



Southend, Essex
& Thurrock Domestic
Abuse Board



Chelmsford Community Safety Partnership

Domestic Homicide Review / Domestic Abuse Related Death Review

Overview Report

Case of Robert - Date of Death September 2022

Age 46

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

This report was commissioned by Southend, Essex and Thurrock Domestic Abuse Board on behalf of Chelmsford Community Safety Partnership. It must not be altered, amended, distributed, or published without the express permission of the review Chair.

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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

- 1.1 This report of a death by suicide of an individual will follow the principles of a Domestic Homicide Review (DHR) which considers agency support given to ‘Robert,’ a resident of the Chelmsford area, prior to his death in September 2022. The review will also explore if there is any learning that can be taken that may prevent future deaths.
- 1.2 In line with the national approach outlined by the government to better recognise domestic abuse related suicide¹, this review will be conducted as a Domestic Abuse Related Death Review (DARDR). When a death resulting from suicide occurs, it is often challenging to establish whether a DARDR is appropriate, particularly in the absence of a clear perpetrator or criminal charges for domestic abuse.
- 1.3 This means that a DARDR can be commissioned whenever there is a death that has, or appears to have, resulted from domestic abuse. As well as physical abuse, this includes controlling or coercive behaviour and emotional and economic abuse. It will help to ensure that lessons are learned from fatal domestic abuse cases.
- 1.4 A DARDR is a review into the circumstances around a death of someone where domestic abuse could have been a factor in their death. The purpose is to establish what can be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims.

2. Confidentiality

- 2.1 The content and findings of this review are confidential, with information available only to those participating officers and professionals and, where necessary, their appropriate organisational management. It will remain confidential until such time as the review has been approved for publication by the Home Office Quality Assurance Panel.
- 2.2 To protect the anonymity of the deceased, and his family, the subject of the review will be known as ‘Robert’.
- 2.3 This pseudonym was chosen by the Review Chair. Robert’s family expressed the need to maintain anonymity, but after initial conversations with the brother, they did not want to engage further, therefore, the name chosen was by the Chair only.
- 2.4 The family requested that they had no further involvement and therefore have not seen the final report, although before final publication the family point of contact will be notified.
- 2.5 The Chair also agreed that to support the writing of this report that Robert’s partner and wife at the time of his death would have a pseudonym of Sarah.

¹ <https://www.gov.uk/government/news/fatal-domestic-abuse-reviews-renamed-to-better-recognise-suicide-cases> - This change of name from a Domestic Homicide Review took place during this review and therefore recognises the need to ensure appropriate use of terminology.

3. Review Process

- 3.1 This summary outlines the process undertaken by the Southend Essex and Thurrock Domestic Abuse Board (SETDAB) in partnership with the Chelmsford Community Safety Partnership in reviewing the death of Robert who was a resident in their area.
- 3.2 Robert sadly took his own life in September 2022. in a hotel room where he had placed a bag over his head and an empty medicine box was next to him. He was a 46year-old white male, who worked in the financial sector.
- 3.3 The process began with a meeting of the Southend Essex and Thurrock (SET) Domestic Homicide Review Core Group in December 2022, when the decision to hold a DARDR was discussed. There is limited information regarding domestic abuse and Robert and his wife.
- 3.4 A total of 64 agencies that potentially had contact with Robert and his wife were contacted and asked to confirm whether they had been involved with them; 10 organisations responded to confirm that they had. It is worth noting at this point that not all contact with those 10 agencies were related to domestic abuse.
- 3.5 SETDAB processes require that any decisions around DARDRs are considered by the Southend Essex and Thurrock (SET) Domestic Homicide Review Core Group, following a scoping exercise. The Core Group is made up of professionals from a range of agencies including Domestic Abuse specialists who consider all agency responses, and the information provided, in order to collectively reach a decision if a wider review is required.
- 3.6 Based on the scoping information gathered, the Core Group agreed that a DARDR (or a DHR, as they were known at the time of decision making) did not meet the Home Office criteria for a DARDR.
- 3.7 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. Purpose of a DARDR

- 4.1 A DARDR is required to follow the statutory process set out through the Domestic Violence, Crime and Victims Act 2004. In 2011, DHRs were established on a statutory basis to ensure that lessons are learnt when a person has died as a result of domestic abuse.
- 4.2 Statutory guidance states: A DHR must be undertaken when the death of a person aged 16 or over that has, or appears to have had, resulted from violence, abuse or neglect by:

a person to whom they were related or with whom they were or had been in an intimate personal relationship, or a member of the same household as them, held with a view to identifying the lessons to be learnt from the death.

4.3 In more recent years a death has also considered suicide where there is evidence, or it is suspected that domestic abuse has contributed to an individual taking their own life. In 2019, the first Domestic Abuse Commissioner was appointed with the key priority of preventing domestic abuse related deaths, including domestic homicides and suicides.

4.4 As a partnership, SETDAB commission a number of reviews including suicide cases where it is felt that the national criteria have been met and where there is potentially multi-agency learning. In this case the Core Group was not satisfied that the scoping had identified domestic abuse as a contributing factor to Robert ending his life, the rationale for this was sent to the Home Office.

4.5 However, in April 2023, the Home Office communicated with SETDAB requesting that the death of Robert should undergo a statutory domestic homicide review process. SETDAB commissioned and agreed that the review would be delivered through a 'Level 3' process.

4.6 A level 3 is set out by SETDAB as a single or twin agency review, or for cases where no pertinent information was held by any agency, but it was felt that there was still some learning. A multi-agency partnership event would be held to consider the case and to capture key issues, opportunities and learning to be written up in the DARDR report.

4.a Report Author

4a.i SETDAB appointed Colin Wilderspin to chair the review and to author the overview report. He is an independent registered DHR Chair. He has extensive experience in the statutory sector specifically around community safety and safeguarding and has undertaken internal reviews for organisations. He has never previously worked in Essex and is independent from all the agencies involved in this case.

4a.ii Colin Wilderspin has over 15 years working in a number of Local Authorities. The majority of this time has been as Head of Community Safety and through this work has commissioned over 20 DHRs. He has worked as a peer reviewer for Community Safety as part of the Local Government Association peer review process. Colin has completed relevant Chair training through AAFDA in February 2019.

4a.iii Due to the initial decision through the SETDAB Core Group, this review was commissioned later than the expected timeframe. Initial investigations by the police raised no concerns of domestic abuse and/or economic abuse including fraud taking place against the victim.

4a.iv This outcome from the police and the lack of any evidence or known domestic abuse history has made this review challenging and unusual in the sense that there was no clear domestic abuse history. Therefore, time has been taken to best consider the information to ensure a robust and suitable review outcome.

4.b Panel Membership

4b.i 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.

4b.ii 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

4b.iii A SETDAB DARDR partnership half day virtual workshop with the agencies listed above was

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

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.

4b.iv The panel met once as part of the half day virtual workshop to discuss the initial partnership responses and discuss any organisation or regional learning. Thereafter due to the

limited information of domestic abuse communication with panel members and the report was through email circulation.

- 4b.v Due to the information supplied as part of the initial responses from partners IMRs were not formally requested as the information supplied from most partners were concise and the question of domestic abuse records were part of the initial scope. Additional information was requested and supplied by Essex Police and Essex Partnership University NHS Foundation Trust.

4.c Timeframe

- 4c.i Timeframe was set out through the Terms of Reference (Appendix A). Due to personal reasons of the Chair this report has been delayed.
- 4c.ii There was a Coroners Hearing that took place pre the establishment of a panel and appointment of the independent chair. This concluded that Robert died from suicide.

4.d Involvement of Family, Friends, and Wider Community

- 4d.i As part of good practice, this review reached out to the family of Robert, contact was made with his brother, and some conversations were had between him and the Chair, and information shared by him has been included within this review. As the report was being concluded the brother was contacted by the Chair to go through the report. However, he explained that he did not want to be involved further.
- 4d.ii It was also requested that Robert's parents were not contacted due to wellbeing concerns from the brother in response to the initial news of his death. In addition, the brother confirmed that other members of his family were not aware of the circumstances surrounding his death, and the brother reiterated on a number of occasions that he was not comfortable with supporting the review in respect of his late brother Robert and his tragic death. Robert's brother stated to the police at the time, and to the Chair when they spoke, that he was not aware of any domestic abuse concerns regarding Robert and his wife's relationship.
- 4d.iii The Chair did ask the brother if there was anyone else that would be useful for him to liaise with, but no further individuals were provided, and it was suggested that Robert didn't have a big social network. The review does recognise that the review is restricted to a limited knowledge and scope of information in drawing its analysis and conclusion.
- 4d.iv The panel discussed whether meeting with Robert's wife was appropriate, and there were mixed views around this. The majority of the panel members felt that this would likely not be beneficial, particularly given the delay in commissioning the review following the Home Office request, the limited information from agencies to suggest there had been domestic abuse, and the potential impact this could have on the wellbeing of Robert's wife and her children if they felt accused of playing a part in his death.
- 4d.v The general view of the panel that engagement with Robert's wife and children would probably be counterproductive and unlikely that it would add to any lessons to be learned. Therefore, it was decided that his wife would not be contacted.
- 4d.vi Due to the family sensitivities and that some members of his own family are not aware that he took his own life any wider participation would have provided some difficulty. There was a consideration that the review should contact his employment, however as outlined within

the outcome of this review there was no evidence of domestic abuse. It was decided that with this information and the length of time for this review to commence that contacting his employer would likely be challenging and personal records would be limited. Additionally, Robert was working from home substantially due to COVID and new office ways of working alongside his health vulnerabilities; so discussions with colleagues would have been limited. To support the family request, it was agreed that reaching out to his employer may have been counter productive to the sensitivity of the family.

- 4d.vii At the time this report was sent to the review panel, there had been no further communication with family members, and both the Chair and panel respect the decision of Robert's brother. Before final publication the Chair will notify the brother and refer again to support on offer including AAFDA. This was previously supplied to the brother.

5. Background

- 5.1. Robert was 46 years old, born in 1975. Robert had a brother whom he saw regularly. Robert had been married previously, losing his first wife to a terminal illness in 2016. Robert did not have any children of his own but had two stepdaughters with his second wife (Sarah, 45 years) who he married in April 2021. One daughter was in her early 20's, and the other child was in the last years of primary school at the time of Robert's death.
- 5.2. Robert worked for a large well-known bank and was a manager responsible for analysis and reporting of financial status around consumer credit based in Canary Wharf. During COVID19, Robert worked from home and was still working from home in January 2021. Due to his health, he was considered high risk if he were to catch COVID. Regarding his work Robert mentioned during numerous assessments and conversations with agencies that he often worked 'long hours' 12-14 hours per day.
- 5.3. Robert was close to his parents who were vulnerable, and this had some impact on him not being able to see them during COVID19, although he kept in regular contact with them via Facebook Messenger. He also had a supportive brother and two nieces. Both his parents and brother lived under an hour away, and up until COVID19 they had a good relationship, meeting with them often. Robert alludes within some notes that the distance meant he was not as close as they once were.
- 5.4. Robert suffered from medical conditions including diabetes and a bowel condition. His brother stated that this affected his quality of life alongside other physical health concerns, which also affected his confidence and mental wellbeing. His brother was of the opinion that Robert was a long-term sufferer of undiagnosed depression which was significantly worsened by the passing of his first wife and from which he had never recovered. From GP records in 2017 and subsequent medical visits, it is highlighted that Robert was treated for depression numerous times over the five years before his death. Robert had also had a private consultant in 2018/19 and tried different medication to tackle his depression.
- 5.5. Robert described himself as a shy individual who lacked confidence and was self-conscious, largely due to having Tourette's. He was also lactose intolerant and conscious of this when he was out.
- 5.6. Robert suffered from Arthritis in his knees and hips and had an operation to remove neck discs at some point in his adult life, which resulted in issues with his neck.

- 5.7. At the time of moving in with Robert, Sarah had built up some debt primarily relating to housing arrears. Sarah's previous Council area notes that in 2019 she received a discretionary housing payment of £4000 to cover her rental arrears. Sarah contacted the Department of Work and Pensions (DWP) in January 2020 stating that she could not continue to meet her rent with her income of £1,137 when her rent was £900 per month. Robert's partner claimed single Universal Credit for 2 dependent children until March 2020.
- 5.8. According to DWP, Sarah had been self-employed and got into some difficulties in August 2018. Her self-employment suffered further during the COVID outbreak in 2019, and this was the likely cause for her rent arrears. Sarah attempted to restart her self-employment but was unable to get a loan and therefore unable to return, and by October 2019 Sarah was going through a debt relief order.
- 5.9. Robert and Sarah met in 2019 on an online dating app and in March 2020, she moved into Robert's home with her daughters. It is for this reason that the Terms of Reference starts at this point, as there were no recorded concerns relating to domestic abuse prior to this period.
- 5.10. There is very little domestic abuse concerns raised by agencies or by Robert's family that lead to him talking his own life in September 2022. However, as part of the review it is important to consider all events recorded by agencies and specifically to consider domestic abuse in its entirety.

6. Chronology

	Date	Summary of Agency record	Agency
1.	20 Feb 2020	Sarah moves in with Robert to his home with her 2 children. Confirmed by Sarah to DWP on 02 March where she provided her new address which was Robert's home address	DWP
2.	31 Oct 2020	<p>Sarah calls Police as concerned partner left address with a bag full of pills. They have had a row that morning and left. Partner named as Robert, who contacted by Police and confirmed he had taken himself to Broomfield Hospital, where he was subsequently located by Police.</p> <p>Hospital staff confirmed tablet consumption not life threatening. Seen by Mental Health Team at hospital and agreed to support and conditions put in place. Collected by wife.</p> <p>As an argument was recorded Police completed a DASH Risk Assessment with Robert, disclosed he had been on and off anti-depressants for past five years. Following the events, he is going back on anti-depressants and has the support from doctors should he feel low. No risk identified. No</p>	Essex Police

		previous Domestic Reports. Graded Standard Risk.	
3.	01 Nov 2020	<p>First presentation to secondary EPUT MH Services, Seen and assessed by the mental health team. Robert agreed to the assessment.</p> <p>Notes highlight that he claimed he was in debt for around £30,000 – debt started when he met his fiancé, spent lots of money on her.</p> <p>Reports low mood in response to 1st wife's death and relationship difficulties. Sign posted to debt services and the crisis number.</p> <p>Physical health problems</p> <p>Tourette's from the age of 4 which made him feel self-conscious.</p> <p>Advised GP to prescribe anti-depressant medication.</p>	EPUT
4.	11 Dec 2020	<p>Following a psychology assessment Robert's risk assessment was updated. Robert stated he had no suicide intent, and no thoughts when he is not arguing with Sarah, however, says that if they have a big argument again that he would attempt suicide again.</p>	EPUT
5.	4 Jan 2021	<p>999 calls for male who attempted suicide. The patient was in a car in a layby. The 999 caller was a mental health nurse calling when the patient stopped replying to questions whilst on the phone. Patient had taken an overdose in response to an argument with his fiancée the previous evening. Patient still felt suicidal. Transported to Broomfield hospital.</p> <p>Brought to A and E by ambulance at 16:50 hours. Took intentional overdose of analgesia and sleeping tablets. Trigger was recent argument with fiancé and break up of relationship. Lives with fiancé and her children.</p> <p>Admitted informally to Peter Bruff Mental Health Acute Unit. His brother attends with him.</p> <p>Records show that Robert informally admitted himself to Mental Health Acute Unit</p>	<p>East of England Ambulance Service</p> <p>Broomfield Hospital</p> <p>EPUT</p>

		<p>leaving on the 8th of Jan 2021 returning to home with Sarah and her children. His brother accompanied him to the acute unit. His brother supported him in a hotel for a few nights following leaving hospital and he returned home on the 10th Jan 2021.</p> <p>Police attend and Robert confirms argument with partner and taken an overdose as a result. Ambulance is taking responsibility for him and taking him to hospital.</p> <p>Verbal argument around family debt. Robert believes partner spending too much and will cause the family to go into debt; he cannot see a way out so has tried to take an overdose.</p> <p>Primacy has been given to the NHS owing to the victim's overdose. They are then going to make a Social Care referral for him. He will then see the Crisis team who will manage his immediate care from there. No other safeguarding concerns at this time.</p> <p>DASH Risk Assessment completed with Robert who commented that wife died 5 years ago and suffered depression since.</p> <p>No immediate concerns raised by Police who advise Hospital doing a social care referral. Graded Medium Risk.</p>	Essex Police
6.	5 Jan 2021	GP update - Drug overdose - relationship issues; financial stress; relationship issues mainly on financial matters	GP surgery
7.	5 Jan 2021	Sarah contacted the customer service centre regarding her housing situation. Advised that she had been living with Robert in his house with her 2 daughters. He has had a serious breakdown and attempted suicide 3 times in a year, twice in the last 2 months. He has stated that he wants her to move out.	Chelmsford Council
8.	5 Jan 2021	<p>Recording from A&E visit on 4 Jan 2021. stated he had an altercation with his 'now ex-partner'. As they had decided to split. Robert stated he was upset that his attempt had been unsuccessful. Referred to the Mental Health Team.</p> <p>Records stated that the argument was largely around finances and that Sarah would need to leave the property.</p>	EPUT

		<p>Robert stated during this assessment that he had paid off all of Sarah's debts leaving him unable to manage his own bills. Robert stated that one of the conditions of working for the bank was that he is not allowed to get into financial debt as they could dismiss him from his job. His current house is mortgaged with the bank that he works for and he is anxious about the loss of both his job and his house.</p> <p>Claimed he was currently on a payment break for his mortgage, however, feels that once this has elapsed, he will lose the property.</p> <p>Robert stated that he had recently purchased Sarah a vehicle with the finance in his name.</p> <p>Stated that Sarah said he would need to pay 6 months of rent if she leaves.</p> <p>Robert was described as feeling very flat, not seeing a way forward. Both financial stress and relationship are current triggers and has experienced trauma when his first wife died of cancer. Accepted that since the death of his wife he would never be 'as happy' and feels there is no point to life.</p> <p>He was due to have a psychology assessment on the 8th of Jan 2021 following his suicide attempt in October the previous year.</p>	
9.	6 Jan 2021	<p>Housing advice team called back Sarah when she advised that Robert's brother had picked him up and taken him to Colchester Mental Health unit. Confirmed with Sarah that no DV was evident in the relationship, Sarah was just concerned as she has nowhere to go with her 2 daughters.</p>	Chelmsford Council
10.	7 Jan 2021	<p>Assessment at Mental Health Acute Unit Robert said that he had hit rock bottom, and had not shared his issues with anyone, however, has recently shared his concerns with his brother and sister in-law who he described as really supportive and organised.</p> <p>They were helping him with his debt as he could not use a debt management charity due to his job.</p>	EPUT

		<p>He also stated that he had stopped Sarah using his credit card and running up more debt, he also said that he had made his bills more manageable.</p> <p>Robert returned home on the 10th of Jan 2021. He left the MHAU on the 8th of Jan where his brother put him in a hotel near to him.</p>	
11.	12 Jan 2021	Email received on 12.1.21 from Sarah to advise Robert has returned from hospital and they have worked things out, so no further support needed.	Chelmsford Council
12.	14 Jan 2021	7 day follow up – Living with his partner and the relationship was much better and they had discussed a way forward. He is under the Specialist Mental Health Team and has a care coordinator.	EPUT
13.	18 Feb 2021	Attended a routine appointment with Mental Health team, Robert stated that he was feeling much better mentally, although had some side effects from the medication.	EPUT
14.	7 March 2021	Robert attended GP - Risk of suicide or self-harm very low.	GP Surgery
15.	31 Mar 2021	Telephone contact with EPUT, stating that the medication is helping, and he is sleeping. No concerns of suicide intent recorded.	EPUT
16.	April 2021	Robert and Sarah get married	Chelmsford Council
17.	20 May 2021	Robert attended GP - No suicidal or deliberate self-harm intent risk low	GP Surgery
18.	25 May 2021	Robert described his mental state as stable. Stated that he had been working hard and in regular contact with his GP over his medication.	EPUT
19.	July 2021	Drug Overdose 7-day blister pack issued	GP Surgery
20.	21 Aug 2021	Review of Needs by telephone. Robert stated his mood had remained stable for a number of months. Plan to remain on current management plan and medication and discharged from service, but Robert to contact 'Duty' if he needs the services.	EPUT
21.	16 October 2021	Malicious Communication - Harassment Robert received text message (as did his partner Sarah) concerning debt of £4000 that Sarah had accrued and failed to pay off, advising them that the person owed the money would be instructing bailiffs to col-	Essex Police

		lect the debt if not paid. This communication caused victim distress so was recorded. Matter was investigated however victim appears to have withdrawn support, received no further messages, and therefore investigation was closed.	
22.	12 June 2022	<p>Assault occasioning actual bodily harm (ABH)</p> <p>Robert was a victim of an assault in the street by two unrelated suspects who came into area shouting.</p> <p>Robert was one of a number of persons who came out to ask them to be quiet, resulting in him being assaulted along with four other victims.</p> <p>Attended A and E after alleged assault. Hit several times by unknown person and has bruising to left eye. Jaw pain and has hit head, pain to left hand. Feeling sick. No loss of consciousness. Discharged home.</p>	<p>Essex Police</p> <p>Broomfield Hospital</p>
23.	14-17 June 2022	Seen in hand trauma unit for left hand ligament injury - reviewed and discharged with soft tissue injury.	Broomfield Hospital
24.	Sept 2022	Robert is found dead in a hotel room. Called by hotel staff when he did not check out and staff went to check the room. Robert had evidently taken his own life via a significant overdose of prescribed medication with alcohol and also placing a plastic bag over his head.	

7. Definition of Domestic Abuse

7.1 The Government's definition of domestic abuse is:

“Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”

7.2 Many people think that the definition of domestic abuse is limited to physical violence. But domestic abuse is about control – about how one person uses an intimate relationship to control another person, often their partner or former partner. The controlling behaviour forms a pattern, rather than being a one-off incident.

7.3 There is no evidence amongst partner agencies or from Robert's brother that there were any concerns of physical violence, therefore this review will consider the wider domestic abuse and specifically economic/financial abuse.

7.4 Economic abuse involves behaviours that interfere with an individual's ability to acquire, use and maintain economic resources such as money, transportation and utilities. It can

be controlling or coercive. It can make the individual economically dependent on the abuser, thereby limiting their ability to escape and access safety².

7.5 Examples of economic abuse include:

- having sole control of the family income
- preventing a victim from claiming welfare benefits
- interfering with a victim's education, training, or employment
- not allowing or controlling a victim's access to mobile phone/transport/utilities/food
- damage to a victim's property

7.6 From agency notes there is not a clear domestic abuse link as per the government's examples above, however, we can note from the chronology and agency notes that the pressure of finances on Robert was significant and was a factor in his decision to take his own life.

7.7 Therefore, it will be key that financial control is considered as part of this review.

8. Equalities and Diversity

8.1. The Equality Act 2010 sets out nine protected characteristics and discrimination is recognised when at least one of these characteristics determines the way in which a person is treated. The nine characteristics that are protected are: Age, Disability, Gender reassignment, Marriage or Civil Partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation.

8.2. The nine protected characteristics identified in the Equality Act 2010 were assessed for relevance to the DARDR. The characteristics of Age, Disability, Race, Religion or belief, and Sex, were discussed by the DARDR panel, and the potential vulnerabilities of mental health, and ill health were recognised by agencies working with Robert.

8.3. Robert was a heterosexual male, who had been married twice. His first wife passed away in 2015 after a short battle with cancer. Since the death of his first wife, Robert had been under medical support for depression and had worked with mental health services over the last 5 years including privately, pre 2019 and NHS between October 2020 and July 2021.

8.4. Robert's second wife Sarah was a white British female of a similar age to Robert.

8.5. Robert did have several physical health challenges including arthritis in his knees, irritable bowel syndrome and had some discs removed which affected his neck, particularly when working from home during COVID19. In addition, he was receiving treatment for diabetes. Robert did not consider he had a disability and was just part of the challenge of life.

8.6. It is recognised that the prevalence of female as victims of domestic abuse is higher than in comparison to males, 1 in 4 women in England and Wales will experience domestic abuse in their lifetime³. In the year ending March 2022, the victim was female in 74.1% of domestic abuse-related crimes. Additionally for the same year ending March 2022, the

² <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet#what-do-you-mean-by-economic-abuse>

³ <https://refuge.org.uk/what-is-domestic-abuse/the-facts/#:~:text=Fact%3A%201%20in%204%20women,partner%20in%20England%20and%20Wales.>

Crime Survey for England and Wales (CSEW) estimated that 1.7 million women and 699,000 men aged 16 years and over experienced domestic abuse in the last year. This is a prevalence rate of approximately 7 in 100 women and 3 in 100 men⁴. This data highlights that essentially a third of males will be a victim of domestic abuse in their lifetime.

- 8.7. According to a recent study by the Centre for Justice “support agencies often fail to recognise the abuse of men and overlook cases involving female abusers. Recent studies of Homicide Reviews highlight a lack of training and support in the recognition and handling of male domestic abuse: ManKind Charity reports that in 2021, out of 238 refuge spaces for victims of domestic abuse, only 58 were committed to supporting male survivors. Another study conducted by Bristol University details how male victims seldom get asked about their domestic relationships by health professionals⁵.
- 8.8. From an equality perspective, the DARDR panel are well aware that female victims have many challenges reporting domestic abuse, but being a male victim of domestic abuse does make reporting even more challenging.
- 8.9. The report from the Centre of Justice supports a general view that male victims of domestic abuse often face unique challenges when seeking help or support. These challenges can include:
- Societal Stigma: The stereotype that men should be strong and unemotional can deter them from reporting abuse.
 - Lack of Awareness: Limited awareness of support services tailored to male victims can leave them feeling isolated.
 - Legal Barriers: Legal systems may not always recognise or adequately respond to male victims.
 - Fear of Retaliation: Concerns about retaliation from the abuser can discourage men from seeking help as is the same for female reporting.
 - Lack of funding to support male victims.
- 8.10. The DARDR panel discussed non bias response and if males were treated differently, with the general consensus that nationally and locally this was recognised. This view is supported by the ManKind charity which is a domestic abuse service for males “*There are lots of missed opportunities to identify and support male victims of domestic abuse as no one understands the issue. As a result, professionals less readily recognise victims and men feel that they won’t be believed or taken seriously,*” states Mark Brooks of the ManKind Charity⁶.
- 8.11. As part of the review, the DARDR panel had a discussion around barriers to male victims- against the lack of available and suitable services for male victims and the social stigma. The DARDR panel agreed that there was a lack of resources both nationally and locally to support males and that more needs to be done to raise awareness both with statutory agencies and within all communities. Recent national focus has been on ‘violence against women and girls’ although the Government guidance suggests that The Tackling Violence Against Women and Girls Strategy, and the Domestic Abuse Plan, are both clear that while

⁴ file:///C:/Users/cwild/Downloads/Domestic%20abuse%20victim%20characteristics,%20England%20and%20Wales%20year%20ending%20March%202022%20(1).pdf

⁵ <https://www.centreforsocialjustice.org.uk/newsroom/why-are-men-often-overlooked-as-victims-of-domestic-abuse>

⁶ <https://www.centreforsocialjustice.org.uk/newsroom/why-are-men-often-overlooked-as-victims-of-domestic-abuse>

they use the term ‘violence against women and girls’ in both documents, this refers to all victims of any of these offences including males⁷. However, there needs to be some consideration around how male victims can be clearly considered within statutory guidance to reduce some of the additional barriers.

8.12. The government is committed to ensuring that all victims/survivors of domestic abuse crimes, of all protected characteristics, receive the support they deserve, and recognises its responsibilities under the Public Sector Equality Duty provided for in the Equality Act 2010. However, it is questionable as to whether this goes far enough with regards to terminology and transparency for male victims.

8.13. It should be noted that during this review it was recognised that locally Next Chapter who are commissioned in Essex to support victims are currently working on a specific website and resources focussed on male victims, Next Chapter, and it is important to highlight that their services are for all victims of domestic abuse.

<https://www.thenextchapter.org.uk/who-we-support/men>

9. Review Themes

9.1 It has been ascertained that specifically for this review there is limited information from agencies regarding domestic abuse. Therefore, this review will focus on the following themes around the death of Robert:

- Financial
- Professional Curiosity (particular focus around male victims) unwise decisions
- COVID19
- Suicidal ideation

9.2 Other considerations such as the trauma of losing his wife have been considered and whilst this was clearly significant to his decision to take his life, it does not directly impact the scope of this review. However, as part of the themes above it has been considered throughout.

9.3 The review process also recognises that the GP records note that in July 2021 Robert was prescribed a blister pack for 7 days. This was a shorter number of days than the usual 28 to reduce the risk for suicide, however, the following month he was discharged from the mental health services claiming he had been stable. This suggests a need to ensure that medical records need to be shared more robustly, as it is likely Robert would have remained under the mental health services for longer. The majority of DHR’s conducted nationally and regionally highlight information sharing as a significant issue, although due to lack of information surrounding this review it does not form part of its findings.

9.a Financial

9a.i Robert was employed as a financial analyst working for a well know bank in Canary Wharf. In most of his assessments with mental health services he raised the issue that much of the arguing between him and Sarah was based around her poor management of finances and the debt they were in.

⁷ <https://www.gov.uk/government/publications/supporting-male-victims/supporting-male-victims-accessible>

- 9a.ii According to agency reports Robert suggested that they had at least £30,000 of debt, that he had accrued since being with Sarah. Robert had paid off her debts and was also financing her to have a vehicle. According to Robert, Sarah liked to spend and from notes all arguments between them were often about money.
- 9a.iii In addition to paying off debts, Robert also described to one mental healthcare professional that since being with her they had led a lavish lifestyle and some of the debt was due to mini breaks and holidays. Indeed, this can be backed up by the brother who felt that some of the financial stress Robert was under was more down to poor decision making than anything else.
- 9a.iv Robert's brother also said that his debt was not as bad as Robert had thought but that he would get very agitated due to his job. His brother also added that during both incidents of attempted suicide (October 2020 and Jan 2021) Robert told him the main drive to this was his concern around debt.
- 9a.v Robert stated on a number of occasions that he could not access any financial support as this would affect his job and he would be at risk of losing it. Whilst we do not know the specifics to Robert's employment it can be assumed that this was a likely and accurate reflection. When applying for positions at banks or other financial institutions individuals will often have to pass a credit check, showing the employer that they can manage money, and that financial behaviour won't impact on the job. In the instances of a poor credit score, this could be seen as a risk to the business. It is likely that Robert would have had to declare if he required financial intervention. There is no doubt that the loss of income, job and house would have been a major stress on Robert.
- 9a.vi There is a question around the compliance of financial institutions and their responsibilities around economic domestic abuse support for their staff from the consequences of domestic abuse. Legislation and guidance should be considered at a national level for this sector, particularly as personal economic issues could impact careers, and therefore, likely increase the risk that it would not be reported to authorities or to the company themselves as it could risk individuals losing their jobs.
- 9a.vii There is very little evidence that there was financial abuse following Robert's death, we know from the review that Essex Police did investigate potential fraud and considered other financial offences against Robert's wife at the time of his death, but after speaking with Robert's brother and his wife, the police took no further action. The initial requests from Essex agencies also highlighted during the initial scoping through this process that financial coercion was not evident in any records or concerns raised by professionals.
- 9a.viii We are aware through agencies that Sarah did have issues of financial management before meeting Robert, as we are aware of housing debt, and that she had financial difficulties being self-employed which was further impacted by COVID19. We are aware that Sarah had several short-term contract roles, such as a delivery driver for a takeaway, to get income before moving in with Robert. It would appear that Sarah continued this approach to spending once in a relationship with Robert and this was also confirmed by his brother. Sarah relied on Robert for funding whilst she tried to reestablish her self employment status post COVID19, and due to living with Robert she was no longer able to receive wider benefits or financial support.

9a.ix If we look at the examples of finance control outlined earlier in this report, we can conclude that there are limited concerns raised by agencies or his brother that any of the below was evident.

- *having sole control of the family income.*
Robert was the main earner, and assumptions can be made that the vehicle purchase for Sarah was to support her self-employment. Robert stated that he would give her the credit card to go shopping but he stopped this after his second suicide attempt in January 2021.
- *preventing a victim from claiming welfare benefits.*
Sarah ceased claiming DWP payments, and there is no evidence that either Sarah or Robert was prevented from accessing welfare benefits. It can be assumed that if they were entitled to any benefits that these would have been accessed to address the debts of both Robert and Sarah. Any increase in income would have supported both a 'lavish lifestyle and Sarah's shopping habits.
- *interfering with a victim's education, training, or employment.*
We know that due to COVID19 Robert was working from home, and often worked long hours. There is no evidence that either Sarah or Robert was impacted by this particular issue.
- *not allowing or controlling a victim's access to mobile phone/transport/utilities/food.*
Whilst Robert had not seen his family due to the COVID19 constraints, and him being considered 'vulnerable', the review process has highlighted that Robert was in regular contact with his mother and brother by text and Facebook messenger. This is significantly noted with the support of his brother during his suicide attempts, where on both occasions his brother supported him. Despite this, his brother was concerned that after both incidents he returned home to where the stress was being caused, and he was frustrated with his brother that the relationship continued because of the stress it caused Robert. His brother feels very strongly that domestic abuse was not present in the relationship.
- *damage to a victim's property.*
There is no evidence of this from the agencies or Robert's brother. Robert accepted that they had recently spent money on furniture for their home, but this was part of their married life to make it their home. Whilst the home was untidy, it was well maintained.

9a.x Regarding financial coercion, there is very little evidence recorded. However, it can be argued that it was not considered and therefore was not asked during his assessments following his 2 recorded attempts to commit suicide. It is worth noting that aside from the DASH which was conducted by Essex Police following the January 2021 attempt, due to the fact that it was related to an argument with his partner, the only other time in the Chronology from agencies where domestic abuse is mentioned is when Sarah contacted Chelmsford Council regarding housing, and she was asked if there were domestic abuse concerns when she notified them she would be leaving as the relationship was over with Robert. Sarah denied any issue of domestic abuse and there is no further record of domestic abuse having been considered in any agency records for either Robert or Sarah. It is positive that Sarah was asked about domestic abuse at this point, and this should be highlighted as positive practice, especially as she requested a need for housing.

9a.xi Other economic abuse was considered as part of this review including financial exploitation in that Sarah may have seen Robert as an easy target to support her family and pay off her debts. In this scenario the review would have expected to see evidence of control from Sarah. From family accounts and partnership records Robert willingly helped her pay off

her debts. This could have been likely due to his fear of the risk to his career, this could also be considered 'normal' behaviour for a husband and wife in working together as a team. For example if Sarah was paying off the debt with high interest rates, Robert would have likely got better interest rates with good credit, and would have made paying debts off more affordable.

- 9a.xii Another form of economic abuse considered was economic sabotage. Economic sabotage in domestic abuse is a deliberate pattern of controlling, exploiting, or obstructing a victim's financial resources and independence to trap them, often involving restricting work/education, controlling earnings, sabotaging job performance, building debt in the victim's name, and limiting access to necessities like food or transport. Robert through partnership records and input from his brother to be in control of his financial decisions, as demonstrated by him ceasing the credit card he gave Sarah. The review found no evidence of any form of domestic abuse that would support further analysis of this form of abuse.
- 9a.xiii Essex Police highlighted that following a previous local DHR findings, there were recommendations to ensure both parties are risk assessed where it is not clear who is the victim/perpetrator. This approach has now been implemented, and this is positive progress which may or may not have prevented Robert's death. Essex Police now use the Domestic Abuse Risk Assessment (DARA) which has been developed to ensure that it supports first responders to assess risk. It supports frontline officers and staff by helping them recognise patterns of controlling and coercive behaviour including financial/economic abuse more easily and as early as possible but is dependent on the response from the persons.

9.b Professional Curiosity

- 9b.i Practitioners need to apply professional curiosity, as it offers individuals' a framework that can be used to foster an understanding of how interlocking oppressions manifest in the lived experiences for the people concerned. Agencies working on the front line must be proactive with professional curiosity and must actively acknowledge the multiple inequalities people experience as a result of oppressive behaviours, especially in regard to domestic abuse. However, in this case, domestic abuse was not identified, recorded or recognised by either the family or agencies. However, as alluded to in the financial section, potential financial abuse does not appear to be considered and therefore not asked when conversations took place. This was a potential missed opportunity to ascertain if financial/economic abuse was present in his relationship.
- 9b.ii During the review the panel discussed if training around domestic abuse was focussed enough on male victims. The training on offer in Essex is robust and constantly reviewed and does include all victims. As part of this discussion, the challenge around client overload and managing the immediate risk of suicide rather than the cause in that short period was outlined.
- 9b.iii It does not appear that during this review period that Robert, either through Mental Health assessments or the DASH that was completed by the police in January 2021, considered the financial abuse and the link between the financial stress and difficulty Robert was facing, and his relationship issues he raised.
- 9b.iv This point is particularly highlighted when EPUT liaised with Robert's brother following him raising concerns about Robert going back to Sarah and the risk that Robert claimed he

would 'do it again' (attempt suicide) if they had another argument. Records state that Robert 'had capacity to make unwise decisions. In the context of domestic abuse, there is a question that had this been a female victim able to make 'unwise' decisions; would this assumption have been made or would domestic abuse/coercion been a consideration in this context.

9b.v It is clear that during the period of November 2020 and August 2021 Robert was supported for depression and suicide prevention rather than any consideration of financial concerns relating to domestic abuse. There are no patient notes that provide any assurances that this was asked or even considered by any agency. The panel agreed that we do not know how Robert would have responded if asked the question directly to him and had financial coercion explained to him if he would have felt he was a victim.

9b.vi This creates an outstanding concern that if Robert had been asked or given the opportunity to discuss or been made aware of the definition of financial coercion and domestic abuse; whether he would have come forward and disclosed domestic abuse, or if the assumption made by his family and others was correct regarding domestic abuse and particularly financial abuse not being present in the relationship. Whilst there is some confidence that domestic abuse would have been asked at this point it is not recorded within substantial medical records.

9b.vii Since Robert's death we were made aware that Domestic Abuse Services are now co-located with Mental Health Services in an attempt to embed practices and work more closely together, this is a very positive step forward to ensuring two often very linked themes, as often mental health is prevalent in a number of domestic abuse cases and homicide reviews., this should increase the professional curiosity of partners due to colocation and closer working together.

9.c COVID-19

9c.i In response to the coronavirus (COVID-19) pandemic, lockdown restrictions came into effect from 23 March 2020 and imposed strict limits on daily life.

9c.ii Police recorded crime data show that there was an increase in offences flagged as domestic abuse-related during the coronavirus (COVID-19) pandemic, however, there has been a gradual increase in police recorded domestic abuse-related offences over recent years as they have improved their recording of these offences. Therefore, it cannot be determined whether this increase can be directly attributed to the coronavirus pandemic.

9c.iii The Office for National Statistics highlighted that there was a general increase in demand for domestic abuse victim services during the coronavirus pandemic, particularly affecting helplines as lockdown measures eased; this does not necessarily indicate an increase in the number of victims, but perhaps an increase in the severity of abuse being experienced, and a lack of available coping mechanisms, such as the ability to leave the home to escape the abuse, or attend counselling⁸.

9c.iv Lockdown facilitated abusive behaviours; as a result of reduced contact with the outside world, perpetrators had less accountability and were able to carry out more controlling behaviours. Financial hardship particularly during COVID-19 has given rise to more financial

⁸ <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020>

abuse. The barriers faced by victims of domestic abuse to access support were exacerbated during this period.

9c.v As outlined previously, specific to this review it is hard to ascertain if Robert was a victim of financial coercion or if it was simply poor financial management by both himself and Sarah. What we can confirm around COVID19 is that both poor financial management and the impact of the pandemic likely had an impact on Robert as a person.

9c.vi Robert was considered to be vulnerable to COVID19 due to a number of health issues. Due to lockdown he began to work from home, often working long hours. He would have lost regular contact with work peers. Although Robert has been described as shy, we cannot ignore that he would have lost daily / regular conversations/contact with colleagues and line management would have been moved to online. Both could have added an additional barrier to reporting domestic abuse, or for colleagues or his manager to recognise any concerns or changes in behaviour.

9c.vii In addition to this Robert did not see his parents for a considerable time, and mainly remained in contact via text and messenger mainly. Again, this could have made it challenging for those who knew him best to recognise any change. Robert's brother was clear that he was not aware of or had any domestic abuse concerns.

9c.viii We should also recognise that Sarah moved in with Robert in April 2020, a month before the first lockdown, and so their relationship was very much in its infancy regarding living together. Changes for Robert in sharing his home, both with a partner as well as the partner's two daughters must have been challenging, especially as the lock down would have prevented him going outside. Notes suggest that in 2021, when he was in a more 'stable' situation, he recognised removing himself for some fresh air was a coping mechanism which Covid lockdown would have prevented this happening previously.

9c.ix We also know from Robert's medical records that his physical health suffered further due to lockdown which is likely to have affected his moods more frequently, a point supported loosely by his brother.

9c.x Without generalising, much of what we can see from agency records, and conversations with his brother, are similar to most relationships and the challenges faced when we first move in and the 'change' for individuals.

9.d Suicidal Ideation

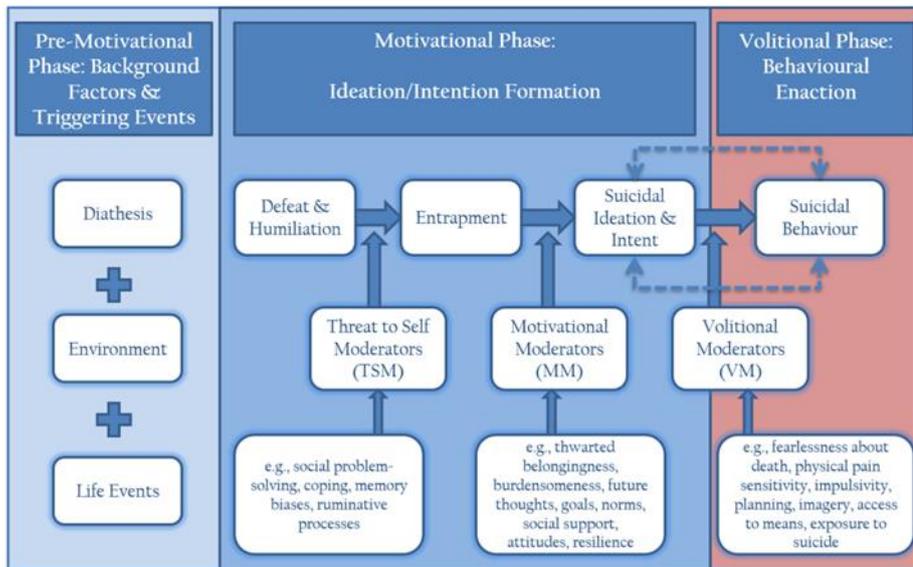
9d.i Robert suffered from depression, which was either triggered, but most certainly compounded by the loss of his first wife. His mental health then continued to deteriorate as a result of the stress he felt regarding financial pressures and concerns about losing his job, which arose during his relationship with Sarah. As part of this review, we are aware that Robert had at least two major suicide attempts, and that following the second incident, he repeatedly suggested that he did not see the point in life, and there were concerns that if they argued again, he would 'take more pills.'

9d.ii We do not know all the factors which may have contributed to Robert taking his own life. However, the medical records indicate that his mental health deteriorated significantly, and which was compounded by financial concerns. Although it is not possible to say that domestic abuse was a factor in this instance, we are aware that the prevalence of mental ill health and experience of domestic abuse can often lead to suicide.

- 9d.iii Analysis undertaken by Kent and Medway Suicide Prevention Team of 93 nationally published DHRs, found that 26% contained suicide of either the victim or the perpetrator with serious financial concerns being a contributing factor in 11% of these⁹. Wider research consistently highlights that economic adversity including debt, unemployment and financial instability is a significant risk factor for suicidal ideation and behaviour. The debts Robert had built up would have made him potentially uncomfortable, and the risk that he could lose his job for having debt could have been considerable.
- 9d.iv Refuge, in their research, explain that Weaver, et al. and Williams developed understanding about suicidality through what they called a ‘cry of pain’ hypothesis. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible. It is suggested further that this constellation of feelings and beliefs can lead anyone, irrespective of psychiatric diagnosis, to consider, and even enact, suicide. A key finding, from wider research, suggests that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide, with some research indicating that a completed attempt often follows an uncompleted attempt within an average of one year. Therefore, to dismiss suicidality and attempts as ‘merely a cry for help’, risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future. This research fits well with this review and Robert’s situation.
- 9d.v Suicide is complex, and the journey of suicidal ideation to suicidal behaviours is not static but fluid and can be seen as being cyclical in nature. The Integrated Motivational-Volitional model aims to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind.
- 9d.vi The Integrated Motivational-Volitional Model of Suicidal Behaviour was first proposed in 2011 by Rory O’Connor (IMV; O’Connor, 2011) and it was refined in 2018 (O’Connor & Kirtley, 2018). Its aim was to synthesise, distil, and extend our knowledge and understanding of why people die by suicide, with a particular focus on the psychology of the suicidal mind. The model was developed from the recognition that suicide is characterised by a complex interplay of biology, psychology, environment, and culture (O’Connor, 2011), and that we need to move beyond psychiatric categories if we are to further understand the causes of suicidal malaise¹⁰.
- 9d.vii The model below has been suggested to be an effective tool to help map a story of suicide and highlight specific points or factors, of which the review should take note.

⁹ Domestic abuse and suicide, Refuge and Warwick Law School, 2018

¹⁰ <https://suicideresearch.info/the-imv/>



9d.viii Pre-motivational phase - This first phase sets the context for suicidal ideation, and Robert had some vulnerability factors and stressors (some of which have been discussed in the previous section), as well as environmental influences that should be noted when considering suicide risk: The below are a list of the pre-motivational phase we know for Robert.

- Relationship difficulties
- Financial stress and fear of losing his job
- History of suicide behaviour (attempted suicide in October 2020 and January 2021 and, discussion of suicidal ideation following January incident)
- Trauma of losing his wife to cancer
- Depression
- Long-term physical health issues (chronic pain)
- Potential domestic abuse and financial coercion.

9d.ix Motivational phase: Ideation/Intention formulation phase – it is challenging to reflect on this as little is known regarding the period prior to his death in September 2022. However, in summarising the two occasions when he had tried to complete suicide, much of his mental wellbeing was around debt, his job, and arguing with his partner and it would be remiss for this review not to highlight these areas and consider they remained a constant issue for him.

9d.x When considering domestic abuse and suicide, it is a useful tool to consider the Eight-stage domestic homicide and Suicide Timeline for domestic abuse related suicide. It is another practical tool, for use by professionals, developed through research and analysis of case studies to understand the interactions between perpetrators of coercive control and their victims, and how these interactions may be linked to escalating and de-escalating risk of serious harm or homicide.

9d.xi The behavioural data gathered through this research was organised into a sequence of stages that represent potential escalating risk. The further along the stages, the higher the risk of serious harm, with opportunities at every stage to cease the progression. Each stage provides indicators of perpetrator and victim characteristics. Although the stages are arranged sequentially, they are not necessarily mutually exclusive, they can and do overlap and may not occur in order with ‘circling’ through the stages occurring in some cases.

Stage	Alleged perpetrator characteristics	Victim characteristics
1. History	History of domestic abuse, coercive control, stalking, routine jealousy, violence, history of criminal behaviour	History of vulnerability. Previous domestic abuse, coercive control or sexual assault, away from home (student), previous local authority care
2. Early Relationship	Speed and intensity	Speed and intensity
3. Relationships	Dominated by controlling patterns, violence in many cases	Subject to violence, drugs and alcohol, sexual violence
4. Disclosure	Control escalating, violence may escalate, persistent harassment	Starts to tell other about the abuse
5. Help-Seeking	Alleged perpetrator may use victims' mental health against them, may make threats to family/friends, counter allegations	Mental health services, GP for mental health, A&E, child services, social services, police
6. Suicidal Ideation	Alleged perpetrator may encourage suicide, persistent contact, threats	Suicide attempts, self-harm, may so they 'can't go on', may be convinced they will be killed, may have lost custody of the children
7. Complete Entrapment	Stalking, threats, persistent contact, threats to others, violence	May say 'I will never be free' or similar,
8. Suicide	Common for alleged perpetrators to find body, in some cases abuse transferred to victim's family	Most common to be at home with ligature, other methods also noted

9d.xii In most cases of domestic abuse related suicides, the above model is often all too evident. It is recommended that agencies consider this (and/or alternative models) in order to help reduce the risk of further suicides, and particularly those related to domestic abuse.

9d.xiii It is difficult to apply this approach to this specific case given the gaps in our knowledge due to minimal contact with a large number of agencies and in turn a lack or absence of evidence of domestic abuse. Robert's brother himself disclosed that the financial debt he got

himself into was more to do with poor decision making and inappropriate spending control, particularly around new purchases or trips away with Sarah.

9d.xiv However, looking at the eight-stage cycle we can briefly analyse this review into Robert's death:

1. History – There is limited history, pre-Sarah moving in, of any domestic abuse, although relationship moved quickly and they moved in together and soon experienced COVID19 lockdown together, which put a strain on many long-term relationships at the time. However, no recorded domestic abuse was recorded.
2. Speed and intensity – As stated above, it appears the relationship moved forward fast, and the intensity, due to COVID19, may have forced the relationship forward more than a relationship outside of the pandemic. Robert stated after his 2 attempts that he found being able to walk outside was one of his coping mechanisms, something he was unable to do during lockdown, due to legislation and his health vulnerabilities.
3. Relationships – The panel is confident that no physical abuse took place in this relationship but has reservations whether there was financial coercion due to the debts he paid off on behalf of Sarah and the debt he got into himself. Although we can assume that in most relationships the financial burden is often shared, we cannot assume Robert paying her debts off was due to abuse or due to being in a relationship and living with someone, particularly when there are concerns any debt within the household, including their partner/wife's, could affect their job and income.
4. Disclosure – The panel remain confident that Robert did not disclose any information around domestic abuse and remains confident that had he done this (if there was a case of domestic abuse) that he would have received appropriate support. The lack of disclosure does not mean that Robert was not a victim, it is just that through this review, including availability of agency records, there is little evidence that any form of abuse was taking place, although if there was, financial abuse would be the most likely. It is worth highlighting for this review and future considerations that some victims do not disclose wider abuse in fear of it resulting in physical abuse. There is nothing to suggest in this review that this was the case for Robert.
5. Help seeking – This depends on whether domestic abuse is present, which this panel was not able to find evidence of. It could be loosely argued that Sarah calling housing, following Robert's second attempt, to say that she was leaving, followed by Robert having reported that if she left, he would have to pay for her 6 months' rent. Additionally, at this time, it is also recorded that Sarah stated this suicide attempt was a 'cry for help' as if he really wanted to do it, he would have taken more tablets. When considering this from an abusive perspective it could be argued this stage is present, although there are no further records to build on this. Regarding Robert specifically, he was under mental health services and regular visits to his GP for various reasons including his mental health. His treatment for mental health from all services was more targeted to address his suicidal ideation rather than tackling domestic abuse in the relationship as it was never disclosed by Robert.
6. Suicidal Ideation – From the review we are aware that Robert attempted suicide at least twice and had likely taken other overdoses without requiring urgent medical treatment. Following the second attempt, Robert was recorded as saying that he could not see a way out or if he would be happy again. However, some of this was contributed to by the

trauma of losing his first wife, which his brother claimed he never got over, rather than just focusing on his relationship with Sarah and any potential abuse.

His job in the financial environment clearly put stress on his personal finances and his concerns of getting into debt, and concerns about losing his career played a significant role during the period of the review.

7. Entrapment – We have no record of any alleged ‘perpetrator’ behaviour at this point, however, as per section 6 above, we do know that Robert felt there was no way out. It is important to note here, however, that these comments were recorded over 12 months before Robert took his own life. There is very little recorded after July 2021, until his death in June 2022.
8. As confirmed within this review; Robert was found deceased in June 2022.

10. Review Summary

- 10.1 There is little evidence of Robert being a victim of domestic abuse, and this was the challenge for the panel in this review. Whilst there are lessons to be learned generally, it was challenging for the panel to justify making contact with Sarah and her children. There was not enough from agencies to make contact in what would have likely resulted in further upset for her, and formal notification of a review exploring domestic abuse may have caused undue and further trauma for Sarah and her children. In addition, contact with his brother suggested that he was not aware of domestic abuse, rather that Robert was suffering from depression following the death of his first wife which he never got over.
- 10.2 Robert was concerned about his finances and with his role in the financial sector, working in Canary Wharf, we can empathise with the pressure this would have put him under. It was challenging as part of this review to see how much of this debt was coercive, or just a sign of an early relationship and attempt to provide future finance stability as husband and wife.
- 10.3 Therefore, it is impossible for this review to assess if Robert’s suicide was related to domestic abuse, or rather that it is a sad case of depression and concerns around debt which are two substantial reasons for many suicides. It is therefore challenging to say that his suicide was as a result of domestic abuse, and more significantly, financial coercion.
- 10.4 Whilst it remains that locally this review did not meet the threshold, the Home Office requested that one be conducted. This review panel supports the need for raising awareness about the existence of male domestic abuse victims which is crucial, and it’s equally important to provide resources and support at a local level. There is some positive work occurring within Essex to provide additional and more flexible support to male victims and this needs to be recognised, whilst continuing to ensure that this is further developed.
- 10.5 The other significant aspect of this review is the need to highlight financial coercion as a theme of abuse, and the revised definition hopefully provides some support for victims who experience this form of abuse on a daily basis. This review highlights the challenges between recognising financial abuse and the normality of relationships and the pressures faced when in an intimate partnership, where domestic abuse is not present.

11. Conclusion

- 11.1 This review has the statutory focus around domestic abuse. As this review has stated, neither agencies or Robert's brother had concerns around domestic abuse in the tragic death of Robert.
- 11.2 Suicide is the biggest killer of people under the age of 35 and the biggest killer of men under the age of 50. Robert was 46 when he took his own life. There is a gender bias embedded in suicide rates in the United Kingdom. In 2022, the Office for National Statistics reported that men represent three quarters of UK suicides¹¹. According to research by National Debt line, nearly one in two people were worried about their personal financial situation at the start of 2024¹².
- 11.3 Finding oneself in financial difficulty is a known suicide risk and one of the main reasons behind individuals choosing to take their own life. This review concludes that Robert's decision to take his life was likely due to his financial situation alongside his fear of losing his job because of the perceived debt he thought he was in.
- 11.4 Suicide is preventable; especially when associated with problem debt. Preventing suicides requires a holistic effort, bringing together a wide range of agencies, each doing their part to support those who disclose suicidal feeling, spotting those who may be at risk, and minimising the psychological distress associated with financial difficulty, in order to tackle systemic risk factors. Whether as government, a local authority, essential services provider, advice agency, healthcare provider, regulator, employer or individual, it is everyone's responsibility to play our part in saving lives.
- 11.5 Whilst no domestic abuse is apparent in this case, it is the Chair's view that there is a risk around other individuals who may not come forward to disclose domestic abuse to their employer if there is a risk of them losing their job, particularly for those working in the finance industry. As part of this review, the Chair will be contacting the Domestic Abuse Commissioner to highlight the need for the finance sector to have a clear safeguarding process to support those experiencing financial hardship and those who are victims of domestic abuse.
- 11.6 As part of this process, it is the view of the panel that, had there been any indication of domestic abuse or disclosure; there are appropriate male domestic abuse services locally and Robert would have been referred to them by those agencies who were supporting/had contact with him.
- 11.7 The review noted that work was already being delivered to improve provision for males, including a revision of website pages and literature which can often be female focussed, and this should support male self-referral in the future. In addition, there has been a recent shift to ensure domestic abuse services work closer with mental health services including co-locating of staff.
- 11.8 The Chair would like to highlight that SETDAB lead on significant communication and awareness across the region, and this also includes the sharing of best practice and campaigns and recommendations from previous domestic abuse reviews.

¹¹ <https://www.gov.uk/government/statistics/suicide-prevention-profile-updates/statistical-commentary-suicide-prevention-profile-may-2024-update>

¹² <https://www.sjp.co.uk/individuals/news/national-suicide-prevention-day-talking-about-debt-can-save-a-life>

11.9 Due to no evidence of domestic abuse being present in this review, the recommendations are limited but focussed on ensuring potential links to both debt and domestic abuse and how those in the finance industry could seek support and have confidence from employers if they were a victim of domestic abuse. As part of their professional curiosity, practitioners should consider all factors which may be impacting someone's mental ill health, including financial hardship.

12. Recommendations:

No.	Recommendation	Who	When
1.	<p>The Chair to write to the Domestic Abuse Commissioner outlining the need to ensure that finance industries are compliant with employer responsibilities around domestic abuse and debt.</p> <p>The letter will highlight the need to recognise the risk to employers around disclosing domestic abuse and the risk to their job.</p>	Review Chair Colin Wilderspin	October 2024

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
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October 2023	<ul style="list-style-type: none"> ○ Independent Chair establishes ToR and timetable
Oct 23 – Feb 2024	<ul style="list-style-type: none"> ○ Agencies review the deceased and partner. ○ Chair to liaise with family and other contacts
7 March 2024	<ul style="list-style-type: none"> ○ Partner DHR Review Workshop ○ Summary of events and Chronology
April 2024	<ul style="list-style-type: none"> ○ Draft Report sent to SETDAP and Workshop partners
April/May 2024	<ul style="list-style-type: none"> ○ Final Report to Chelmsford Community Safety Partnership
Post May 2024	<ul style="list-style-type: none"> ○ 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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