, see further Expert Advisory Committee on Perpetrator Interventions 2018; Fitz-Gibbon et al. 2024). However, relatively little attention has been paid to the presence (or indeed, as is often the case, absence) of perpetrator accountability throughout the coronial system, and specifically in official responses to deaths by suicide in the context of family violence. This section discusses current and emerging issues in Victoria and England and Wales that centre on perpetrator accountability following deaths by suicide in the context of family violence victimisation.

PERPETRATOR ACCOUNTABILITY AND DEATHS BY SUICIDE IN THE VICTORIAN CONTEXT

Perpetrator accountability was not an identified focus of this study at the outset. Throughout the interviews, however, the absence of accountability on the part of the family violence perpetrator emerged as a concern among stakeholders interviewed in Victoria and the UK. The limited focus on perpetrator accountability during the investigation process, and as an outcome of a coronial investigation, is perhaps unsurprising: it is not the purpose of the coronial investigation process to undertake a criminal investigation and meet the relevant evidentiary standards. However, because it is the primary investigative mechanism for deaths by suicide, limited attention to perpetrator accountability within the coronial investigation process may create a vacuum of accountability. As two Victorian family violence stakeholders commented:

> *I can go on whole different rant for another hour for that … so that that's certainly I think a really missing piece is we're not looking at perpetrator behaviours and their role … in the … escalation and the cause of the mental health in women.* (Family violence stakeholder 4, Victoria)

> *There's no perpetrator accountability when someone completes suicide. And it'll be really interesting to hear and understand what our – how we can build in perpetrator accountability, when their partner completes suicide as a result of domestic and family violence.* (Family violence stakeholder 2, Victoria)

Justice practitioners explained the challenges encountered when making findings regarding responsibility for a death by suicide. For example, one participant commented:

> *And there are – as strange as it may sound – natural justice issues. [The coroner] can't make a finding against someone without there being cogent evidence, and they get an opportunity to address it. So it's a difficult thing to do in the average suicide case, particularly if there's no note, or if there's no clear stressor … So what happens during life, that [they] can get evidence of, is going to be critical in terms of what [they] can say. Does that make sense?* (Justice practitioner 2, Victoria)

Another justice practitioner emphasised that the process through which the investigation is conducted can, in and of itself, seek to hold the perpetrator to account. This approach shifts the emphasis from accountability through an outcome/finding/conviction to the process of accountability. However, the inability to raise a defence in coronial investigation processes was acknowledged by those familiar with the process as necessitating caution in this area. As this justice practitioner went on to explain:

> *… clear stepping stones of a recorded history of family violence isn't always there and so then [the] findings might be absent that reference because I mean [the coroner] would say "there's been an allegation or it's been alleged that she was a victim of family violence" to get it on the papers. But [they have] got to be very careful because [they're] making an accusation against somebody that's not getting a right of reply really so it's a real tricky balance to come to.*
> (Justice practitioner 1, Victoria)

There was also an acknowledgement among one UK-based participant that some families do not seek an investigation focused on perpetrator accountability for the death of their loved one; rather, they are focused on uncovering system failings. They explained:

> *Everybody's different, and different families want different things. For some families, it's very much focused on the perpetrator; for other families, it's very much focused on state failings.* (Justice practitioner 3, England and Wales)

These reflections raise important questions about the focus and outcomes of the coronial investigation process. This study did not seek to comprehensively engage with this tension, but it is important to consider the extent to which the coronial process can – and indeed whether it should – be part of wider systems change to support improved perpetrator accountability in Victoria. Given its role as the primary investigative mechanism for deaths by suicide, the coronial process could serve as a key site for recognising and documenting patterns of coercive control and abusive behaviours that contribute to suicide, even if it does not assign direct culpability. Ensuring that perpetrator behaviours are meaningfully identified and acknowledged within coronial investigations and findings could be important steps toward bridging the accountability gap on this issue.

ACCOUNTABILITY VIA CRIMINAL PROSECUTION AND CORONIAL INQUIRY

At the time of conducting interviews for this study, efforts to seek criminal charges in English cases where a domestic abuse perpetrator was alleged to have played a contributing role in an individual's decision to commit suicide were garnering significant media attention. Resultingly, this prompted discussion on the merits or limits of this approach among some Victorian participants despite (to our knowledge) there being no active prosecutions to this effect currently in Victoria.

Victorian practitioners expressed caution regarding the pursuit of criminal charges in such cases, questioning whether this approach would meaningfully contribute to increased perpetrator accountability. Issues were also raised about the evidentiary challenges inherent in establishing a causal link between a perpetrator's actions and a victim's death by suicide. The necessary legal threshold for prosecution was raised, with one family violence stakeholder commenting:

> *Unless they can prove inciting suicide, they basically have no avenue in Victoria … So, unless I have clear text from the perpetrator is saying go kill yourself, do this, do that. They actually can't take action.*
> (Family violence stakeholder 4, Victoria)

UK participants interviewed consistently discussed perpetrator accountability in the context of recent efforts to prosecute domestic abusers in cases where their partners have died by suicide. In particular, the prosecution of Steven Gane, following the death by suicide of his partner, Kellie Sutton, was frequently cited by UK participants as a promising example of holding perpetrators of abuse to account. Following Sutton's death by suicide, Gane's history of physical and psychological abuse was subject to police investigation, including text messages sent in the period leading up to Sutton's death which encouraged her to take her life (Broadfoot 2024). In March 2018, Gane was convicted of coercive and controlling behaviour, and of two counts of assault against Sutton (Bhatt Murphy Solicitors 2023). Following this criminal prosecution, in a landmark decision in July 2023, a Coroner's Inquest jury found Gane's abusive actions in the lead up to Sutton's death constituted an unlawful act that directly led to her taking her own life, amounting to unlawful act manslaughter (Bhatt Murphy Solicitors 2023). This is the first UK coronial inquest to conclude that a self-inflicted death following coercive control constitutes unlawful killing.

Despite this legal precedent, UK-based participants acknowledged that such prosecutions remained rare. One participant described them as "the exception rather than the rule":

> *We're just not seeing a lot of post-death investigation ... Very rarely do you see charges come out of that, and we haven't seen a lot of post-death charging in these cases as a whole.* (DHR stakeholder 3, England and Wales)

A core challenge in these cases is establishing causality between a perpetrator's abusive conduct and the victim's death. Linking back to earlier analyses examining the complexity of women's lives and experiences of violence, one participant commented:

> *They say there isn't enough evidence to link it to the suicide, in the sense that the suicide might well have been caused by other things which pre-existed before the relationship, because she already had problems before she met him, so those kinds of things.* (Justice practitioner 3, England and Wales)

Beyond legal hurdles, UK participants emphasised that securing a prosecution relies heavily on police engagement. Unlike homicide cases, where in-depth police investigations can be assumed, deaths by suicide often do not prompt comprehensive evidence gathering. The same justice practitioner described the advocacy required to ensure a thorough investigation:

> *So, what you have to do to get a proper suicide inquest, as well as police investigation for a potential prosecution, is you have to get the police to actually gather the evidence in the first place. So, a lot of the lawyers, what they're doing ... is actually just trying to engage, and have face-to-face meetings with the police to try and get the police onboard, and get them to understand that actually there is something to investigate here.* (Justice practitioner 3, England and Wales)

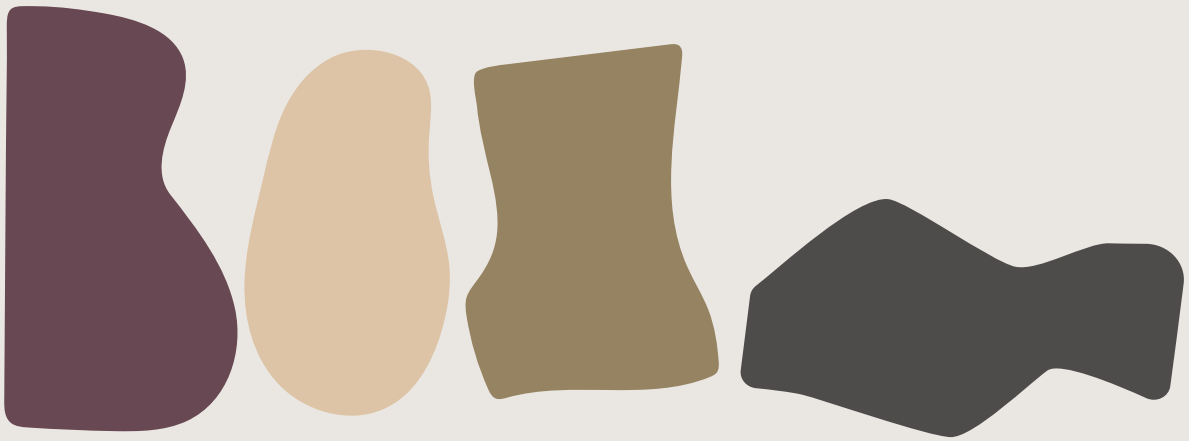
As seen following the death of Kellie Sutton, there have also been recent efforts in the UK to charge domestic abuse perpetrators with coercive and controlling behaviour in cases where evidence of abuse emerges after a victim's suicide. This approach was met with support and scepticism among participants interviewed. As one participant explained:

> *I can see why people would want that [a charge for coercive and controlling behaviour], and I can see why that might be really meaningful for families and so on. I guess it's my normal anxiety about, sure, I want perpetrators to be held accountable, but that doesn't actually necessarily fix very much if all we're going to do is prioritise new law. And it kind of misses the point. It's not going to help us prevent these deaths in the future, so I would much rather a broader conversation about perpetrator accountability ... which criminalisation may be part.* (DHR stakeholder 4, England and Wales)

Victorian family violence practitioners echoed similar concerns, questioning whether posthumous criminal prosecutions should be a justice system priority. One Victorian participant argued that efforts should focus on prevention and victim safety rather than retrospective accountability. Notwithstanding these concerns, these discussions point to the importance of ongoing examinations regarding how legal systems could more effectively respond to the full spectrum of harm caused by abuse, including following deaths by suicide.

Conclusion:

Towards improvements in understanding, policy, and practice



This research sheds light on family violence and women's deaths by suicide with a view to enhancing Victorian-specific understandings of the intersection of these phenomena and coronial investigation processes. In doing so it has sought to highlight opportunities for adopting a more informed understanding of women's suicide and the role of family violence victimisation. There is emerging evidence to suggest that the number of deaths by suicide in the context of family violence victimisation may be three times greater than the number of women killed by a current or former intimate partner (Campbell et al. 2024). Given the absence to date of Victorian-based research that qualitatively explores family violence-related suicides, this study has sought to generate new insights into the circumstances in which women victim-survivors of family violence die by suicide, the coronial investigative processes into these deaths, and opportunities for enhanced intervention to reduce women's risk of suicide. Exploring the relationship between risk factors, stressors, and causal links to understand what leads to a woman's death by suicide remains a complex process. However, understanding this context is critical to informing the ways in which we reconsider how current systems operate (including response systems and coronial investigation processes) and where opportunities for reform exist.

Understanding the impact of family violence victimisation prior to women's deaths by suicide

Reflecting prior research, there was broad recognition among participants interviewed of the profound impact that family violence victimisation can have on women's risk of death by suicide. A key theme was the pervasive role of coercive and controlling behaviours. Connected to this was the need for greater recognition of specific forms of intimate partner violence (such as coercion to suicide) and of how perpetrators can exploit their victim's suicidality and other aspects of their identity as part of a wider pattern of coercive control.

Our analysis also speaks to the varied contexts of women's lives. It highlights the need to recognise that there may be different situations and pathways to suicide among those who have experienced family violence victimisation. For example, some participants highlighted the importance of recognising the sense of being "trapped" in an abusive intimate partner relationship due to limited options, to understanding the impact of family violence victimisation on women's risk of death by suicide. Participants also reflected on the subjective impact of coercive control and their understanding that suicide can be one pathway out of violence. Or it can be a way to exercise control over an otherwise uncontrollable situation. Our findings also highlight that precipitating events – such as a perpetrator's release from prison or a woman's fear of the perpetrator – may support understandings of women's risk. However, our findings also point to the cumulative impact of violence, which can endure long after the relationship has ended. The concept of "slow violence" offers some salience here. It starkly illustrates the long-term effects of intimate partner violence, reinforcing the critical importance of sustained recovery and healing efforts. This point is emphasised in Australia's National Plan to End Violence Against Women and Children 2022–2032 (DSS 2022). We also highlight this in part because of the question of temporality that is often key to the consideration of factors that may be contributory in understanding a death by suicide.

Investigating histories of family violence victimisation in suicide cases

As outlined throughout this report, we acknowledge that determining which suicides should be investigated as family violence-related deaths, and to what extent, is a complex process. Our analysis explored some of the ways that the coronial investigation process has sought to identify histories of prior family violence victimisation in suicide investigations. Participants raised several key issues related to how the impact of family violence is recognised in suicide cases. For example, family violence may be hidden because it has not been reported to any authority, or because other more immediate issues, such as health issues, may be the main point of engagement with women.

In particular, participants highlighted the challenges of investigating suicides where family violence is suspected but not formally recorded. A number of reflections focused on the question of the proximity of circumstances – that is, how closely linked the violence is to the suicide – which can be important in assessing the relevance of available evidence. Some participants discussed how to proceed with investigations when this link is less direct, and they emphasised the importance of addressing the cumulative and long-term impacts of victimisation over time. Participants also underscored the need for appropriate and timely access to information to better understand the circumstances of a woman's death and inform more effective prevention and intervention strategies. In this context, findings suggest that there may be opportunities to strengthen evidence-gathering practices (for example, some noted the value of specialist police training) and enhance information-sharing. Both would support more consistent identification of family violence histories in suicide cases.

Several participants also noted the importance of gathering a broad range of evidence. In this regard, the involvement of friends and extended family members was seen as valuable, especially where no formal record of violence exists. However, some participants noted that motivations for cooperation – or resistance – can be complex, presenting challenges throughout the investigation process. These findings speak to the importance of continuing to interrogate the nature and impact of family violence histories and their relationship to suicide, through the coronial system. This was positioned as a key avenue to continue building evidence-based insights into the circumstances surrounding women's deaths.

Opportunities to better understand and respond to risk to prevent women's deaths by suicide

The connections between intimate partner violence victimisation and (risk of or) death by suicide are neither linear nor always predictive. Intimate partner violence has both short- and long-term impacts on victim-survivors, and a range of different factors can elevate women's risk of suicide at the individual, relational, familial, and systemic level at different points in time. In our interviews, participants emphasised that understanding the context within which women's experiences of suicidality occur provides critical insight into their support and safety needs. Exploring these intersections requires careful attention; for example, there are important distinctions between the experience of self-harm, suicidal ideation, making a suicide attempt, and death by suicide. Our analysis suggests that it may be helpful to consider how risk of suicide could be more explicitly incorporated into family violence screening and risk assessment tools to support a more specific consideration of the broader risks to women themselves.

Our findings also suggest that more work is needed to understand the cumulative impact of histories of violence and trauma on women's risk of suicide. While various factors or "triggering events" were identified as potentially contributing to heightening risk, our findings suggest that it is critical to consider how risk identification, assessment, and management practices can look beyond the identification and cataloguing of individual risk factors to focus on contextual accounts of women's lived experiences of violence. More broadly, many participants highlighted the need to view family violence victimisation, mental health, and suicidality as intersecting issues. They recognised the importance of understanding effective family violence response as a suicide risk-mitigation strategy. Participants also noted that it may be valuable to consider workforce training for practitioners across a variety of sectors – family violence, legal, health, mental health, child protection, and police – to support both the identification of suicide risk for victims of family violence and responses to it.

Looking beyond risk, some participants highlighted that there can be numerous points of service system engagement for victim-survivors who experience suicidal ideation. We recognise that no single point of the system in and of itself will serve to interrupt all trajectories of harm. Rather, our findings highlight the importance of fully-resourced and integrated family violence system responses that are attuned to the risk of suicidality in the context of family violence victimisation. Support system responses can play a central role in reducing women's risk of suicide, whether they be for victim-survivors seeking help for family violence or for any other concerns stemming from the experience of victimisation (for example, mental ill health, substance use, housing). A key point of risk identified in the interviews is the use of motels as crisis accommodation; participants emphasised that motels may heighten women's sense of isolation, exacerbate trauma, and fail to provide the necessary support structures, all of which can increase the risk of suicide. These concerns reinforce the urgent need for better-resourced crisis housing options that prioritise women's safety, wellbeing, and access to ongoing support.

Aligning with our findings about strengthening cross-sector engagement to improve suicide prevention efforts, steps could be taken to support the timely uptake of existing coronial recommendations into policy and practice. For example, there is scope to utilise the coronial investigation process and its resulting recommendations to build evidence-based understandings of how risk identification, assessment, and management processes across the family violence, mental health, and justice systems can help to prevent women's deaths by suicide in the context of family violence. Systematic tracking of recommendations from recent investigations and monitoring of their uptake could generate greater accountability in this process. Given that such recommendations span the family violence, health, criminal justice, and other related sectors, there appear to be opportunities to further support translation into practice for improved early intervention and response.

Exploring opportunities for enhancing perpetrator accountability in the context of family violence-related deaths

The issue of perpetrator accountability remains a central yet largely unresolved challenge in this space. Deaths by suicide have so far failed to prompt the level of scrutiny around responsibility and culpability that can be seen in other family violence-related deaths, leaving an arguably significant gap when it comes to the question of accountability. The UK case example of the prosecution of Steven Gane, following the death of Kellie Sutton, demonstrates an evolving legal approach that seeks to hold perpetrators accountable for their role prior to a victim's suicide. However, even in jurisdictions where such prosecutions have been pursued, legal and evidentiary thresholds remain key barriers. Findings from this study indicate that there is an opportunity to consider the extent to which the coronial process can – and indeed whether it should – be part of wider systems change to support improved family violence perpetrator accountability in Victoria. Given its role as the primary investigative mechanism for deaths by suicide, the coronial process could serve as a key site for recognising and documenting patterns of coercive control and abusive behaviours that contribute to suicide. As legal and policy discussions evolve, it will be important for responses to family violence-related suicides to balance the need to hold individual perpetrators to account where possible and to continue critically interrogating system failings with a view to preventing future deaths.

Conclusion

This study sought to draw greater attention to the intersection of women's deaths by suicide and family violence victimisation by exploring expert views on current investigative practices, the contexts of women's deaths by suicide following family violence, and opportunities for reform. There is significantly more work needed in Victoria and elsewhere in Australia to better understand and respond to the contexts that contribute to suicide for victims of family violence and to build the evidence base for what works to prevent these deaths.

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Legislation

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