

## BACKGROUND

A Domestic Abuse Related Death Review (DARDR) was commissioned to identify how agencies worked together and to learn from any lessons to improve multiagency responses to domestic abuse.

This DARDR was not published but the learning has been shared across the partnership.

The review relates to the suicide of a family member who had caring responsibilities for the person causing them harm.

## AGENCY INVOLVEMENT

- Essex Police
- Essex Partnership University Trust (EPUT)
- Safe Steps
- Southend Adult Social Care
- Southend Safeguarding Adults Board
- Mid and South Essex ICB (Replaced by Essex ICB April 2026)
- Mid and South Essex NHS Foundation Trust
- Department of Work and Pensions
- East of England Ambulance Service NHS Trust

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Kate  
Domestic Abuse Related  
Death Review  
(DARDR)

## RECOMMENDATIONS

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There were 11 recommendations summarised below:

- Essex Police: review processes/capacity to ensure effective monitoring of standard-risk DA cases. Update DA procedures to ensure mental health referrals are considered for suspected perpetrators with identified mental health needs and risk factors.
- ASC: produce a practice note to ensure awareness/understanding of the duty to investigate Safeguarding Enquiry concerns for Carers under the Care Act 2014 and review the Carers Assessment and Support Policy to ensure private, confidential assessments that consider DA and wider risks.
- EPUT practitioners to consider what the barriers may be for carers accepting support and how these may be overcome, through practice guidance which includes an ask, probe the answer, address the barriers and ask again approach (Ask-Probe-Explain-Ask Again).
- EPUT to develop and implement clear guidance outlining the circumstances when a professionals' meeting should be convened and review and update its policies and practices relating to risk assessment and safeguarding in situations where domestic abuse is identified within carer and cared-for relationships.
- National Police Chiefs' Council (NPCC) and College of Policing should ensure that all police forces implement routine enquiry and accurate recording of individuals' gender identity when making referrals to DA services supported by clear national guidance and incorporated into DA referral training and policy frameworks.
- ASC, in partnership with EPUT and the ICB, ensure that practitioners understand and communicate the distinction between Care Act eligibility for residential care and financial considerations, such as property ownership.

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## KEY THEMES

- **Under-assessed risk.** The review found that agencies did not fully recognise the cumulative impact of the domestic abuse, the victim's increasing isolation, and their repeated disclosures that they were struggling to cope.
- **Significance of the victim's role as a carer.** There was evidence of carer stress and burnout, and opportunities across agencies to offer and pursue carers' assessments were missed. The focus remained primarily on the care and support needs of the family member, with limited recognition of the significant impact this was having on the victim.
- **Alternative accommodation options.** More holistic exploration of alternative accommodation or support pathways may have helped reduce risk and alleviate pressure within the shared living arrangement.
- **Multi-agency working.** Opportunities for coordinated multi-agency discussion and problem-solving were missed. A professionals' meeting could have helped ensure that partner agencies had a collective understanding of the risks and challenges and identified all available sources of support.
- **Transgender-related abuse.** The victim experienced transphobic abuse from a family member. The review found that this aspect of the abuse may not always have been fully recognised or recorded and highlighted learning regarding the recording of gender identity within domestic abuse referrals.