Executive Summary

Chelmsford CSP

A Domestic Homicide Review (DHR) concerning the death of Rachel (pseudonym) (April 2023)

Author – Jackie Dadd

Date completed – August 2025

The Domestic Homicide Review Panel and the members of the Chelmsford Community Safety Partnership would like to offer their sincere condolences to the family of Rachel, who have lost their loved one in tragic circumstances.

Contents

1. The review process

1.1 This review examines agencies responses, provisions and support provided or available in the Chelmsford area and wider County of Essex to Rachel, a 37-year-old female with two children prior to the point of her death, having been murdered at the home address of her ex-partner, Noel, having received substantial head injuries and strangulation.

1.1.2 Due to the knowledge of previous domestic abuse history within the relationship on police record, a referral was promptly made for consideration for a Domestic Homicide Review (DHR) to the Southend, Essex and Thurrock Domestic Abuse Board (SETDAB). Following a meeting, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.3 Following an investigation, Essex Police charged Noel with murder to which he was subsequently found guilty following a trial at Chelmsford Crown Court to which he received a life sentence with a minimum to serve of 16 years.

1.1.4 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Rachel's death).

Rachel – The deceased. A white, British female aged 37 years old.

Noel – Husband of Rachel. A white, British male aged 39 years old. Convicted of the murder of Rachel.

Kerry – Eldest child of Rachel in their Teens.

Jody – Youngest child of Rachel in their Teens.

1.1.5 Following the initial letter from the Chelmsford CSP to the mother of Rachel, of whom now both children of Rachel lived with, the Author received an email from her sister (Rachel's Auntie) requesting that she be the point of contact early in the review and was responded to via email from her sister, requesting that she be the point of contact as her sister was not able to deal with things at that time. Family viewpoints made in the initial contact are outlined at 3.1 of this report.

1.1.6 The author re-contacted Rachel's Auntie following the conclusion as was agreed and was informed that the family did not wish to take part in the review as 'after nearly two years, it is time to get on with our lives the best we can'. The panel respected this request. Consent to speak with the children had been asked by the Author to obtain the voice of the child within the review, but consent has not been provided. The family were informed and reminded of the opportunity for AAFDA support and sent a leaflet but did not feel they required this as they were supported by a Homicide Case worker from Victim Support.

1.1.7 They were not sent a copy of the report for family scrutiny and feedback as was their wishes. In 2023, Rachel's mother released a short statement through Essex Police stating

"I have not only lost my daughter, but I have lost my best friend too. She was a fantastic mother to her children and she was loved by everybody"

1.1.8 The Author made contact with Noel via letter to His Majesty's Prison (HMP) to ascertain whether he wished to partake in the review but no response was made.

2. Review panel members

2.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of IMRs, Summary reports and chronologies.

2.2 The panel comprised of the following:

Name	Area of responsibility	Organisation
Val Billings	Senior Domestic Abuse Coordinator	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
Ifthahar Ahmed	Minute taker	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
Spencer Clark	Public Protection Manager	Chelmsford CSP
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
Alison Hawkins	Housing Solutions Manager	Chelmsford City Council
Emily Batch	Tenancy Specialist Manager	Clarion Housing Group
Ruth Cherry-Galal	IDVA Service Manager	The Next Chapter
Rebecca Walsh	Clinical Specialist for Safeguarding	Essex Partnership University Foundation Trust (EPUT)
Sara McParland	Senior Caseworker	Victim Support
Sarah Davies	Senior Caseworker	Victim Support
Carole Eden	Service Manager	CFS
Emma Barker	Detective Chief Inspector	Essex Police
Emma Bundy	Service Manager	Adult Social Care
Ilona Benjamin	DHR Project Officer	Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)
David Messam	Head of Probation Delivery Unit	Probation Service

2.3 Thanks go to all who have assisted and contributed to this review with their valued time and cooperation.

3. Contributors to the review

3.1 The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of scoping their records and if necessary, providing reports and chronologies.

Agency	Contribution
Essex Police	IMR, panel member
Essex Partnership University Foundation Trust (EPUT)	Summary report
GP Surgery	Scoping, Panel member
Strategic Housing Service Chelmsford City Council	IMR, panel member
Clarion Housing Group	IMR, panel member
IDVA, The Next Chapter	Panel member
Southend, Essex, Thurrock Domestic Abuse Board (SETDAB)	Oversight, panel member
Essex Probation Service	Summary report, Panel member
Adult Social Care	IMR, panel member
Chelmsford Community Safety Partnership	Panel member
Victim Support	Panel member
Provide	Scoping
Essex Children and Families Social Care	Summary report, panel member
NHS Mid and South Essex Integrated Care Board (MSE ICB)	Panel member

4. Author of the Overview report and Chair

4.1 The chair of the review panel and Author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues, having been the Force Lead for domestic abuse, stalking and harassment and serious sexual offences and has been involved in the DHR process since its inception in 2011.

4.2 She has completed several training courses including the Home Office online training, the Continuous Professional Development accredited AAFDA (Advocacy After Fatal Domestic Abuse) DHR Chair training, the domestic Abuse and suicide accredited course, and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed the new Home Office DHR Chair training and obtained the qualification of an ONC level three certificate.

4.3 Mrs Dadd has completed and published several DHRs.

5. Terms of Reference

The Terms of Reference were discussed and agreed upon during the first panel meeting and was a working document throughout the review.

It was agreed that the main areas of focus and discussion would be based on the following:

a) Were there adequate risk assessments and support for safeguarding measures for both Rachel and her children

b) Is the correlation between domestic abuse and carers recognised amongst agencies within Chelmsford

c) The recognition of Children as victims of domestic abuse

The full Terms of Reference are below:

- The date parameters under consideration are from January 2020 up to the date of death of Rachel.
- This is to be reviewed as a homicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Rachel.
- Was adequate support in safeguarding measures put into place to assist in the protection of Rachel and her children and not reliant on existing constraints such as the Restraining Order, Remand in Custody and Rachel's own actions?
- Are agencies within Chelmsford considering Clare's Law and providing guidance and advice when it is identified that this may be relevant?
- Is the correlation between domestic abuse and carers recognised amongst agencies within Chelmsford for
    a) Identifying the vulnerability and impact of carers to being either the abuser or subject to domestic abuse due to their role within the relationship and are adequate safeguarding measures and recording processes implemented in these situations.
    b) Information sharing between services with regard to the safeguarding of adults and their careers.
    c) Are referral mechanisms adequate and were they sufficiently made to support and safeguard
- Where we know children are victims of domestic abuse, what protections and support are provided to those children?
- How do agencies take account of the voice of the child?
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process, including voice of the child.

- Do support provisions work collaboratively and communicate sufficiently to provide a collective approach when assisting victims?
- Were procedures sensitive to the vulnerabilities, disabilities, and sex of the deceased and the family as a whole? Were any of the other protected characteristics relevant in this case?

6. Summary chronology

6.1 Rachel had a previous marriage in which she had two children in which there are two recorded standard risk domestic abuse incidents. Noel had a previous relationship in which he has convictions for harassment and threats to kill convictions with a restraining order against his ex-partner and her child which resulted in custodial sentences. He also had multiple convictions that were not domestic related. Rachel and Noel had known each other since they were 15 years old having met at school.

6.2 Noel has several medical issues including visual impairment (registered blind), diabetes, epilepsy, bulimia, stress and a personality disorder. By 2020, it was established that he had eligible needs under The Care Act (2014), and he was receiving a Direct Payment from Essex County Council, enabling him to arrange his own care and support.

6.3 Records show that Rachel and Noel were married in 2011 which Rachel later stated that it was based on the fact that she was Noel's carer and they lived separately until 2015. Rachel became Noel's full-time carer 24 hours a day and they both had regular contact with Adult Social Care over the years due to claims and assessments.

6.4 Children's Services had three separate referrals between 2011 to 2013 whereby the oldest child of Rachel made disclosures 'Pupa (Noel) pushes me and punches mummy. Pupa and mummy are always fighting and arguing.' No further action was taken in relation to the referrals as there were differing accounts of the child and Rachel and it could not be corroborated that the child had been deliberately hurt.

6.5 As a couple, Rachel and Noel first came to the attention of Essex Police in November 2022. A2 02.16hrs, a 999 call was received from Kerry, who was 14 years old at the time. She reported that she was at home with her mum (Rachel) who was being assaulted by her partner Noel. Officers attended and Rachel stated that she was Noel's Live-in carer and that they were not in a relationship. Noel had been argumentative throughout the previous day during which he had grabbed Rachel by the throat (although not causing a shortness of breath or injury) and sha managed to push him away.

6.6 However, during the early hours of the morning, Rachel had gone to bed and Noel followed, trying to speak to her in which she refused because it was late and he had become violent, jumping on her and hitting her with a remote control from the television, causing reddening to the leg. Kerry saw all of this happen. A DASH risk assessment was not initially

completed but when re-evaluated, a DASH was completed and eventually risk assessed as standard.

6.7 Whilst in custody, the police contacted Adult Social Care (ASC) to assist with identifying suitable accommodation if he were to be released. He was charged and remanded in custody and in fear of him being released at some stage, Rachel contacted ASC to ask them to find him alternative accommodation to their home address and stated that she could no longer care for him. Rachel contacted them on more than one occasion and was disappointed that no-one had asked how her or the children were and the focus for caring centred around Noel.

6.8 Noel made counter allegations against Rachel to ASC when they spoke to him in prison and there was uncertainty as to whether they should record these with the Police as there was already an ongoing investigation. He pleaded guilty to battery and the non-fatal strangulation charge was withdrawn but he was still on bail for malicious communications committed when he was first released from prison.

6.9 Rachel fled her home with her children through fear of Noel returning and had to stay with her mother as housing did not find any accommodation that Rachel felt acceptable due to location. Noel's mother made expletive phone calls to Rachel which were reported to the police but filed a week later.

6.10 During April 2023, Essex police received a 999 call at 00.19hrs from Rachel's mother reporting that her daughter had left home about 15.50hrs the previous day and had not returned. Her children had tried to contact her by phone and she had not answered which was out of character for her. Her mother was extremely concerned for her.

6.11 The incident was initially risk assessed as low by the inspector but three hours later, following further enquiries with the family, it was raised to medium risk and initial enquiries were conducted throughout the early hours in order to locate Rachel.

6.12 About 05.09hrs that morning, the Metropolitan Police contacted Essex Police stating that Noel had attended Ilford Police station stating that something had happened to his wife and he had placed a blanket over her to make it look like she was asleep. He appeared confused and not making much sense and as a result of this, they contacted Essex Police for urgent welfare checks at his home address.

6.13 The Police attended his home twenty minutes later and found Rachel inside with head injuries and was unresponsive. An ambulance arrived but Rachel was declared deceased at the scene.

6.14 Noel was arrested on suspicion of murder and subsequently charged. The investigation established that CCTV captures Rachel approaching the house at 16.09hrs. The care agency had attended four visits to Noel that day and at teatime, he had stated that he was not feeling well so the carer did not stay long. When the carer returned for the bed visit, they were met at the door and did not enter as Noel stated that he did not need anything and was going to go to sleep. Noel was seen entering a nearby pub at 18.50hrs that evening

where he concealed Rachel's phone in the toilets. He then went on to visit a family member and then two massage parlours prior to going into Ilford Police Station.

6.15 He was sentenced at Chelmsford Crown Court where he received a life sentence with a minimum 18 years to serve.

7. Key issues arising from the review

7.1 The recognition of Children as victims of domestic abuse

Within ASC records, there is no reference to the impact of Noel's needs on the children within the household. Having made an initial 999 call in the middle of the night in November 2022, neither Kerry nor Jody were spoken to by the initial police officers who attended which was not complying with Force procedure as it states,
'It is mandatory that the voice of an involved child in any investigation, including their appearance, demeanour and environment will always be captured[1]
The Officers stated that they had not thought to speak with the children and were not aware of the requirement to do so.

Although processes have undoubtedly changed through the years, the voice of the child was not listened to in the three referrals made to Children Social Care between 2011 and 2013 when comment was directly made from Kerry and this can correlate to recent times when the voice of the child is either not asked or disregarded.

The steps that Rachel was taking to safeguard herself and her children were seen as adequate whereas involvement by CFSC could have enhanced this and also provided assistance to Rachel at a traumatic time.

7.2 Recognition of the correlation between carers and domestic abuse

Essex County Council, Adult Social Care and Children and Families produced an All-age carers strategy in 2022 in which it does not include domestic abuse as a risk factor or highlight the correlation of increased risk of domestic abuse where a carer is present, either to the carer or the person being cared for.

Rachel had initially had a carers assessment and monies were being paid in relation to this and Rachel began to outline how she was not coping with providing 24hour care to Noel, Even though Adult Social Care were aware of the circumstances and it is now known throughout professionals that the risk of domestic abuse is significantly heightened with a carer in the home, no checks or discussions were made with Rachel to ensure that she was safe and even when she had reported offences to the police, ASC were inclined to be more concerned about the needs of the perpetrator as he was the one eligible under the Care Act.

[1] Essex Police Procedure B0602 – Investigation of Crime

8. Conclusions

8.1 The involvement of ASC with the family was limited to activities around assessment, a review or in situations where Noel had a problem that he needed support with. There were opportunities to have done somethings differently, including having a better understanding of why Noel needed so much paid support and the level of support both he and Rachel had reported that he also required from her. It is possible that professional curiosity may have given case workers some of the views that have now been voiced to include how Noel controlled meetings and other interaction with ASC. By opening up conversations and offering challenge in relation to an understanding of a persons need, which is due process, can lead to other conversations. This includes potential limitations in ASC's understanding of Noel, his family, and his social network. Due process and in line with Care Act (2014) around consideration for Carer's Assessments, for Rachel and for his grandmother may have assisted in triangulating information and provide a better understanding. Similarly, ASC had limited details of persons who Noel identified as cousins and/or Personal Assistants, who he was employing through a Local Authority Direct Payment and only had a first name which prevents informed assessments in risk and also what care is being provided.

8.2 Agencies were aware of Noel's previous domestic abuse history yet no consideration to advice or application for Clare's Law was given at any time.

8.3 Although a statement was eventually obtained from Kerry later in the first investigation, the voice of the child was neither considered or undertaken and no referrals were made throughout the investigation for support or safeguarding yet Rachel had stated to officers that she could no longer cope as Noel's carer and she feared for her children and the environment they were being brought up in. This was another missed opportunity for a MARAC referral or multiagency meeting.

8.4 Investigative decisions impacted on both the welfare and the safeguarding of Rachel and her children. Kerry's evidential account should have been obtained via an ABE interview. This was not considered by the officer and seen as a failure to provide support to a child witness in the provision of their evidence although Kerry was considered for special measures[2]. This was also the case with the decision to obtain a written statement from Rachel on both occasions and as a consequence, the officers did not discuss the alternative ways in which Rachel's evidence could be obtained and the wider Enhanced Rights under the Victims Code to which Rachel may be entitled.

8.5 The effects of the Prosecution not being case ready to present at court are self-evident and can have a significant impact upon witnesses and victims. In this case the delay in taking

[2] A request was made for the witnesses statement to be given behind a screen should she have to provide evidence at court.

the statement, which was clearly needed to be obtained from the commencement of the investigation, was avoidable. Throughout all investigations, there was a lack of application of the Victims Code of practice.

8.6 The absence of any attending or investigating police officers accessing previous history of Noel prevented a holistic risk assessment which may have led to the risk assessment being high and the opportunity for a referral to MARAC providing a multi-agency approach and information sharing platform so that the risk was known to all agencies and appropriate support services could have engaged with Rachel.

8.7 Good practice should be recognised in the positive action of taken by the police in obtaining a Harassment Order and then the response to the breach of the Harassment Order of Noel's arrest and incarceration. Also, the acknowledgement of the swift response by Essex Police in attending the address of Noel once contacted by the MPS, although sadly, this was too late to have been able to save Rachel.

8.8 Neither the Council or Rachel were able to obtain quick action to seek to determine whether there was an option for the social housing joint tenancy at which she had resided to be moved to her sole name alongside an occupation order etc. This may or may not have been possible, but there was no swift response or suggestion that it might be viable from the landlord, Clarion Housing. Both Rachel and Noel separately were seeking legal remedies for an occupation order.

9. Lessons to be learnt

Professionals understanding and recognising domestic abuse

9.1 There was a view held by Adult Social Care case workers that Noel should be going back to the home that he shared with Rachel and her children, and instead, that they move out. This was on the basis that he had initially had the tenancy, and the home was adapted to meet his needs. This did not consider Rachel or the children as victims of domestic abuse and their need for stability with the children's schooling and prioritised one perpetrator over three victims.

9.2 ASC were very focussed on the fact that Noel had care and support needs that met the criteria under the Care Act which appeared to overshadow Rachel's needs as a domestic abuse victim and a carer. They offered him advice and assisted him with an Occupancy Order and whilst Rachel had discussed her concerns about Noel returning and was advised to seek support from CAB and housing, this approach was not mindful of the wider issue around Domestic Abuse and how victims and families should be supported and protected. As a carer, Rachel had equal rights under the Care Act 2014.

9.3 The S42 Enquiry that was open, following allegations that Noel made against Rachel in November 2022, did not progress due to concerns of interfering with the criminal justice investigation. Whilst the social worker had informed the police that Noel had made these allegations, it was not reported to the police as a crime until the February 2023. Reporting

it earlier to the police as a crime, which is due process, and following through as a s42 strategy meeting, would have given opportunity for MDT consideration and understand the wider context. (Recommendations refer)

Housing issues/barriers faced

9.4 The circumstances within this review highlight and accentuate the barriers that victims of domestic abuse, and in particular with children face at a time when they need protecting the most. Noel and Rachel's home was a joint tenancy.

9.5 ASC case workers explicitly supported Noel returning to his home was he was the individual under there care and they disregarded the risk towards or feelings of Rachel and her children. ASC actively cited reasons why Noel should return home and Rachel and her two children who were all victims of domestic abuse, should be moved elsewhere.

9.6 Rachel fled the home in which she had joint tenancy as she was fearful of Noel returning and harming her and her children and although she was offered a place in refuge, this was out of the area and she declined as she would not practically be able to keep the children in their schools or travel to work. Essex only has one refuge available near to Chelmsford which is twenty miles away. The remainder are towards North Essex.

9.7 Rachel made a homeless application following her fleeing her home but although she was offered two temporary accommodations whilst her homelessness application was considered, they were declined for the same barriers she faced with the refuge.

9.8 The properties that she was being offered were not 'safe accommodation' in which Essex have identified they have very few. (Recommendation refers)

9.9 This review highlights the issues and difficulties for social landlords in dealing with decisions around tenancy matters when there are joint tenants and one is subject to domestic abuse. Landlords should be able to end the joint tenancy earlier and allow a sole tenancy for the DA survivor if it would be safe for them to remain or return to the property especially as, in this case, the perpetrator had been charged and gone to court. Even if not safe for the victim to remain in the home, but enabling a sole tenancy, it then opens up the option to grant a management move in the survivor's sole name elsewhere.

9.10 Consideration of a recommendation in regard to additional Safer Accommodation was considered by the panel but was not deemed necessary at this time.

Absence of a multi-agency approach

9.11 On reviewing the referrals made within this review, there are identified occasions when they were either not made or the information provided was insufficient and they were made on the basis of one agency to another with no consideration of Multi-agency meetings.

9.12 There were missed opportunities to provide this platform as there was no referral to MAPPA which should have been considered owing to Noel previously being a MAPPA subject, his criminal history and his current offending.

9.13 Also, due to the absence of secondary risk assessments and police officers not accessing previous records for a holistic risk assessment, Rachel was not deemed to be at high risk and therefore, a MARAC referral was not made.

9.14 There was a lack of referrals to support services which may have then negated the lack of application of the Victim's Code of Practice as they would have been able to provide advocacy and identify these gaps.

9.15 There was no holistic working between Adult Social Care and Children's Services to provide support for Rachel and her children and see them as a family who were victim's to domestic abuse rather than separate entities. (Recommendations refer)

9.16 Essex has a Wider Eastern Information Stakeholder Forum which has an Information Sharing Protocol which overarches safeguarding across geographic Essex. All agencies involved in safeguarding activities across geographical Essex are partners to this protocol. This outlines and provides guidance on the sharing of information for the purpose of safeguarding both adults and children. Panel members voiced their reticence to sharing information due to a lack of knowledge as to what could be shared in what circumstance.

10. Recommendations

10.1 Due to the length of time this review has taken whilst awaiting the judicial process to be completed, agencies have managed internal action plans to expeditiously address internal learning and individual staff learning. These individual actions have not been replicated within this report unless not addressed or not deemed necessary for this review.

National

There are no National recommendations identified from this review

Local

1. **ASC to include domestic abuse and the heightened risk of this as part of the carer's strategy.**

   Domestic abuse is not included in the carer's strategy at this time and as carer's do not generally meet the adult safeguarding threshold, this leaves them with little means of support or recognition of the heightened risk within the household. Inclusion will provide a framework to address the specific correlation between carers and domestic abuse.

2. **ASC to provide an awareness event of the correlation between carers, disabilities and the heightened risk of domestic abuse in these circumstances.**
   This will provide awareness of the issues amongst professionals and front-line responders and increase the identification of risk and submission of relevant referrals.

3. **Essex Police are to educate and communicate the MAPPA process and referral mechanism to all staff and officers, providing accessible guidance.**
   This is to provide a clear understanding of the process and an increased identification of individuals that meet the criteria for referral and how to complete this.

4. **Essex Police to refresh training and communication to provide awareness around policy and procedure within domestic abuse investigations and Victims Code of Practice for vulnerable and/or intimidated witnesses.**
   This will provide compliance with procedures including secondary supervisory risk assessments and ensure the most appropriate means of capturing evidential accounts is obtained to provide the witness with the options for special measures as outlined in the Domestic Abuse Act 2021.

5. **The following statutory agencies within Essex are to be reminded of the opportunities/existence for multi-agency meetings/forums in order to share information and make holistic risk assessments based on all information.**
   A – Essex Police
   B – ASC
   C – CSC
   D – Probation Service
   This will improve relevant referrals/requests for multi-agency meetings in cases where it has been identified that multiple agencies may have or should have involvement and input. It will promote conversation at the 'point of need' for issues that may 'sit outside' of the formalised multi-agency meetings.

6. **Children's Social Care to work with the Children and Adults Safeguarding Boards in Essex and their SET partners to continue developing the Whole Family Approach.**
   This will assist all agencies with identifying their responsibilities and roles within a holistic approach when responding to domestic abuse and alleviate assumptions from agencies that others may be conducting an action when they are not.

7. **The following statutory agencies within Essex to ensure that they include any relevant historic information they hold on record when submitting referrals to other agencies.**
   A – Essex Police
   B – ASC

C – CSC

D – Probation Service

This will provide additional context to the referral to make an informed risk assessment and safeguarding response.