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# Exploring the Intersection of Cancer, Domestic Homicide, and Domestic Abuse-Related Suicides Using Domestic Homicide Reviews

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## Abstract

**Purpose** Research about the overlap between cancer and domestic abuse (DA) is limited. We analyzed Domestic Homicide Review (DHR) reports from England and Wales where the victim or perpetrator had a cancer diagnosis to investigate the nature of DA in a cancer context, and cancer care and other healthcare professionals' (HCPs) responses to DA.

**Methods** We adopted the READ approach to document analysis: Ready materials (including manually searching reports for the term 'cancer'); Extracting data; Analyzing data; and Distilling findings (using thematic analysis). We framed results using the social-ecological model of violence.

**Results** We retrieved 24 DHR reports, which covered 27 domestic homicides/DA-related suicides. Victims had cancer diagnoses in 15/27 cases, perpetrators in 8/27, and both in 1/27. Three cases involved two homicides. Victims were mostly older (median 67). Most (19/24) domestic homicides/DA-related suicides occurred within 3 years of diagnosis, yet cancer HCPs rarely made explicit contributions to the DHR process. Our qualitative themes explain how: (1) cancer and DA affected each other; (2) professionals missed opportunities to identify and respond to DA (including because cancer masked DA indicators, turning down care and support offers were underrecognized indicators, and care was fragmented and non-holistic with insufficient information-exchange); and (3) cancer diagnoses were under-considered and misunderstood in the DHR process.

**Conclusions** Since cancer masked DA indicators, professionals working with affected people and families should have a low threshold for concern. More explicit contributions to DHRs by cancer HCPs may improve understanding of this intersection and improve future practice.

**Keywords** Domestic violence · Domestic abuse · Family violence · Domestic homicide · Suicide · Cancer · Document analysis

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The intersection of cancer and domestic abuse (DA) has been under-researched despite the prevalence of both. In this article we present an analysis of Domestic Homicide Review (DHR) reports where the victim or their partner or family member had a cancer diagnosis. To begin, we present the health impact and healthcare response to DA in England and Wales, review the scant research about cancer and DA, and summarize the DHR process and implications for researchers using data from DHRs, before presenting research questions and aims.

In England and Wales, 20.5% of adults (27.4% women, 13.7% men) have lifetime DA experience (ONS, 2024). These figures are likely an underestimation due to barriers to recognizing and reporting DA and data collection limitations (Hester et al., 2023), e.g., data on 60+ year olds has been collected since only 2017. DA disproportionately affects women and disabled people (ONS, 2024), and cancer is a disability under UK equality legislation (Cancer Research UK, 2023). Although in the current article we consider all DA types, most research focuses on intimate partner violence (IPV). Experiencing IPV is associated with subsequent alcohol and drug use (Ogden et al., 2022), depression, anxiety, sleep disorders, self-harm, suicidal thoughts and attempts (Chandan et al., 2020; Gallegos et al., 2019; McManus et al., 2022; Trevillion et al., 2012), and many other mental and physical health sequelae (Campbell, 2002).

Due in part to the health consequences, and perceptions of healthcare as safe, confidential, and trustworthy (Heron & Eisma, 2021), survivors are more likely to disclose DA to healthcare professionals (HCPs) than other professionals (Domestic Abuse Commissioner, 2022). In England, healthcare-based interventions have significantly increased HCPs' DA enquiry and identification rates. Interventions have largely targeted primary care, (e.g., Feder et al., 2011), sexual health (e.g., Sohal et al., 2020), emergency medicine (e.g., Halliwell et al., 2019), and maternity care (e.g., Baird et al., 2013). Maternity patients are routinely asked about DA but in most areas, HCPs are trained to ask if they identify DA indicators (e.g., health sequelae, frequently missed appointments, non-compliance with treatment, requesting early inpatient discharge (NICE, 2023)). Direct referral pathways to healthcare-based DA workers have increased identification rates, earlier intervention, and support for survivors less commonly seen in community DA services, including older survivors (Feder et al., 2011; Halliwell et al., 2019). Responses to perpetrators in healthcare are underdeveloped, although perpetration is also associated with health issues, e.g., mental health problems and substance use disorder (Bracewell et al., 2022; Cafferky et al., 2018; Spencer & Stith, 2020).

The cancer and DA intersection is under-researched, even though inequality in cancer mortality is a well-recognized issue (Lancet, 2023). The UK National Health Service

(NHS) (2019) has driven a personalized care agenda in cancer, including the use of structured care-planning discussions in primary (cancer care reviews) and secondary care. Part of this agenda is Macmillan Cancer Support<sup>1</sup>'s holistic needs assessment, which informs care planning and increases discussion about wider health problems and practical and emotional concerns for patients (Snowden et al., 2023). DA has not been considered within these initiatives. The few studies about the cancer and DA intersection all explore IPV rather than all types of DA, mostly towards women with breast cancer, and are largely from the US, with none from the UK (Myall et al., 2023). These studies show that IPV survivors are more likely than people in the general population to receive a cancer diagnosis (Reingle Gonzalez et al., 2018). Some studies show that IPV is linked to a later cancer stage at diagnosis (Mejri et al., 2023; Modesitt et al., 2006), although others found the difference non-significant (Coker et al., 2017; Jetelina et al., 2020). Moreover, research has shown a relationship between IPV and lower cancer-related quality of life, higher depression and stress post-diagnosis, and lower levels of physical, social, family, emotional, and work functioning, with poorer outcomes for women with current rather than past IPV experience (Coker et al., 2017). Research has shown how perpetrators use cancer diagnoses to further their abuse (which often predates the diagnoses: Myall et al., 2023): for example, by blaming the survivor for their diagnosis (Sheikhnezhad et al., 2023), physically assaulting treatment sites (Mejri et al., 2023), and humiliating them about treatment-related appearance changes (Speakman et al., 2015). Abusive partners also used behaviors that sabotaged treatment and recovery. For example, they made the patient feel guilty, burdensome, attention-seeking, or undeserving of treatment; prevented rest; restricted access to food, money, health insurance, informal support, medicine, treatment, and clinical care; obstructed appointments; and interfered with prescriptions (Coker et al., 2017; Mejri et al., 2023; Sawin & Parker, 2011; Sawin et al., 2009; Speakman et al., 2015). Walker et al. (2023) describe perpetrators' use of chemical substances, including stealing and restricting access to prescriptions, as 'chemical control'. The research shows that patients were often physically and financially reliant on, and thus trapped with, perpetrators: their resultant isolation made HCPs' support especially crucial. Jetelina et al. (2020) call for increased IPV enquiry by cancer HCPs. Two US-based intervention studies found IPV enquiry in cancer care is feasible but hindered by a lack

<sup>1</sup> A cancer charity that provides services for patients and caregivers, supports and produces resources for them and professionals, and influences policy.

of training, time, and privacy from patients' companions (Narayan et al., 2019; Owen-Smith et al., 2008).

Although not cancer-specific, a longitudinal study with older survivors found that DA intensity increased after illness or caregiving onset (Solace Women's Aid, 2021), whether the victim or perpetrator was ill: this, and other such research e.g. by McCausland et al. (2016), dispels myths that older or ill people cannot be perpetrators. Illness is theorized to be a trigger for domestic homicide: it can create a loss of control which perpetrators seek to regain, and create new opportunities for control of which they take advantage (Bracewell et al., 2022; Monckton Smith, 2019). In particular, being a female caregiver is a risk factor (Benbow et al., 2019; Cohen, 2019). In England and Wales, there were 353 domestic homicides between March 2021 and 2023, mostly ( $n=224$ ) females killed by males (ONS, 2024),<sup>2</sup> a gendered disparity reflected in global prevalence statistics (Stöckl et al., 2013). Graham et al. (2022) developed a social-ecological framework for intimate partner homicides (IPH) adapted from an earlier IPV model (Heise, 2011), which centers gender as a critical factor in IPHs. It organizes risk and protective factors that can function alone or interact with others, at four levels: individual (e.g., mental health problems, firearm access), relationship (e.g., social support), community (e.g., services available and accessible), and societal (e.g., ageism, ableism). Crucially, it presents factors amenable to risk-reducing intervention. Equivalent theorization is missing for other types of domestic homicides, though some risk factors are shared (Bracewell et al., 2022).

## DHR in England and Wales

DHRs are one way of generating evidence about the circumstances of domestic homicide and DA-related suicide and are an example of what are known globally as Domestic Violence Fatality Reviews (Websdale, 2020). A DHR is conducted when the death of a person aged 16+ "has, or appears to have, resulted from violence, abuse or neglect" from a former or current partner or family member (UK Home Office, 2024). DHRs were established on a statutory basis in 2004 and implemented in 2011. Since 2016, deaths by suicide can also be examined. Partly to reflect this change, in 2024 the UK government announced that DHRs will be renamed as Domestic Abuse Related Death Reviews (UK Home Office, 2024). DHRs are commissioned by local Community Safety Partnerships (which bring together local partners to prevent crime and disorder) and are led by an independent chair, who works with a multi-agency review panel comprising criminal justice, health,

domestic abuse, and other agencies. Testimonial networks (e.g. family, friends) may also be involved. The aim is to learn from these deaths to improve understanding and drive prevention (UK Home Office, 2016). Once commissioned, a DHR's scope (its terms of reference) is agreed upon (e.g. review period, areas of focus such as health and care needs). Then, relevant information is gathered from agencies and services that had contact with the victim, perpetrator and/or any children, usually in the form of an individual management review (IMR), and from testimonial networks if they participate. Ultimately, a DHR report is produced, and usually published, capturing case findings, learning, and any recommendations in response.

Given that they provide accounts of the circumstances before a death, researchers are increasingly using reports of DHR as data sources (Rowlands & Bracewell, 2022), including to understand domestic homicides and DA-related suicides in certain contexts, and agency and service responsibilities in prevention. For example, such research has shown that the NHS has the most contact with victims and perpetrators pre-homicide (Chantler et al., 2021). However, DHR reports are not produced for research purposes and there are limitations to using them for research. Cook et al. (2023) highlight questions about the transparency of how DHRs are conducted, administered, and function, how decisions are made about commissioning a DHR and during the DHR process itself, and how DHR recommendations are shared and implemented. Rowlands and Bracewell (2022) argue that DHR report content is "the product of overlapping layers of interpretation which are reified into fact" (p.522). The first layer is the victim or perpetrator's experience, their interaction with professionals, and if and how that agency or service recorded the experience; the second is analysis, where these agencies and services retrieve, analyze, and report this recorded information; the third is interpretation, where the independent chair and multi-agency review panel members consider and make decisions about the information that agencies provide (they may not give credence to it or may frame it in a certain way); and the fourth is reporting, whereby the DHR report is produced. Researchers' analysis is yet another layer. DHR reports furthermore give little detail on how testimonial network contributions are elicited, selected, presented, and balanced with those of other contributors (Cook et al., 2023). Thus, data available to researchers may be variable, because of these interpretative layers and differences in the quality of DHRs' conduct and reporting. A further issue is the accessibility of DHRs and missing data within them (Rowlands & Bracewell, 2022), which frustrates efforts to build DHR samples with specific case circumstances. However, the UK Government recently established a DHR Library to improve access ([homicide-review.homeoffice.gov.uk/](https://homicide-review.homeoffice.gov.uk/)). Reports are tagged e.g., "mental health (victim)" to enable filtering by theme.

<sup>2</sup> The UK Home Office categorizes by sex not gender.

## Our Research

Due to the scant research about the cancer and DA intersection, we decided to analyze DHR reports while acknowledging these limitations and engaging critically with them as a data source. No published research has explored this intersection using DHRs. Our research questions (RQs) were: according to DHR reports where the victim had a cancer diagnosis, or the victim was caring for a partner/family member with a cancer diagnosis: (1) how did the cancer diagnosis affect experiences of DA, risk of DA, and risk of domestic homicide and DA-related suicide, and how did DA affect the experience of cancer care?; and (2) what were professionals' documented identifications of DA, identifications of its risk factors, or responses to these for those affected by a cancer diagnosis? A less central research question was (3) to identify relevant learnings for the conduct of DHRs. Overall, we aimed to develop and deepen understanding at the intersection of cancer and DA for researchers which could in turn inform training and policy, primarily for UK cancer HCPs.

## Methods

We adopted document analysis for DHR reports using the systematic READ approach (Dalglish et al., 2020)—see Figure—with Framework analysis (Gale et al., 2013), guided by the social-ecological framework (Graham et al., 2022). The READ approach is flexible and was thus appropriate for use with DHRs. The layers of interpretation within each report mentioned earlier shaped and constrained our ability to answer our research questions. We aimed to enhance the trustworthiness of our analysis by reflecting on and

critiquing report content (e.g., language choice) and decisions the chair or panel made (e.g., panel membership, review timeline). We also documented ambiguity and our interpretations in reports. Report numbers are presented in the Results section Fig. 1.

## Ethical Issues

Institutionally, this study was exempt from ethical approval due to the public availability of DHR reports and the absence of an ethical framework for using DHRs for research in England and Wales. Cook et al. (2023) applied a published research integrity framework (Women's Aid, 2020), which promotes best practice in DA research, to the use of DHR reports in research. Applying that framework, the key issues relevant to the current paper are confidentiality and consent. Although sometimes friends and family members ask for real names to be used, DHR reports usually use pseudonyms or initials (e.g. Victim A) for parties involved, including living friends and family members and perpetrators. However, the details included in a DHR report usually make cases identifiable e.g., via media reports (Websdale, 2020). Seeking consent from living parties for the use of the DHR reports in research is not currently practicable. Using DHRs as data is particularly contentious if these parties are disappointed with or do not endorse the DHR's findings or if they felt there was no DA pre-death, but the DHR and researchers question whether there was. We have balanced these issues with the potential research benefits: awareness-raising about cancer and the risk of domestic homicide and DA-related suicide, especially needed in the UK given that no such research exists. Nevertheless, we have presented findings with family members and friends in mind, withhold unnecessary detail, and use names or pseudonyms from DHRs where available to refer to victims. For reports without a

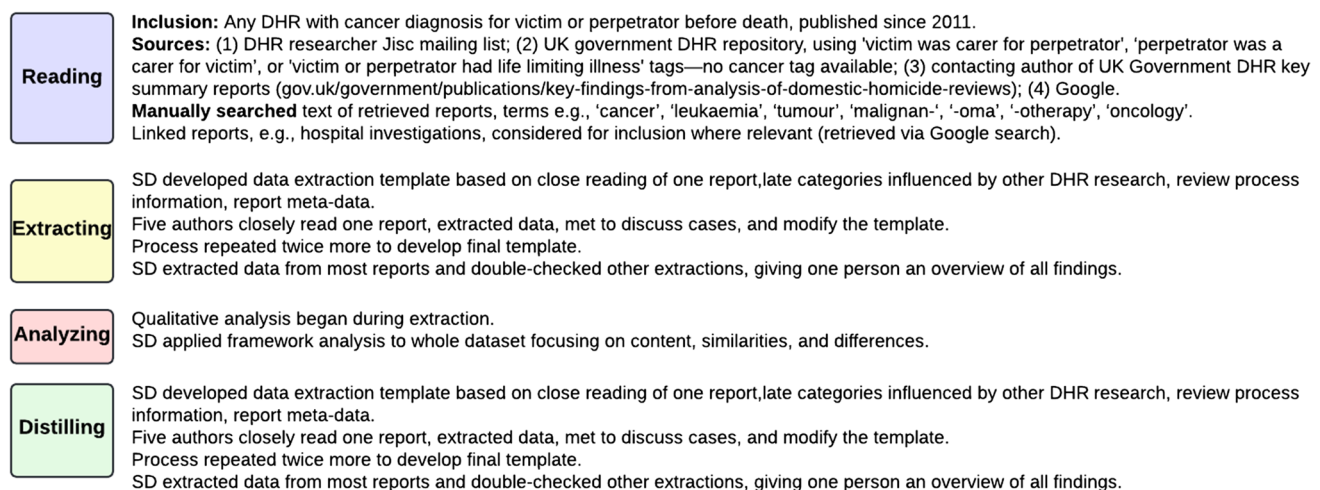


Fig. 1 READ approach to document analysis



first name pseudonym for victims, we used our own (e.g., replacing Mrs Y with Ivy: see Online Resource for full list). We checked whether family and friends engaged in or disapproved of the report content (if this was reported). To honor victims, we sensitively question assumptions that they did not experience DA pre-death and (aside from in Annette's case where her son was cleared of manslaughter) use the term 'perpetrator', but acknowledge its stigma.

## Results

We retrieved and reviewed 41 DHR reports and included and analyzed 24 of these. We excluded 17/41: 15/17 because they mentioned cancer once or twice with no detail, 2/17 due to postmortem diagnoses, and one where the perpetrator and person living with cancer were not personally connected. Table 1 summarizes report meta-data and our Online Resource contains details of all reports and deaths, summarized here. Ivy's report was an executive summary, but we included a separate mental health hospital investigation about the case. Family and friends engaged in all DHR reports: none stated their disapproval but across DHRs, some declined to contribute information and feedback on content. In 14/24 reports, victims of domestic homicides had cancer diagnoses; in 1/24, a victim of DA had a diagnosis and died by suicide; in 8/24 offending (ex)partners/family members

of victims had cancer diagnoses; and in 1/24, both victim and perpetrator had diagnoses. In three cases, the perpetrator killed two family members (Claire & Charlotte, Jean & Sarah, Olga & Viktor) thus our sample included 27 deaths. Regarding the familial dynamics of individual deaths, most (14/27) were IPHs. Most (21/27), including all IPHs, were men killing women (femicides). Three cases were shootings (Nell, Claire & Charlotte, Diane). In 11/24 cases, there was a caregiving relationship between perpetrator and victim for a health condition besides cancer: of these, most (7/11) were women killed by men (4/11 were male caregivers who killed female care recipients, 3/11 were male care recipients who killed female caregivers). There were nine homicide-suicides. Regarding DA history, in four matricide or patricide cases (Roy, Lily, Olga & Viktor, William), male perpetrators had IPV history towards female partners. One patricide victim, Roy, also used IPV towards his female ex-partner (the perpetrator's mother). One woman who killed her son (Peter) previously disclosed IPV from her husband. Two reports (Annette; Julie) indicated that a female victim abused the other (male) party before they died.

Where agencies and services had evidence of DA, the evidence was pre-cancer diagnoses. Considering just those cases where agencies and services did *not* have evidence of DA ( $n = 15$ ), most (10/15) involved victims aged 60+ and 8/15 involved a caregiver dynamic. These included IPH reports for Barbara who had depression and a partner with a cancer

**Table 1** Report meta-data

Victims' names/ pseudonyms & familial dynamic	<b>Intimate Partner Homicides (IPH) (14/27):</b> Barbara, Claire, Ivy, Gale, Nell, Mary, Andrea, Janice, Jean, Fay, Bridget, Irena, Julie, Diane. <b>Matricide (5/27):</b> Kathleen, Olga, Sana, Lily, Zoe. (In a sixth for Annette, her son was cleared of manslaughter). <b>Patricide (3/27):</b> Roy, Viktor, William. <b>Filicide (3/27):</b> Peter, Sarah, Charlotte. <b>Suicide (1/27):</b> Connie
Date range	Deaths between 2012–2020
Who had cancer diagnosis	15/27 the victim, 8/27 the (ex)partner/family member, 1/27 both. In three cases another family member was killed alongside the patient/by the patient
Diagnosis–homicide time lapse	Most deaths (19/24) within 3 years of diagnosis including 7/24 within 6 months, 6/24 within 7–12 months, 4/24 within 13–24 months, and 2/24 within 25–36 months
Country	All England except one from Wales (Andrea)
Victim + perpetrator ethnicity	Largely White British. $N = 3$ White Other (Irena, Olga & Viktor). $N = 1$ British Indian (Sana). Both parties unstated in four cases, perpetrator unstated in one case
Sexual orientation	Mostly unstated: in those where it was ( $n = 6/24$ DHRs) both were heterosexual
Age	Mean 62, median 67. 3/24 DHRs provided an age-band, rather than exact age.
Children under 18	3/27: Andrea; Connie, Julie
Gendered dynamics of killing	<b>21/27 women killed by men:</b> 14/27 IPHs, 2/27 filicides (both co-occurred with IPH), and 4/27 matricide (2/4 previously perpetrated IPV towards women). One female suicide after male-perpetrated IPV. <b>3/27 men killed by men:</b> all patricides, all men who killed the victims had IPV history to women. One co-occurred with matricide. <b>2/27 women killed by women:</b> both matricides resulting in hospital orders. <b>1/27 man killed by woman:</b> filicide
Review period	2/24 excluded cancer treatment period (Claire & Charlotte; Diane)
Terms of reference mention cancer?	4/24: Barbara; Jean & Sarah; Bridget; Olga & Viktor. A fifth report (Fay) mentioned carer stress
Cancer care represented in review?	Cancer HCPs on the review panel in 2/24 cases: Barbara (cancer charity); Julie (hospital was a cancer centre). Hospital safeguarding leads were often on panels. All DHRs had secondary healthcare 'Individual Management Reviews' but with unclear cancer services contribution

diagnosis (the report raises a suicide pact possibility based on family reports); Bridget whose diagnosis was terminal (her son felt the IPH was assisted suicide); Fay and Mary, who had dementia diagnoses and husbands with terminal cancer diagnoses (both reports indicate caregiver stress); and Nell whose diagnosis was terminal and whose husband had a dementia diagnosis. In “suicide pact”, “assisted suicide”, and dementia cases, partners/husbands admitted guilt before parasuicide or suicide, reports did not present evidence of victims’ wishes to die, and testimonial networks emphasized there was no DA pre-killing, although Bridget, Mary, and Nell’s reports explicitly framed the homicides as DA acts.

Qualitative findings comprised three themes. Theme 1 answered RQ 1, theme 2 RQ 2, and theme 3 RQ 3. Findings aligned with the social-ecological framework’s four levels (Graham et al., 2022).

## **Theme 1: How Cancer and DA Affected Each Other**

### **Cancer Diagnoses Affected Vulnerability to DA and DA Affected Cancer-Related Quality of Life**

Victims facing cancer diagnoses and DA were physically, emotionally, and financially vulnerable. Connie’s suicide report stated that she told her mental health team she felt vulnerable to being hurt by her ex-partner while she was in treatment. Victims moreover felt they had a reduced ability to cope with cancer treatment/caregiving because of the DA, and reduced ability to seek help for DA because of cancer treatment/caregiving. The stresses of cancer treatment also exacerbated the impact of the DA and vice versa. Connie’s report for example stated that she found her ex-partner’s harassment via text message especially hard to cope with while also coping with her diagnosis. Olga and Viktor’s matricide-patricide report similarly suggested that Olga’s ability to cope with, and seek help for, her son’s economically abusive and financially exploitative behavior was reduced because she was caring for her husband Viktor, who had a terminal cancer diagnosis. The impact of financial exploitation was even worse because Olga was already anxious about funeral costs for Viktor. Olga told a friend she was afraid of her son. However, her ability to seek help was constrained because as a migrant, she was fearful about her rights in the UK. Their son did not have the correct permission to be in the country, yet had coerced his parents into moving into their one-bedroom apartment with his large dog: a fact that Olga felt she had to hide from professionals who visited the home (see 2.2). The report suggested that her son took advantage of the fact that she was preoccupied with caring for Viktor. In other cases, perpetrators used physical abuse towards victims during treatment, while they were dealing with its physical effects (Andrea [IPH]; Connie [suicide]; Gale [IPH]). Victims often faced related issues

that contributed to their vulnerability, e.g., older age, mental health problems, social isolation, and financial difficulty, sometimes due to giving up work.

In a few cases (Andrea, Connie, Gale, Irena [IPH]), victims used alcohol to cope with DA, which could jeopardize their recovery from cancer, mask the signs of DA (e.g., depression, bruising assumed to be from injuries while intoxicated), and create dependency on the perpetrator to acquire alcohol. Irena’s report stated that she also faced unstable housing, mental health problems, and social isolation (having migrated to the UK a year pre-diagnosis). Her cancer treatment moreover pushed her into financial difficulty as it caused her to give up work (which the report stated was low paid, indicating she would not have had savings to fall back on), and she had to borrow money from acquaintances of herself and her partner. These difficulties made ending her relationship with her partner less possible. Financial difficulty also featured in Kathleen’s matricide report, which stated Kathleen faced emotional and financial “strain” (p.25) looking after her son. Both were unable to work: the son due to his mental health problems and Kathleen due to cancer treatment and caring for him.

DA also had the potential to affect cancer recovery and/or quality of life. Firstly, the abusive behavior included interference with patients’ basic necessities. Olga’s friend recounted that Olga’s perpetrator son exerted control in the flat: e.g., Olga wanted the window open so Viktor, who was bedbound, could get fresh air, but their son disallowed it as he said it could affect his dog: Olga felt unable to go against his wishes. She furthermore felt unable to leave Viktor alone with their son as she did not know what he would do to Viktor. Secondly, the abusive behavior involved chemical control (Walker et al., 2023), i.e., medicating the victim and interfering with their prescribed medicines. For example, Zoe’s matricide report stated that her perpetrator daughter stole her morphine. Irena’s IPH report stated that her partner injected her with vitamins acquired abroad during her cancer treatment, which the report framed as indicative of coercive control. Thirdly, the abusive behavior prevented victims from focusing on rest and recovery. William’s patricide report stated that his ex-partner asked if their perpetrator son could live with him. He had physically assaulted her and resultantly had to move out of her house. William was reportedly upset, wanting to focus on recovery and having too much to deal with given his treatment. He was especially anxious because he had limited space at home due to hoarding behavior, which he wanted to address after his treatment. He tried to express his vulnerability to his GP (explored further in 2.1).

### **Lack of Informal Support From, and Exploitation by, Partner/Family Member**

Victims faced barriers to seeking informal support for both cancer and DA, for example, because they were too afraid

to leave the house (as in Olga's matricide report), or were socially isolated, being off work and having a limited social circle (as in Kathleen's matricide and Irena's IPH reports). Victims and perpetrators also declined offers of formal support, as Theme 2.2 describes later. Thus, the reliance of victims on perpetrators, and vice versa, was intensified. For victims living with cancer, dependence on neglectful, abusive partners or family members for basic cancer support increased their vulnerability to preexisting DA. Diane's IPH report stated that she talked to friends about her unsupportive husband, telling them he did not attend appointments with her, and continued alcohol abuse during her treatment despite her asking him to stop. Other perpetrators gave support but enforced repercussions e.g., taking financial advantage post-treatment as "payback", as per Kathleen's report.

For victims who were caregivers for perpetrators living with cancer (all women caring for men), reports suggested that the perpetrators coerced victims to re-instate relationships with them in order to meet their support needs. The hospital investigation report linked to Ivy's IPH stated that pre-diagnosis, she and the offending ex-partner had been estranged for a decade. Janice's IPH report similarly stated that her ex-partner wanted to rebuild his relationship with her. Reports implied that perpetrators exploited gendered obligations to provide care, manipulating women into re-instating relationships. Janice's daughter reported that Janice felt no one should die alone, and were it not for the perpetrator's terminal diagnosis, she would not have re-entered the relationship. In a different, related example, Roy's patricide report stated he was terminally ill and wanted to see his estranged son before he died: the son moved near Roy ostensibly to support him but killed him days later.

### Using Cancer Diagnoses as a Trigger to Instigate or Escalate DA

In some cases, perpetrators used a cancer diagnosis as a trigger for escalating preexisting abuse. Firstly, perpetrators made overt attempts to manipulate others using their own cancer diagnosis. Lily's matricide report, for example, stated that her perpetrator son abused his wife and children, and "those that knew him described how he would use [his chronic myeloid leukemia diagnosis] as an excuse for his behavior" (p.29). It described how the perpetrator repeatedly asked his pastor and friends to pray for him, saying he was dying (although the report indicated that his prognosis was good). He told children's social services that "he was dying of leukemia and could not see his children" (p.30). He repeated this claim to police officers a month later after being arrested for a DA incident towards his wife, saying that his wife was keeping them from him because of his leukemia. He also accused his wife of causing his leukemia by poisoning him. The perpetrator thereby used his diagnosis to

elicit sympathy, manipulate, and excuse, minimize, and justify his behavior. In a more subtle example, Claire & Charlotte's IPH-filicide report stated that the perpetrator "considered himself to be meticulous and organised...a foundation based on the diagnosis of prostate cancer, where he lived by a very rigid calendar...to feel in control of his life" (p.18). His sons said, "his needs became paramount and even the family's food had to be tailored to his requirements" (p.18). Our interpretation is that the perpetrator used his diagnosis to justify domestic control and a sense of entitlement.

Secondly, perpetrators were jealous of, had a sense of spurned entitlement about, and exacted punishment for the increased attention to victims living with cancer. For example, Claire's report stated that when she was diagnosed with cancer 3 years earlier, "the perpetrator made an outburst to [their sons] when they were discussing their mother's health... 'Do you know what it's like having a wife who's got cancer[?]'...aimed at creating a sympathetic approach to him, rather than concern for his wife" (p.17). In another example, Gale's IPH report stated that her perpetrator husband claimed he was receiving insufficient family attention during her recovery from a mastectomy. He used this as justification for increased aggression: he tried to hit Gale, but their daughter stood in between them. The report stated Gale went "to live with [her daughter], taking pictures from the walls and intending to live separately from [the] perpetrator" (p.14). Our interpretation is that punishments, and resultant safety strategies, were disruptive for victims given their diagnoses. Gale returned after 2 weeks, suggesting coercion or dependence on her husband for care. The report suggests physical abuse went on until the homicide 7 years later: post-mortem pathology found significant injuries over a long period.

Thirdly, perpetrators' sense of spurned entitlement was also evident when victims living with cancer changed their routines and domestic duties and thus contravened gender norms. In Kathleen's matricide report, her perpetrator son told a psychiatrist (post-killing) that his mother "disrespected him...How could she let her son starve? There was food at her flat that I could have. After a while she stopped buying food and started buying special diet food [linked to her recovery] that I hated" (p.21). The report stated that Kathleen may have reduced support for him post-diagnosis: we interpret that he may have thereby felt his punishment was justified.

Perpetrators who used a cancer diagnosis as a trigger for escalating preexisting abuse linked their behaviors to mental health issues and alcohol use. For example, Kathleen's report stated that her perpetrator son discussed the impact of Kathleen's cancer diagnosis in GP consultations about stress and depression. Moreover, Williams' patricide report stated that his perpetrator son said he assaulted his mother because of an alcohol relapse, which he in turn blamed on the stress



of his father's cancer diagnosis. Furthermore, Diane's IPH report cites her friends as saying her perpetrator husband drank through guilt and shame at being unable to cope with her diagnosis. Perpetrators thus used diagnoses to justify alcohol abuse, which along with mental health problems, is a known risk factor for homicide (Spencer & Stith, 2020).

In several cases, the cancer diagnosis was a trigger for abuse escalation in another way: it led to a breaking point whereby the victim tried to end or ended a relationship (another domestic homicide risk factor (Spencer & Stith, 2020)). As described in Olga and Viktor's matricide-patricide report, stress and DA escalated as Viktor became more ill, eventually leading Olga to seek help and ask their perpetrator son to leave: days later, he killed them. Ending a partnership was also a trigger: Andrea's IPH report stated that she ended her relationship with the perpetrator around the time of her cancer diagnosis: DA, including physical abuse, was ongoing during her treatment and he killed her within a year. Moreover Diane's husband's lack of support led her to draw support from a friend who became her partner, who said her cancer diagnosis was a turning point, leading her to end the marriage. Her husband killed her as she collected belongings to move in with the partner.

Turning to IPHs where one party had a dementia diagnosis or the possibility of a suicide pact (Barbara) or assisted suicide (Bridget) was raised, four reports framed the cancer diagnosis as the homicide trigger. In the first example, Nell's husband, who was living with dementia, called the police after killing her, saying he could only see "death and horrible things" ahead (p.7). Second, Fay's husband left a suicide note explaining that he killed Fay because of her dementia symptoms and challenges of caregiving while living with his terminal cancer. Third, before killing Mary, her husband, whose cancer diagnosis was also terminal, told his GP he feared what would happen to Mary if he died first. Fourth, in a slightly different example, Barbara's report framed a *good* prognosis as the trigger: family said Barbara's partner felt low when told his cancer was treatable: he and Barbara were depressed, cancer was his "way out" (p.14) and he "couldn't go on like this" (p.12).

## Theme 2: Professionals Missed Opportunities to Identify and Respond to DA

### Cancer, Mental Health, and Older Age Masked Indicators of DA

Reports suggested that at times professionals interpreted possible DA indicators as normal presentations of living with cancer and its mental health and stress-related consequences (including when caring for someone with a diagnosis). As a result, cancer diagnoses limited or obscured professional curiosity. DA indicators were more likely to be masked or

explained away if mental health problems, and/or older aged featured. DA indicators that GPs assumed to be due to the cancer diagnosis included sleep disruption, depression, and anxiety (Katheleen matricide, Diane IPH), suicidal ideation (Julie IPH), alcohol use (Gale IPH; Andrea IPH), or the latter two in co-occurrence (Irena IPH; Connie suicide). DA indicators misinterpreted as responses to caring for someone with cancer featured in Olga and Viktor's matricide-patricide report: Olga told her GP about her financial worries, likely exacerbated by economic abuse from her perpetrator son, but the GP assumed the worries were a normal part of funeral planning for Viktor. In another example, Janice's IPH report stated that she saw her GP after a panic attack, which the report suggested was due to the perpetrator's recent release from prison on license to stay with her. According to the reports, in neither case did the GPs enquire about DA. A cancer nurse also misinterpreted DA indicators: Annette died after an altercation with her son. She reportedly perpetrated DA to him. The son told Annette's Macmillan nurse that he was unwell and no longer coping with caring for her. The nurse recommended that he seek support from his GP and social services, but his mother had declined their at-home help. In the report, the nurse reflected that she could have explored his concerns and support options further, although whether she knew about Annette's abuse is unclear. Professionals also missed perpetration risk factors such as the perpetrator son's drug use in Lily's matricide report. Misinterpreting indicators precluded opportunities to enquire about DA.

Considering cases featuring mental health diagnoses, Zoe's report stated she told her GP that her perpetrator daughter headbutted her (before her cancer diagnosis). The report framed this as a missed opportunity to explore DA, potentially because the GP assumed this behavior was unremarkable given the daughter's serious mental health disorder. The report for Julie, who had autism as well as mental health problems, described that hospital ward staff found her eating just before her surgical cancer treatment, so cancelled her surgery. She became distressed and tried to self-harm, and when a nurse phoned her husband, the perpetrator, to collect her, Julie threatened to "beat him up and go wild again" (p.24) and ran from the ward. The report framed this behavior as related to her anxiety and autism; the way staff members' framed the behavior was unreported. We question whether unconscious ableist biases about autistic individuals may have clouded judgement over whether Julie in fact felt fearful of her partner. Julie had previously told her cancer care team, while distressed, that she had enough pills for suicide: the report simply noted that staff removed her medication, and no one enquired about DA. Irena's report described that she was hospitalized after alcohol use post-cancer diagnosis, and told ward staff she had agreed with the perpetrator not to tell them she was depressed: the report did not state whether anyone questioned her comment. Finally,

Ivy's IPH reports stated that her partner, who was living with cancer, accused Ivy of infidelity and disclosed thoughts of hurting or killing her, both to Ivy and his mental health professionals. Professionals explored his plans to kill up until the day pre-homicide, but diagnosed these as intrusive thoughts. Ivy told her GP about his accusations days before her death, who missed the opportunity to enquire about DA. The report suggests HCPs did not consider DA as Ivy had not disclosed it previously.

Regarding cases featuring older age, Ivy's report also stated that she had several falls during the patient's treatment period. She gave two professionals two different explanations for (possibly) the same fall. The report pointed out that no evidence suggested the falls were *not* age-related, but opportunities to enquire about DA, especially considering the accusations and threats, were missed. William's patricide report pointed out that professionals did not consider DA in his case—likely because he was an older *man* and the abuser was an adult *son*—and thus inadequately safeguarded him, with no DA support referral. HCPs and police underestimated the risk of DA, even after his cancer diagnosis and disclosure to his GP that he feared his son, who was about to move in with him. The GP contacted the police who tried to instigate a non-DA specific multi-agency response to risk, however, William did not consent for the police to take further action, and DA avenues that would not rely on victim consent (e.g., multi-agency risk assessment conference [MARAC]) were not considered. In Sana's matricide case, our interpretation is that the victim's dementia diagnosis and normalized use of family members for language translation, as well as her older age, may have led to an unethical suggestion going unchallenged. Here, Sana's daughter told the consultant that she did not want Sana to know about her own diagnosis and that her sister (the perpetrator) would sign all consents, e.g., for diagnostic biopsy, without her mother knowing. Whether formal safeguarding concerns were raised was unstated. HCPs' reliance on family members for language translation perpetuated health inequalities for migrants and removed disclosure opportunities. Nurses similarly relied on Olga to translate for Viktor.

In IPH cases with older victims and no evidence of DA apparent (e.g., Fay, Bridget), reports tended to question whether male partners' personality attributes and relationship dynamics could be DA indicators: however, family, friends, and professionals normalized these attributes, based on arguably ageist assumptions that older women are content with gender norms where men are *in control* or *in charge* (report quotations) of domestic life. Male partners were described as *rigid*, *judgmental*, *traditional*, *responsible*, and *proud* in these reports. Family members moreover described couples or families as *private* or *insular*, sometimes not talking about cancer and treatment (Jean and Sarah IPH & filicide; Bridget).

As well as explaining away DA indicators, professionals explained away DA incidents as being due to cancer. Lily's report described that a children's school safeguarding lead visited her perpetrator son's family at home after his child's school absences. The perpetrator (who had leukemia) disclosed that he had kicked the child. A month earlier the child's mother disclosed physically hurting the child. In both cases, the safeguarding lead felt the family's cancer-related stresses explained the incidents; she thus chose not to refer to children's social care. Moreover, in other cases, professionals explained away the homicides themselves as being due to cancer. In Bridget's case, police officers who initially attended the homicide scene assumed she had died from her cancer, raising a practice issue for future consideration. In Jean and Sarah's case, a trial judge sentenced the perpetrator on the basis that he killed his wife due to an "adverse psychiatric reaction" (p.4) to cancer steroids: the perpetrator was part of a drug trial, testing a new drug combination, which he stopped taking 6 days pre-homicide due to side effects. The report cited mood swings, confusion, and aggression as possible side effects, but also a hematology consultant and professor, who considered it "very unlikely that the steroids... would have had any effect on him that day" (p.8) as "aggressive behaviour... rapidly resolve[s] once the steroids are no longer taken" (p.24). In Barbara's report, framed as a possible suicide pact, we question whether the report panel would have similarly considered iatrogenic contribution to the homicide had the partner not suicided. Barbara and her partner lived with depression, and her partner had a cancer diagnosis. The report stated that his hormone therapy had a depressive side-effect. The partner's consultant stated that he usually discusses this risk with patients, monitors depression, but prioritizes treatment.

### Turning Down Formal Support and Treatment as a Potential DA and/or Homicide Indicator

As 1.2 mentioned, victims frequently declined formal support and treatment offers. Offers may have been inadequate or inappropriate: however, HCPs, other professionals, and most report authors overlooked the possibility that victims feared retaliation if they accepted support or that perpetrators were isolating victims by depriving them of it. Nell (IPH) discharged herself early from a hospital stay when cancer was suspected (she was readmitted and diagnosed days later), declined a social care service for herself and her husband (who had "worsening dementia" [p.8]), and delayed a carers assessment upon hospital discharge: it was rescheduled for a few days later but her husband killed her before it could be done. Perpetrators also declined support and treatment, e.g., mental health referrals offered by cancer HCPs (Jean and Sarah IPH & filicide; Lily matricide). Annette declined a range of support offered to herself and her carer son (who disclosed abuse from her).

Victims moreover feared what agencies and services would do in response to disclosures, so did not disclose, thus by definition, did not seek support. Fear of institutional violence, including institutional victim-blaming towards mothers, intersected with cancer and DA-related barriers to support. For example, Connie's mother's testimony in her suicide report explained that services removed Connie's first child and she feared they would remove her second. The report posited that infertility, caused by cancer treatment, intensified this fear. This fear, and her cancer treatment and its priority in other professional interactions, complicated her access to DA and mental health support, leading her to disengage with services. Fear of institutional violence in the form of xenophobia also featured, as 1.1 indicated: Olga and Viktor's matricide-patricide report described that Olga feared the housing association would discover their perpetrator son living with them and evict them: thus, she was anxious when nurses made home-visits. The report stated, "the hostile environment policy towards migrants...which includes a duty to check [their] 'right to rent' (p.9)...increases fear of the use of power by state agencies (p.22)... and the policy of some agencies to report people to the immigration authorities (p.23)".

In other cases, patients' declining formal support and treatment may have indicated that they were planning the homicide. In Peter's filicide report, his perpetrator mother declined further cancer treatment: she told Peter's learning disability support workers she was suicidal and that declining was her way of letting death "happen naturally" (p.23). She and her husband also declined offers of additional support to care for Peter, whose learning disabilities were profound. Often, declining support was under- or unquestioned because the decision-maker had, or was assumed to have, mental capacity. In the IPH report for Mary, who had a dementia diagnosis and husband with a terminal cancer diagnosis, HCPs reflected they could have challenged his decisions to decline support: the need to better understand the way cancer and other life-changing diagnoses may affect decision-making capacity was an explicit 'lesson learned' in the report. In Fay's IPH case, her perpetrator husband declined surgical and radiological cancer treatment: GPs missed opportunities to discuss his reasons in cancer care reviews (as explored in the next subtheme). He and Fay also declined several offers for support around Fay's cognitive impairment, again with no evidence of a capacity assessment for her to make this decision. Their children did not pressure him to accept formal care as they wanted to enjoy their final days together, suggesting informal supporters' possible reluctance to challenge the behavior of an ill or dying person.

### **Fragmented, Siloed, and Non-Holistic Care**

A reason that professionals sometimes missed DA indicators described in 2.1 and 2.2, despite increased contact, was that

co-occurring issues relating to health and care, e.g., cancer, mental health, substance use, DA, and safeguarding were addressed non-holistically, and in isolation, by different services and agencies. Thus, no professional had a full understanding of risk and need. For example, Andrea's IPH report stated that cancer HCPs recorded nothing about DA, despite treatment and DA co-occurring: it is unclear whether they knew about the DA. It also stated that it was unclear whether any cancer HCPs conducted a holistic needs assessment, which would have been an opportunity to share relationship concerns. In another example, while professionals were aware of Connie's multiple vulnerabilities before her suicide (e.g., child protection concerns, alcohol use), GP contacts largely focused on cancer and secondary care on cancer or mental health. Moreover, GP contacts reduced as secondary care for both health needs increased. This transfer from GPs, who might have had a better overview of all issues the patients faced, to more specialized secondary care was a common finding.

Cancer HCPs discussed that holistic care was difficult. For example, in Jean & Sarah's IPH-filicide report they described a "difficult balance between providing acute medical care... [while] being mindful of...emotional and mental health needs and social circumstances". It stated that "little was recorded about [Jean or the perpetrator]" (p22-23). Similarly in Barbara's IPH case, regarding the depressive side-effect of her partner's medication, the consultant urologist stated that "with locally advanced disease... the priority is commencement of treatment and the patient's mood is monitored" (p20-21).

If GP appointments happened while the patient was under secondary care, they sometimes focused solely on cancer; sometimes because other professionals had not shared information with them about additional issues, but at other times for unclear reasons. For example, there was no evidence in William's patricide report of enquiry about DA at a GP appointment for cancer treatment, which followed the police decision to take no further action regarding his perpetrator son. Moreover, there was no evidence of a GP cancer care review for Fay's perpetrator husband in her IPH report: these reviews are intended to encourage a holistic approach to cancer care, but review entries simply stated, "under care Urology" (p18) with a prompt to review every 3 months (p.18). There was no evidence of any other type of review (e.g., wellbeing or medication review), and little evidence of multi-disciplinary working between general practice and other services. This was despite his terminal cancer diagnosis, Fay's cognitive impairment, and them sharing a GP. A year pre-diagnosis, her husband wrote to the practice, "I feel low, tired...and irritable...all the time, humourless and looking for domestic trouble...ask my wife" (p.30). The report stated that there was no evidence of anyone questioning this comment. If they had done so, and if GPs had conducted

cancer care and other reviews, other behaviors (e.g., decisions to turn down care offers, see 2.2) might have prompted DA enquiry.

An underestimation of holistic needs and a missed opportunity to offer a referral to an appropriate service was described in Kathleen's matricide report. Kathleen turned down an offer of group counselling for depression as it was during working hours: the report speculated that taking leave for her cancer surgery potentially made her reluctant to take more. It suggested that she may have been more willing to discuss her cancer recovery and caregiving for her perpetrator son, who had mental health problems, in individual counselling, and to take leave for a more suitable offer. More suitable counselling may have provided an opportunity to disclose DA. Relatedly, in many cases (Annette, Barbara, Bridget, Fay, Mary, Nell, Sana, Zoe), opportunities to support carers through carers' assessments or case conferences were missed or delayed, even in cases of co-existing vulnerabilities e.g., mental health problems and cognitive impairment.

### Holistic Care Undermined by Not Exchanging Information

Cancer HCPs sometimes took a holistic approach within individual consultations, but the approach was undermined and care was still siloed because they did not seek or share information with other professionals in a timely way, if at all. Exchanging information was not embedded into routine practice and as a result, opportunities to build a picture of victims' risk and need were lost. In her suicide report, Connie's oncologist noted her distress and that she was a full-time mother who misused alcohol, but did not make a referral to hospital safeguarding or social services. Rather, they recommended Connie contact her social worker, thereby putting the onus on Connie to make proactive contact at a time when she was struggling to maintain contact with the several agencies and services already involved in her care. The report also points out that the oncology electronic health record was not accessible to other staff, meaning cancer HCPs would need to proactively share information to trigger any further care. Previously, a mental health doctor had similarly not shared information with hospital safeguarding despite Connie talking about her cancer, DA, and fear of her perpetrator ex-partner. The report framed this omission as especially concerning given that "she was very vulnerable" (p.37). For Connie, the lack of sharing also meant children's social workers, who knew about the DA, only became aware of her cancer 7 months after its diagnosis, so they were unable to consider its impact on her decision-making in resuming the relationship with the perpetrator (which instigated child protection proceedings).

Lack of sharing by cancer HCPs also led to missed opportunities to identify perpetration risks. For example, Lily's

matricide report stated that her perpetrator son (who had leukemia) and his hematology research nurse had long conversations about his mental health. The nurse offered advice, support, and signposting, but he declined. She later reflected that she should have formalized and shared her concerns about his mental health with other professionals. In Jean & Sarah's IPH-filicide report, the GP shared that following the perpetrator's diagnosis, oncology letters to the practice were delayed, so he could not determine the perpetrator's support needs. Furthermore, Peter's filicide report stated that the oncology team managed his perpetrator mother's anxieties well, and knew she was Peter's carer, but they did not share information with learning disability social workers, who led the family's care. She told social workers her husband abused her and Peter, and according to ambulance staff, she made threats to kill Peter due to caregiver stress. The report posited that information sharing may have allowed professionals to note increasing stress and decreasing support and create a coordinated whole-family action plan.

Non-cancer HCPs also missed opportunities to exchange information with cancer HCPs who may have had more recent information about the patient due to more frequent contact. For example, Andrea's IPH report stated that she attended an emergency department after her perpetrator partner assaulted her and a nurse made a MARAC referral. Her cancer treatment was ongoing: our interpretation is the nurse could have shared information with her cancer team as a safety net, allowing the team to enquire about and respond to DA at subsequent appointments. This process would have been especially useful because, unbeknown to the referring nurse, the police rejected the MARAC referral. In another example, the hospital investigation report linked to Ivy's IPH criticized her perpetrator partner's mental health professionals for not seeking information from two hospitals where he received cancer care and where "marital disharmony" (p.10) was discussed in every consultation. It moreover criticized them for not sharing information about his mental health and suicide risk with other professionals, and his care plan with his GP. Like Connie's case, the report explicitly stated that the cancer diagnosis made this missed opportunity particularly serious—cancer-related complications would have increased GP contact thus, there would have been many opportunities to enquire.

### Theme 3: Under-Consideration and Misunderstandings of Cancer Diagnoses in DHR process

Several reports explored the impact of the cancer diagnosis on DA and domestic homicide/DA-related suicide and the potential for the diagnosis to trigger abusers to start or escalate DA. However, some reports (e.g., Sana [matricide]) under-considered the impact of cancer, even when the

diagnosis and treatment fell within the report review period. Furthermore, the period in which the cancer diagnosis was made was excluded in two reports, Claire & Charlotte (IPH-filicide) and Diane (IPH), despite family and friends citing the diagnoses as relevant to DA and despite Claire & Charlotte's report stating that scant relevant information was retrievable from other agencies. Other reports arguably over-reported minor and personal medical details.

There were misunderstandings and misassumptions about cancer services, potentially due to a lack of cancer representation on multi-agency review panels. For example, Kathleen's matricide report expressed surprise that no one referred Kathleen to the "Macmillan Nursing service" (p.33) and Jean and Sarah's IPH-filicide report stated that it was unclear whether "the Macmillan service" (p.20) was aware of the perpetrator's diagnosis. However, Macmillan nurses are largely incorporated into multidisciplinary care teams, not a separate service (Macmillan Cancer Support, 2025). Inconsistencies between reports emerged about how a cancer diagnosis might affect the frequency of general practice appointments: e.g., Connie's suicide report reflected that as cancer treatment progressed, general practice contact decreased, while Fay's IPH report claimed "patients quickly resume consultations in general practice at an increased rate to pre-diagnosis and treatment" (p.18). There were even inconsistencies within reports: Fay's later stated that post-diagnosis, the "majority of [the perpetrator's] management was coordinated by secondary care" (p.19). Such comments suggest an overestimation of general practice HCPs' opportunities to identify risk and an underestimation of the same

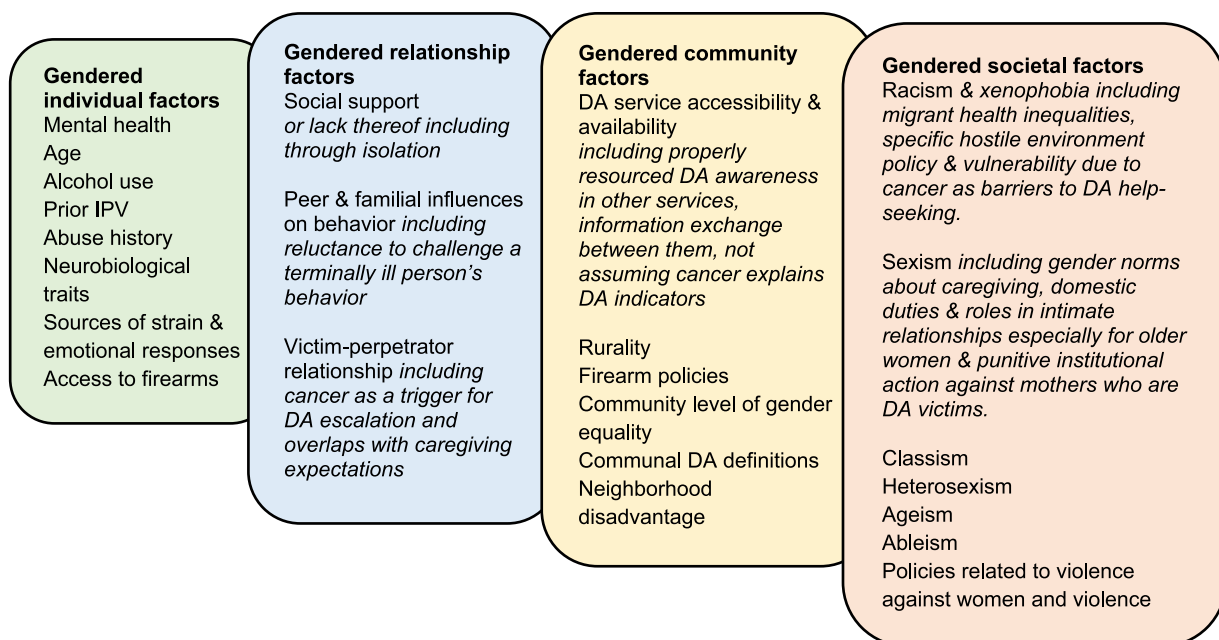
for cancer HCPs. As our Online Resource shows, only 5/24 reports identified lessons learnt, changes made, and recommendations specifically for cancer HCPs. All five featured terminal cancer and/or dementia.

## Social-ecological Model to Summarize Findings

We adapted Graham et al. (2022) social-ecological framework for IPH using the reports we analyzed (Fig. 2): examples from our analysis are in *italics*. Not all factors featured in our analysis but they will likely have been relevant. The figure contextualizes our findings within a more comprehensive theoretical framework. Male-perpetrated femicide was the most common dynamic and male-perpetrated IPV towards women featured in several other cases: thus, gender remained a central factor. We found that cancer diagnoses compounded risk factors across all levels.

## Discussion

This study has illustrated the DA and cancer intersection and how cancer compounded risk. It illustrates missed opportunities to identify and respond to DA by HCPs and other professionals during and after cancer treatment and care, and omissions in DHR process. We found 27 victims across 24 DHR reports spanning 8 years. Victims were mostly older and were mostly women. Most were IPHs, but nine victims were killed by adult children. Most



**Fig. 2** Social-ecological domestic homicide model with cancer-relevant factors



deaths happened within 3 years of diagnosis: more recent diagnoses may have been more likely to fall within review periods. But this finding may also be evidence that illness was a trigger for escalated DA and domestic homicide if it created a loss of control, which perpetrators sought to regain, or an opportunity for control of which they took advantage. There were several examples of gendered caregiver dynamics (where a man killed a female caregiver or care recipient) including a subset of homicide-suicides.

We found that cancer was associated with physical, emotional, and financial vulnerability to DA and that these vulnerabilities intersected with others related to, for example, older age and complex mental health problems. In some cases, abuse intensified when the person took advantage of the physical and emotional changes associated with cancer and in others the victim had reduced resources and resilience to cope. Victims sometimes used alcohol (echoing earlier IPV research (Ogden et al., 2022; Sere et al., 2021)) increasing vulnerability to DA. Alcohol use during cancer treatment can impede long-term survivorship and treatment outcomes (LoConte et al., 2018). Perpetrators also used alcohol, a risk factor for male-perpetrated IPV and domestic homicide (Bracewell et al., 2022; Spencer & Stith, 2020), in some cases to cope with their own or the victim's diagnosis. Family members can be important sources of support for people living with cancer but after victims were diagnosed, perpetrators were unsupportive, or support was conditional. Moreover, some were isolated from informal support due to their ostensibly *private* familial nature, and others left work due to illness and had no contact with colleagues. Thus social support, a protective factor against homicide (Graham et al., 2022), was low. In this cohort, DA was a threat to cancer recovery and/or quality of life, including access to basic necessities and time and energy diverted away from recovery. All these factors, which span the individual and relationship level of the social-ecological model (Fig. 2), meant a cancer diagnosis often led to worsened DA.

DA is part of broader cancer care disparities linked to inequity, which there have been recent calls to address (e.g., Lancet, 2023). Findings support earlier research about cancer and IPV, and domestic homicides in general, where perpetrators isolated victims, increased controlling behaviors, and punished them for changes to attention (i.e., away from perpetrators) and to gendered domestic roles (e.g., reducing childcare and chores): these in turn affected recovery (Coker et al., 2017; Mejri et al., 2023; Sawin & Parker, 2011; Sharp-Jeffs and Kelly, 2016; Sheikhezahad et al., 2023; Speakman et al., 2015). Echoing earlier theory on illness as a homicide trigger (Monckton Smith, 2019) and female caregiving as a risk factor (Benbow et al., 2019; Bracewell et al., 2022; Cohen, 2019), our study uniquely adds that perpetrators used their own cancer diagnosis as an opportunity to excuse and

justify their behavior, manipulate others, and claim entitlement to exert increased control. In a scoping review of DA and life-limiting illness, Myall et al. (2023) found that while illness could be a catalyst for abuse, power imbalances and abuse often pre-dated illness.

Earlier cancer and IPV research points out barriers to ending a relationship, such as economic reliance on perpetrators including for health insurance (Mejri et al., 2023; Sawin & Parker, 2011). Our findings add that perpetrators living with cancer may have coerced estranged victims into re-establishing contact to provide care: victims may have felt obliged due to an internal sense of moral duty and cultural norms on women to provide care (Wuest et al., 2010). Echoed in our study, participants in earlier studies about cancer and IPV (Sawin et al., 2009; Speakman et al., 2015) began to help-seek and decided to end the relationship after the diagnosis, seeing it as a turning point for “reassessing life and re-evaluating relationships” (Sawin et al., 2009, p688-689). In our study, however, threatened or actual separation was another trigger for abuse escalation. We found indications of family reluctance to challenge a terminally ill person's behavior: other research shows that families worry intervening will threaten their own or the victim/survivor's safety and welfare (Chronister et al., 2022).

Linking to the social-ecological model's community level (see Fig. 2), although there was intensive contact with the healthcare service, HCPs often missed DA indicators. There was insufficient recording and exchange of information, fragmented care, missing carer's assessments, and inadequate support options (e.g., counselling): common findings in DHR-based research more generally (e.g., Sharp-Jeffs & Kelly, 2016). We found that patients' cancer care took precedence in different healthcare services. Treatment periods reduced contact with GPs who are more likely than cancer HCPs to have DA training (Feder et al., 2011). In theory, the move towards personalized cancer care might mean cancer HCPs had more information (or at least more up-to-date information) about recent patients than other services, but two reports stated that cancer care reviews were missing or incomplete. In a scoping review about cancer care reviews, Gopal et al. (2023) argue that the template structure makes the discussion into a tick-box exercise rather than an open needs-led discussion, with the latter requiring more investment into time, communication channels with secondary care, and training about long-term cancer care. They also found that caregivers felt cancer care reviews did not address their needs. We suggest that holistic approaches within cancer care were not always possible or successful because the health system is fragmented in design (Bramwell et al., 2023): information exchange with other healthcare departments, agencies, and services does not always happen.

Our findings moreover indicate that cancer itself limited professional curiosity, in that professionals misinterpreted

possible indicators of DA (anxiety, depression, sleep disruption, financial worries) as normal presentations of cancer and/or mental health problems. Chemotherapy and other cancer treatments can increase bleeding and bruising (NIH National Cancer Institute, 2022), some evidence suggests treatments can increase aggression (Ismail et al., 2017), and popular discourse is that cancer causes relationship stress (e.g., Cancer.net, 2021) which might also mask DA indicators. Complex mental health problems or older age made DA indicators even more vulnerable to being explained away. Others (Benbow et al., 2019; Bows, 2018) have written extensively on how DA among older people is underreported, under-researched, and underrecognized in both practice and policy, potentially because of this masking (e.g., social isolation, bruises, and injury being common to both DA and being older (Solace Women's Aid & Dewis Choice, 2021)). Relatedly professionals may not recognize abuse perpetrated by adult children as DA: training and guidelines focus on IPV (Bracewell et al., 2022) and victims/survivors may underreport such abuse due to conflicting feelings, e.g., not wanting their child to have a criminal record. Professionals who do recognize abuse often mislabel it as elder abuse, resulting in a social welfare response rather than access to justice options through DA services (Wydall et al., 2018) or mislabel it as caregiver stress, resulting in support for carer-perpetrators (Solace Women's Aid & Dewis Choice, 2021). Professionals missed DA risk indicators in the nine cases where the person living with cancer committed the homicide. Earlier research shows that HCPs perceive various barriers to identifying and addressing perpetration among patients: lack of training and knowledge on how to intervene, safety fears, insufficient patient-doctor relationships, and uncertain duties of care if suspected victims are not their patients (Penti et al., 2017).

In addition to professionals missing indicators, perpetrators and victims commonly declined offers of formal support—for cancer care, DA, housing, children, mental health, physical illness, and alcohol use. Earlier research using DHRs has illustrated barriers to accessing support, particularly for victims and/or perpetrators with mental health problems (where mental health stigma is a barrier), older victims/perpetrators, and victims who rely on perpetrators for care (Bracewell et al., 2022; Sharp-Jeffs & Kelly, 2016). Barriers to other options for support meant that victims who were patients were more reliant on the (unsupportive) perpetrator. Victims also faced institution-related barriers to accessing support, including fear of institutional violence, relating to intersecting axes of oppression and linking to societal factors of the ecological model (Fig. 2). Specifically, gendered forms of stigma towards mothers experiencing substance use disorder, mental health issues, and DA (McGrath et al., 2023) and the UK Home Office's hostile environment policy towards migrants (Chantler et al., 2023) featured. The impact of barriers relating to oppression was not consistently

explored in reports: replicating findings elsewhere, reports often had missing data e.g., on ethnicity (e.g., Chantler et al., 2023).

Related to this, two cases involved victims whose family members were relied upon to interpret. In a toolkit about using interpreters for gender-based violence survivors, Ali et al. (2023) highlight risks of using family interpreters, and recommend that interpreters have a generic and contextualized level of cultural competence to allow for joint working with professionals. Recent oncology research cites common reasons that HCPs do not use interpreters: unrecorded language needs, suggesting a need for a policy on routine recording, and no available interpreters, highlighting a need for funded posts (Chartkul et al., 2024).

Several DHR reports explicitly raised the complexity of preventing domestic homicides in cases where no pre-homicide DA was evidenced: these included those that raised the possibility of assisted suicide, suicide pact, or caregiver stress. These deaths often involved a gendered caregiving dynamic: but importantly, in assisted suicide and suicide pact cases, reports did not present evidence of women's wishes. Websdale (2024) posits that domestic homicides by caregivers of people with dementia *are* sometimes due to a mixture of mercy and exhaustion, underpinned by depression and desperation. But he also emphasizes gendered aspects: men might be less accustomed to caregiving than women and more likely to reach exhaustion and resort to violence. Earlier arguments by Dawson include that since most alleged mercy killings (in Canada) are of disabled women, they should be seen within the context of ageism, sexism, and ableism (2021; 2019). Salari and Sillito (2016) similarly dispute the mercy rhetoric: they reviewed IPH-suicide cases against the US mercy killing definition and found that few fulfilled the criteria: i.e., there was no evidence that the victim wished to die. Salari (2007) moreover found that where older female victims were ill and older male carers were overwhelmed, there was little evidence that men tried to access formal care, which they frame as indicative of dominance and control. More generally in IPH cases with older victims, MacPherson et al. (2020) suggest that the subtlety of DA, even for victims, may preclude DA from being reported, recorded, or noticed—another barrier to accessing services. They write:

If both partners accept...men are the natural authority in the home, power abuses can remain relatively invisible until something happens to challenge or disturb the status quo. [Coercive control] may have existed quietly...Physical and cognitive decline... may...catalys[e]...more explicit violence... “merciful” motives may end up being attributed to violence that is experienced as unescapable. (p.26)

In our analysis, some family and friends of older victims said there was no DA pre-death and that victims accepted

so-called traditional gender norms. However their views may have been shaped by the ageist, sexist, and ableist biases Dawson highlights: norms that might be questioned only with hindsight. Websdale (2024) moreover points out that social networks of older people tend to shrink, and family and friends may assume that older people are unable to perpetrate DA. He encourages skepticism “about public evaluations of degrees of compassion shown by caring husbands” but also “about degrees of rage, not inferring chronic patterns of angry behavior based on isolated outbursts that make it into the official record” (p.204). An in-depth analysis of homicides framed as assisted suicide or mercy killing is outside the scope of this article,<sup>3</sup> but further thinking is required around disentangling dynamics in cases with older people when one or both parties are unwell. As awareness increases, those involved in DHRs might be more likely to question so-called traditional relationship dynamics. Including DA specialists on multi-agency review panels may help increase understanding of these dynamics. The support required in contexts of long-term, life limiting health problems beyond cancer requires consideration. Ongoing research by Salari and further DHR-based research could help to inform support options. The DHR Library enables filtering of cases by “victim or perpetrator had life limiting illness”, which will make future DHR-based research on this topic more feasible.

Concerning DHRs themselves, increased contact with services and cancer as a juncture of escalation or breaking point means that some DHRs possibly missed rich insight by not including cancer HCPs in information requests or DHR panels, and perhaps could have identified DA indicators where other professionals knew of none. This missingness of insight is reflected in the fact that we excluded 15 reports where cancer was stated with no further detail. Possibly linked were misassumptions in DHR reports e.g., about Macmillan services. These findings underline the importance of seeking information from testimonial networks as there were examples where they saw the diagnosis and treatment as relevant.

## Strengths and Limitations

This study is the first to explore cancer and DA in the context of domestic homicide and DA-related suicide. It is limited because one author was the sole data extractor for some reports. The primary focus of the research was qualitative analysis, thus we do not claim that the findings are

representative of or generalizable to all cases where cancer and DA intersect. DHRs for suicide in particular rely on teams connecting the suicide to DA (Rowlands & Dangar, 2024): we identified only one such case. We also focused specifically on cancer, rather than broader cross-cutting issues e.g., homicide-suicides including in contexts of life-limiting illnesses and gendered caregiving before domestic homicide, which other scholars have explored (e.g., Websdale, 2020). Finally, a small number of DHR reports were retrieved compared with previous studies (e.g., Chantler et al., 2021), but this smallness enabled an in-depth analysis of each DHR report. We have contributed to nascent literature and theoretical development (Graham et al., 2022).

## Recommendations for Practice, Policy, and Research

Regarding changes that healthcare services, and in particular cancer care teams, can make to identify DA and its risk markers, we echo recommendations by Owen-Smith et al. (2008) who argued for ongoing training and protocols for DA enquiry within the cancer setting in one US hospital. However one-off training alone may not change practice. Hospital-based DA practitioners improve survivor outcomes and, given the high costs of treating the consequences of DA, can be cost-effective and cost-saving (Halliwell et al., 2019; Melendez-Torres et al., 2024). Investment in these roles can ease pressures on HCPs and the healthcare service as these practitioners can develop and deliver DA training, establish DA champion networks of staff with enhanced training, improve holistic care, and establish referral pathways to DA services including for risk assessment. Our wider research has included a pilot study, which showed a generic DA coordinator role can be adapted successfully for the cancer setting (Dheensa et al., 2025). The training these practitioners deliver, and support they provide, should help HCPs work collectively to balance emotional and mental health, mood, and social circumstance with treatment, to recognize the impact of DA on treatment and cancer-related health, and to navigate the differences between caregiver stress and DA. Training should focus on all types of DA (not just IPV), and encourage a lower threshold for concern given the risk of DA indicators being masked or explained away in the cancer context (similar to calls from the older survivor context, Solace Women's Aid, 2021). Training should also address what to do if the caregiver rather than the patient is the suspected victim. Research with HCPs and survivors is needed to explore the acceptability and feasibility of DA enquiry and response (including during holistic needs assessments and cancer care reviews). Our work has also produced a “Cancer and domestic abuse toolkit for professionals” (Macmillan Cancer Support, 2024) and a parallel “DA in Life-Limiting

<sup>3</sup> In 2023, Crown Prosecution Service guidance for England and Wales was refined to assist prosecutors considering ‘mercy killings’ and ‘failed suicide pacts’. At the time of writing, the UK Government had just passed the Assisted Dying for Terminally Ill Adults Bill (2024).

Illness Toolkit” (Myall et al., 2024), which can provide some guidance in the absence of hired practitioners.

Other relevant recommendations have been recognized multiple times in earlier DHR-based research (e.g., by Sharp-Jeffs & Kelly, 2016) such as the need for information sharing (guidelines based in part on DHRs are published to make this practice more feasible (Dheensa, 2020)), multi-agency case conferences, and carers’ assessments. These assessments, along with holistic needs assessments and cancer care reviews, may help to establish support needs and pathways to whole-family support. Additional work needs adequate resourcing (e.g., time, funding, staff, private space) and can be led by healthcare-based DA practitioners.

For those involved in DHRs, we argue that illness should be considered as relevant to increased risk and that HCPs and other professionals (e.g., hospice staff (Myall et al., 2023) involved should be invited to share information and participate directly in DHR panels and process. Cancer should be captured within DHR scope to inform learning if diagnosis was near the time of death and/or testimonial networks consider it relevant.

## Conclusions and Further Research

The DHR reports we analyzed suggest that cancer may have led to vulnerability to DA and compounded other risk factors for not seeking support and for domestic homicide. They suggest DA may have affected cancer recovery and/or quality of life for victims with cancer diagnoses, and potentially perpetrators with diagnoses due to them declining support. We found that professionals misinterpreted possible indicators of DA as normal presentations of having cancer. As per other DHR-based studies, we found that siloed care was common. Unique to the cancer context, there was a reduction in contact with GPs, who may be more likely to have DA training than cancer professionals. Sharing information was not embedded into routine practice: non-sharing of information with cancer professionals, who may have had more information about the patient than other services due to more frequent contact, was a key missed opportunity. Cancer and DA co-occurred with other vulnerabilities such as mental health problems and older age which meant identifying indicators of DA was more difficult for professionals. Several reports with terminally ill older parties indicated that DA was not evidenced pre-homicide: there is a need for improved DA detection among older victims and a move away from uncritical framings of such homicides as suicide pacts, assisted suicides, or caregiver stress-related. At the same time, further investigation is needed on the tensions between access to assisted dying and DA in the context of domestic homicides. Regarding research using DHR reports, we agree with Cook et al. (2023) that an ethical framework

for their use is required: in the absence of such a framework, we adopted their approach. Research about the cancer-DA intersection and feasible and desirable interventions to increase enquiry and identification in the cancer context is now needed. Any intervention must incorporate training and support that encourages a low threshold for concern in the cancer context.

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**Data Availability** DHR reports can be shared upon request to the corresponding author.

## Declarations

**Ethics Approval** This study uses publicly available documents. The University of Bristol Research Ethics Committee confirmed that no ethical approval was required.

**Consent to Participate** There are no participants in this study which was a document analysis of publicly available data.

**Consent to Publish** There are no participants in this study which was a document analysis.

**Competing Interests** The authors have no competing interests to declare that are relevant to the content of this article.

**Conflict of Interest** The authors have no conflict of interest to declare that are relevant to this article.

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