Chelmsford Community Safety Partnership

Domestic Homicide Review / Domestic Abuse Related Death Review

Executive Summary Report

Case of Robert - Date of Death September 2022

Age 46

Colin Wilderspin Independent Domestic Homicide Review Chair and Report Author
July 2024

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The author of this Review, together with those who supported its development and the members of the Chelmsford Community Safety Partnership, wish to express their sincere condolences to Robert's family for the loss of their loved one in such tragic circumstances, which have led to the undertaking of this Review.

1. Introduction:

This Domestic Abuse Related Death Review (DARDR) was commissioned by the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB) on behalf of the Chelmsford Community Safety Partnership following the death of Robert (pseudonym), aged 46, who died by suicide in September 2022. The purpose of the review is to establish whether domestic abuse was a contributing factor, to identify lessons for local agencies, and to improve safeguarding responses in future cases.

2. DARDR Overview:

Robert was a 46-year-old man living in Chelmsford with his wife, Sarah (pseudonym), and her two daughters. He worked in the financial sector and lived with several long-term physical and mental health conditions, including depression, which had been treated periodically since 2017. His first wife had died from cancer in 2016, an event that had a profound and lasting impact on his wellbeing.

Robert entered a relationship with Sarah in 2019; she moved into his home in early 2020. The couple married in 2021. During their relationship, Robert experienced significant financial pressures, including personal debt which he attributed primarily to expenses linked to the household and to supporting Sarah. These financial pressures repeatedly appeared in healthcare and police records during periods of crisis.

Robert had two serious suicide attempts, in October 2020 and January 2021, both linked to relationship conflict and financial strain. He was supported by mental health services during this period and was discharged in August 2021 having been assessed as stable. No further agency involvement is recorded until his death in September 2022, when he died by suicide in a hotel room.

3. Panel Membership:

A DARDR Panel was established with relevant partners to oversee, and quality assure the review process and represent the agencies involved. This was led by Colin Wilderspin as an independent Chair. The panel's role involved supporting the collation of engagement information from partner IMRs and other agency information.

The full List of Panel Members and the Agencies contributing to the review are listed below:

- Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
- Chelmsford City Council
- The Next Chapter
- Mid and South Essex Integrated Care Board
- Essex Police
- Essex Partnership University NHS Foundation Trust
- Department for Work and Pensions
- Mid-South Essex NHS Foundation Trust
- Mid Essex MIND

Name	Role title & Team:
Colin Wilderspin	Independent Chair, Author
Val Billings	Senior Domestic Abuse Coordinator, Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)

A	Spencer Clarke	Public Protection Manager, Chelmsford City Council & rep for Chelmsford Community Safety Partnership (CSP)
	Kaylie Charlery	Senior Community Safety Officer - Public Protection Manager, Chelmsford City Council.
	Beverley Jones	The Next Chapter
	Cheryl Gerrard	Associate Designated Nurse Safeguarding, Mid & South Essex ICB (MSE ICB) - Mid Alliance
	Ben Pedro-Anido	T/DI Head of Operational Development, Strategic Vulnerability Centre, Essex Police
	Nicole Alderton	Clinical Specialist for Safeguarding, EPUT
	Aliyah Monroe	DWP Advanced Customer Support Senior Lead
	Alice Faweya	Mid-South Essex NHS Foundation Trust
	Stephanie Vella	Mid Essex Mind

SETDAB DARDR partnership half day virtual workshop with the agencies listed above was held to consider the case and to capture and identify key issues, possible missed opportunities, and learning. The Overview Report and action plan was then shared with the workshop attendees for comment, action and feedback.

On completion, the following will receive a copy of the review:

- Police and Crime Commissioner for Essex
- SETDAB
- Essex Safeguarding Adults Board
- Members of the review panel
- Office for the Domestic Abuse Commissioner.

4. Family Involvement:

Robert's brother engaged briefly with the review and confirmed that he was unaware of any domestic abuse concerns. The wider family declined further involvement due to the emotional impact of the death. The panel considered but ultimately decided not to approach Robert's wife due to limited evidence of domestic abuse, the likelihood of distress, and the time elapsed.

5. Key Findings:

5.1 Domestic Abuse

There is no evidence from any statutory or voluntary-sector agency, nor from Robert's family, that physical, emotional, or coercive control behaviours characteristic of domestic abuse occurred within the relationship.

The panel considered whether economic abuse may have been present, given: Robert's significant debt, his reports of financial strain linked to the relationship, and Sarah's historic financial difficulties.

However, the available evidence does not demonstrate control, restriction, or coercive patterns consistent with the statutory definition of economic abuse. The financial pressures recorded could also be explained by shared household decision-making, lifestyle choices, and Robert's own anxieties linked to his employment in the financial sector.

5.2 Mental Health and Suicide Risk

Robert had longstanding depression, compounded by bereavement, physical health issues, COVID-19 isolation, and financial stress. He made two serious suicide attempts during the review period and expressed persistent hopelessness.

The panel concluded that Robert's death was most likely caused by a combination of deteriorating mental health and escalating concerns about debt and job security, rather than domestic abuse.

5.3 Professional Curiosity

Across mental health and police contacts, practitioners appropriately addressed immediate suicide risk but did not consistently explore potential economic or coercive control, despite financial issues being repeatedly raised. This represents a missed opportunity, although it is unclear whether such exploration would have altered the outcome.

5.4 Male Victims of Domestic Abuse

The review highlights a wider systemic issue: male victims face significant barriers to disclosure, including stigma and lack of awareness of support services. While no evidence of domestic abuse was found in this case, the panel emphasises the importance of ensuring male victims are not overlooked.

5.5 COVID-19 Context

The pandemic likely exacerbated Robert's isolation, limited his ability to access informal support, and placed additional pressure on his wellbeing. Lockdown conditions may have intensified routine household stresses but do not, in this case, indicate domestic abuse.

6. Conclusion

The review concludes that Robert's death cannot be attributed to domestic abuse. There is insufficient evidence of coercive, controlling, or abusive behaviour. Instead, the most influential factors were:

- long-term mental ill-health,
- financial stress and fear of job loss,
- bereavement-related trauma,
- and chronic physical health difficulties.

While the threshold for a statutory DARDR was not met locally, SETDAB proceeded following Home Office recommendation.

The review identifies the importance of:

- Greater professional curiosity around financial stressors,
- strengthened understanding of economic abuse,
- improved recognition of male victims, and
- better cross-agency responses to debt-related suicide risk.

7. Recommendation

The Review Chair will write to the Domestic Abuse Commissioner to outline the need for national guidance supporting employees in the financial sector who are victims of domestic abuse or experiencing debt-related vulnerability, recognising that fear of job loss may be a barrier to disclosure

8. Appendix A

Terms of Reference

1. Introduction

1.1 The Chair of the Essex County Community Safety Partnership has commissioned this DHR in response to the death of a resident after liaising with the Home Office. The death has been recorded as suicide.

1.2 All other responsibility relating to the review commissioners (Chelmsford Community Safety Partnership) namely any changes to these Terms of Reference and the preparation, agreement and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Partnership.

2. Aims of The Domestic Homicide Review Process

2.1 Establish the facts that led to the suicide in September 2022 and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the deceased.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
  - the actions of all the involved agencies.
  - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
  - analyses and comments on the appropriateness of actions taken.

- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

- Identify what those lessons are, how they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic violence and abuse homicide/suicide and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

2.5 Establish the facts that led to the suicide and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to support, manage the individuals involved and raise awareness of Domestic Abuse with particular focus on male as victims of domestic abuse.

3. Scope of the review

The review will:

- Consider the period from 29.02.2020 to 08.09.2022, subject to any significant information emerging that prompts a review of any earlier or subsequent incidents or events that are relevant.

- Request agencies defined in Section 9 of the Domestic Violence Crime and Victims Act (2004), and invite other relevant agencies or individuals identified through the process of the review to a workshop panel meeting.

- Consider the involvement of the family, employers, neighbours & friends to provide a robust analysis of the events.

- Aim to produce a report within 6 months of the DHR being commissioned which summarises the chronology of the events, including the actions of involved agencies, analysis and comments on the actions taken and makes any required recommendations regarding safeguarding of families and children where domestic abuse is a feature.

- To identify if Domestic Abuse was prevalent in the deceased and his relationship.

- Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive and financial control are also fully explored.

- Determine if there were any barriers the deceased had in reporting domestic abuse and accessing services. This should also be explored:
    - Against the Equality Act 2010's protected characteristics.

- Consider what is 'good practice' for agencies to achieve in their response to domestic abuse for male victims of domestic abuse.

- Consider the complexity of domestic abuse and financial support locally.

- Examine the events leading up to the incident, including a chronology of the events in question.

- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment and management and the care and service delivery of all the agencies involved.

- Identify any care or service delivery issues, alongside factors that might have contributed to the incident.

- Examine how organisations adhered to their own local policies and procedures and ensure adherence to national good practice.

- Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of both the individuals who are subjects of the review and whether any additional needs on the part of either were explored, shared appropriately and recorded.

- Consider whether the Covid-19 pandemic affected the accessibility of services for the deceased.

4. Role of the Independent Chair (see also separate Somerset DHR Chair Role document)

- Convene and chair a case review panel workshop.

- Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))

- Review IMR's – ensuring that incorporate suggested outline from the statutory Home Office guidance (where possible).

- Write report (including action plan)

- Present report to the CSP (if required by the CSP Chair)

5. Domestic Homicide Review Panel

5.1 Membership of the panel will comprise:

Agency
Independent Chair
Essex Police
Chelmsford Community Safety Partnership
Housing Support Services
EPUT (ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST)
ICB – Chelmsford
Mid & South Essex NHS Trust – Broomfield Hospital
Department for Work and Pensions
Essex Compass Other ESSEX DOMESTIC ABUSE SUPPORT SERVICES Male IDVA / Next Chapter.
Mid and North Essex Mind

5.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

6. Outline Plan for DHR (subject to change depending on information found during the review process.

September 2023	○ Independent Chair appointed by Essex Community Safety Partnership
October 2023	○ Independent Chair establishes ToR and timetable
Oct 23 – Feb 2024	○ Agencies review the deceased and partner. ○ Chair to liaise with family and other contacts

7 March 2024	○ Partner DHR Review Workshop ○ Summary of events and Chronology
April 2024	○ Draft Report sent to SETDAP and Workshop partners
April/May 2024	○ Final Report to Chelmsford Community Safety Partnership
Post May 2024	○ Report sent to Home Office

7. Liaison with Media

7.1 Chelmsford Council as lead agency for domestic abuse handle any media interest in this case.

7.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

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