# Domestic Abuse Related Death Review

## Robbie/February 2024

## Executive Summary

**Author:** Dr Liza Thompson

**Commissioned by:** Safer Hull Partnership

**Review completed:** October 2025

## Robbie

Robbie was a white British man in his late thirties who had moved to Hull after periods of living in Scotland and Wales. Robbie was described by professionals as sensitive, polite, chatty and reflective. The information available to the review suggests that he had experienced significant adversity from childhood onwards. These experiences appear to have shaped his sense of stability and belonging, and the way he responded to pressure and conflict in adult life. Robbie struggled with low-confidence and had a long history of mental health issues and had made a number of suicide attempts.

All members of the DARDR panel express their sincere condolences to Robbie's family and friends.

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## 1. The Review Process

1.1 This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Robbie, a white British male in his late thirties, prior to his death in February 2024. On that day, Robbie's partner Fiona returned from taking the children to school, to find Robbie suspended from the banister using a dog lead as a ligature. Robbie died in hospital one week later.

1.2 Prior to his death, Robbie had disclosed to his Probation Officer that Fiona's behaviour was abusive. On the afternoon of Robbie's death, a family friend emailed the family's Social Worker with concerns that Fiona's son had told her that Fiona had "been mean" to Robbie that morning.

1.3 The Community Safety Partnership had received a DHR notification on 14th February 2024, informing the partnership that a death had occurred which may fall under the definition of domestic abuse. On 4th March 2024, the Multi-Agency Risk Assessment Conference (MARAC) Core Group met to discuss whether the case met the criteria for the DARDR process. At the meeting, panel members agreed that there may be lessons to be learnt, and that the DARDR was required. The Chair of the Safer Hull Partnership ratified this decision, and an Independent Chair was commissioned in May 2024.

1.4 The key reasons for conducting a DARDR are to:

a) establish what lessons are to be learned about the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are - both within and between organisations; how and what timescales will be acted on; and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

## 2. Review Panel Members

2.1. The panel for the review process consisted of:

| Agency | Name | Job Title |
|---|---|---|
| | Dr Liza Thompson | Independent Chair |

| | | |
|---|---|---|
| Safer Hull | Vicki Paddison | Strategic Domestic Abuse Commissioning Manager |
| City Health Care Partnership | Mags Shakesby | Named Nurse for Safeguarding adults, MCA lead and Integrated Team Manager |
| Humberside Probation Service | Andrea Wilkinson | robation Officer – DA lead |
| Humberside Police | Becky Homes | Detective Inspector, Designated Professional Safeguarding Governance Unit Adults |
| Humber and North Yorkshire Integrated Care Board | Rachael Sharp | Designated safeguarding Adult's Lead |
| Children's Social Care | Alexandra Campbell | Head of Service Safeguarding Children Services |
| Renew | Louise Chester | Criminal Justice Project Manager |
| Together Housing Association | Sue Lewis | Assistant Director Supported Housing & Neighbourhood Safety - safeguarding lead |
| Hull DAP Male Victims Services<br>*Male Victim Specialist* | Paul Staines | Domestic Abuse safeguarding Lead. |
| Hull City Council – Public Health | Sally Barlow | Public Health Suicide Prevention Lead |
| Humber Teaching NHS Foundation Trust | Martin Inglis | Safeguarding Adults Specialist Practitioner |
| NHS Humber Health Partnership (Acute Trust) | Jayne Wilson | Named Nurse for Safeguarding Adults |

**3. Author of the Overview Report**

3.1. The Independent Chair and Author of this DARDR was Dr Liza Thompson.

3.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

3.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews.

## 4. Terms of Reference for the Review

4.1. This review examined whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Robbie.

4.2. The scoping period for the review was agreed as January 2020 until the date of Robbie's death. This period is considered to cover the entirety of the relationship. However, if any relevant information regarding domestic abuse came to light prior to this period, IMR authors were required to send this information within the chronology.

4.3. The panel considered the following specific issues:

i. Were practitioners sensitive to the needs of Robbie and Fiona, knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did the agency have policies and procedures for Domestic Abuse, Stalking and "Honour' Based Abuse (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Robbie and Fiona. Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Robbie or Fiona subject to a MARAC or other multi-agency fora?

iii. In which ways did your agency employ a Think Family approach when assessing, planning and monitoring risks, and making safety plans for Robbie, and/or any of the family members?

iv. How did agencies work together to support Robbie – and Fiona – with their compound needs?

v. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

vi. How were indicators of suicide risk identified and managed regarding Robbie? For example, was he offered – and if so at what point(s) was he offered – bereavement counselling following his brother's death.

vii. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

viii. Had Robbie disclosed domestic abuse to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared, where appropriate?

ix. Were procedures sensitive to Robbie as a potential male victim of domestic abuse?

x. What consideration was given to the children as victims of domestic abuse, as per Domestic Abuse Act 2021?

xi. Was history considered when identifying the risks of harm, from each other, and from themselves?

xii. In what ways does your organization work in a trauma informed way and did you employ this with the parties?

xiii. Were practitioners suitably curious about circumstances, signs and clues – particularly through a trauma informed lens?

xiv. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Robbie and promote their welfare, or the way it identified, assessed and managed the risks posed by Robbie? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xv. How did covid-19 restrictions effect the couple, access to services, or identification of risk within the family?

## 5. DARDR Methodology

5.1. The detailed information, on which this report is based, was provided in Individual Management Reports (IMRs), which were completed by each organisation that had significant involvement with Robbie.

5.2. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

5.3. Each IMR was written by a member of staff from the organisation to which it relates and signed off by a Senior Manager of that organisation, before being submitted to the DARDR Panel.

5.4. Neither the IMR Authors nor the Senior Managers had any involvement with Robbie during the period covered by the review.

5.5. Due to the nature of the review, specifically that Robbie's death was not found to have been directly caused by Fiona, the panel were limited to how much information they could request in respect of Fiona, and the children. The information requested was considered

to be proportionate and relevant, in order to fulfil the statutory duties and Home Office guidance regarding Domestic Abuse Related Death Reviews.

## 6. Summary Chronology

6.1. In the absence of any family members involved in the review, the following section brings together information gathered from agency case notes, recollections from professionals engaged with Robbie, and from Fiona's statement to the coroner.

6.2. Robbie was born in Scotland. His mother, who died in 2014, was understood to be alcohol dependent throughout most of his life and Robbie was believed to have one sibling who died of an overdose in 2020. He moved around the UK before starting a relationship with Fiona around 2020.

6.3. There is a recurrent history of possible traumas including; abuse suffered as a child, working in conditions for a time in Germany which indicated exploitation and a self-reported history of depression and attempts to end his own life - the earliest of which was when he was 13. He was described by Children's Social Care as a sensitive individual who struggled with his confidence.

6.4. In 2019, Robbie was given a diagnosis of mixed anxiety and depressive disorder.

6.5. At the start of Robbie and Fiona's relationship, Fiona's children were already subject to a Child Protection Plan and Children Social Care had been involved with Child A and Child B for a number of years.

6.6. In June 2020, Robbie's Sertraline[1] prescription was restarted, he also self-referred for Talking Therapies. He spoke to the Therapist about past and new relationships - although the name of the new partner was not recorded - and his brother's death. He was referred for bereavement related counselling but did not attend. On 20th July 2020, Robbie disengaged with the Talking Therapies, and he was discharged from the service. His GP was informed.

6.7. In November 2020, there was a request for information about Robbie received by Humberside Police from Hull City Council's Children's Social Care.

6.8. On 11th December 2020, a Safeguarding Manager from the children's school reported to police that there had been a verbal argument between Robbie, Fiona and another male parent. The victim did not support police action but Robbie and Fiona were banned from the school site as a result.

[1] A selective serotonin reuptake inhibitor used to treat various mental health conditions.

6.9. On 29th January 2021, police were called to a Strategy Discussion[2] by Children Social Care, from this it was agreed that a single agency section 47[3] should be undertaken.

6.10. In February that year, Children Social Care contacted the housing provider (THA) to inform them of the Child Protection process commencing and a referral was made to THA's Welfare Benefit team. There is evidence of good interagency practice. On 18th February 2021 the Initial Child Protection Conference was held and a decision made for a Child Protection Plan was agreed.

6.11. On 13th October 2021, police were informed that Robbie was seen in the street with a kitchen knife, and he had chased another male down the street with this. Consequently, Robbie was made the subject of an 18-month Community Order on 3rd March 2022. Initial issues were identified and reflected in the initial OASys risk assessment,[4].

6.12. Robbie attended his Probation induction on 10th March 2022 and attended again later that month. On 13th April 2022 he attended another appointment - arriving early to alleviate concerns of breaching the conditions by arriving late, and again on 25th April 2022, although there are no notes available from this meeting.

6.13. The next two Probation meetings on 15th May 2022 and 8th June 2022 were both attended and reports stated he was generally well despite a frustration about arguments between him and Fiona.

6.14. On 29th June 2022, Child B made an allegation of physical harm against Fiona and Robbie. Both were arrested, and were given bail conditions until 1st August 2022.

6.15. On 4th July 2022, a Strategy Discussion was held, where it was agreed that a joint section 47[5] would be undertaken and on 6th July 2022, following the information being shared between Children Social Care and Probation, the Probation Officer discussed Robbie's case with their manager. The following day discussions were held between Probation and other partner agencies to inform their risk management decisions.

6.16. On 12th July 2022, Robbie attended his weekly unpaid work session.[6] He was very emotional and the supervisor agreed he did not have to do any work but kept him on site

[2] Part of the safeguarding process, used to determine whether a child is at risk of significant harm and outlines the necessary steps for investigation and intervention.

[3] Children Act 1989 – if there are serious concerns about the safety or welfare of a child or children, children's services may decide that a child protection investigation is needed, and they will conduct a section 47 enquiry.

[4] Offender Assessment System – a risk assessment and sentence planning tool used in England and Wales by the prison and probation services.

[5] Where s.47 enquiries are undertaken by police and Children's Social Care

[6] Unpaid work is also known as "community payback" and can include litter picking, maintenance in local parks and other tacks which benefit the local community. Whilst the Probation Officer supervised the whole of probation order, there is also an individual supervising the unpaid work sessions out in the community – they are not Probation Officers.

to ensure his welfare while access to support was sought for him. This was very proactive and trauma informed practice. He also self-referred for Talking Therapies on this day.

6.17. Robbie saw his GP at a face-to-face appointment on 14th July 2022. He presented as very depressed and shared that he had thought about taking his life on the way to the appointment. The GP referred Robbie to the Crisis Team. This was received on 14th July 2022 but a call to Robbie was not attempted until 23rd July 2022.

6.18. Robbie attended his Talking Therapies appointment on 27th July 2022. He talked about hallucinations and suicidal thoughts. There were no disclosures about domestic abuse.

6.19. The unpaid work element of Robbie's Probation Order had been suspended until 30th August 2022. Probation permitted an absence from the Probation appointment on 15th August 2022, with the rationale that Robbie was working with Children Social Care during this period.

6.20. On 15th August 2022, CGL Renew tried to call Robbie following a referral made for him by Fiona. They eventually spoke to Robbie on 17th August 2022, and he was given an assessment appointment for 19th August 2022. When this took place, he reported on cannabis use and poor mental health and stated that he was in good physical health. Robbie reported being prescribed Sertraline and Propranolol and had recently been assessed by the Let's Talk Service.

6.21. Robbie attended the Unpaid Work sessions on 30th August 2022, and 6th September 2022. Robbie also attended his Probation appointment on 8th September 2022. At this appointment there was a difficult conversation around cannabis use and Robbie became angry but he was able to calm down and accept what the Practitioner was saying.

6.22. Robbie attended his Unpaid Work session on 13th, 20th and 27th September 2022 with no concerns and on 26th September 2022, Robbie attended Probation on an electric scooter, which he stated he bought with the money he had saved whilst not using cannabis.

6.23. Robbie and Fiona's bail conditions ended on 2nd October 2022. On 6th Robbie attended his face-to-face appointment with Renew, he reported being free from cannabis for 28 days. On 20th Robbie attended his Probation appointment, and it is recorded that he "looks like a different person". He had completed his Unpaid Work.

6.24. Robbie saw Renew on 10th November 2022, he was 62 days free from cannabis and reported to be feeling "brilliant". He saw Probation on 15th November 2022 and updated them on this situation and then again on 12th December 2022 where he was recorded as coming from volunteering at a local charity shop.

6.25. Robbie was discharged from Renew on 14th December 2022, having completed his treatment.

6.26. Probation met with Robbie on 12th and 30th January, and on 14th February 2023. The reports all state that things were going well at home following the children's return and Robbie asked for support to return to work within the building trade.

6.27. Between 28th February 2023 and 19th May 2023, Robbie failed to attend Probation appointments and his ETE sessions. He was given a breach for the ETE non-attendances and on 1st June 2023 Robbie received a summons due to the breaches.

6.28. Robbie attended the next Probation appointment on 19th July 2023. He spoke about Children Social Care involvement with the family, and that the children had been stepped down from Child Protection to Child in Need. At this meeting, he told the Practitioner that Fiona suffers with poor mental health, which he stated was currently very bad. He stated that Fiona shouts and swears at him, and says "vile" things to him, calling him useless. He said he was feeling isolated and controlled.

6.29. The wellbeing appointment went ahead, with feedback being sent to the Probation Practitioner; *"it was identified that Robbie is currently having difficulties in his relationships and stated that his partner "does not trust him" and "often asks where he is going and with who", we explored this further, and he stated this has an impact on his wellbeing."* He spoke about getting back to volunteering too. The Wellbeing Practitioner shared the information with the Probation Officer, which was good practice.

6.30. There was an appointment with the Probation Practitioner on 2nd August 2023, and he spoke about an argument with Fiona. He said that in public things are wonderful but once home Fiona "kicks off" at him, there had been two physical assaults but generally "she just throws stuff at him", shouts at him and calls him names. He said he helps her as much as he can, making her a drink for when she wakes up, and sorts the children out for school. He said he was scared to leave as he would have to leave the children with her. He also disclosed some issues with debt and finance management. He was asked by the Practitioner if he wanted a referral to the Domestic Abuse Project (DAP) male victim support service, but declined. .

6.31. On 29th January 2024, both adults disclosed to Children Social Care that they were both using cannabis again. The following day, the school raised concerns about Child B's presentation and hygiene. The Social Worker stated that they planned to increase the visits to the family.

6.32. Fiona and Robbie both self-referred to Renew the following day. An appointment was made for Fiona on 8th February, and for Robbie on 16th February 2024.

6.33. In early February 2024, Fiona returned from the morning school run, to find Robbie hanging from the banister by a dog lead. Police were called and Fiona was spoken to at the scene. Following Fiona's disclosure, of an argument that morning, a skeleton DASH was completed, with a non-crime occurrence raised and a secondary risk assessment completed. This is expected practice following the disclosure of domestic abuse incidents.

6.34. Robbie was admitted to Hospital A and died two days later.

## 7. Conclusion

7.1. Robbie had experienced trauma from childhood and appeared to have had a transient lifestyle before settling down with Fiona.

7.2. Fiona appears to have been in previous relationships with men who were abusive, and at the point when Robbie moved into the family home, the children were already subject to Child Protection due to male violence in the home, as well as Fiona's mental health, substance use, and her parenting.

7.3. During a period of Children Social Care intervention, where the children were not in their care, both Fiona and Robbie were able to abstain from cannabis. Both engaged well with services. Robbie engaged very well with Probation, his unpaid work expectations, and the CRS Wellbeing Service.

7.4. Around July 2023, Robbie disclosed being subjected to domestic abuse by Fiona. Robbie was offered a referral to the local specialist men's domestic abuse service; however, he declined.

7.5. The circumstances within the family unit deteriorated towards the end of 2023, with Robbie's mental health also deteriorating. Both adults started using cannabis again, and Robbie was encouraged to return to the mental health support which had helped him previously. Robbie declined this support, and as the children had been stepped down to Child in Need at this point, all interventions were consent based.

7.6. Another factor to consider is that long-term recovery from drug use is very difficult. Robbie had been using cannabis from a young age and had not been abstinent for a very long period when he started using cannabis again, sometime around December 2023. It is not clear whether Robbie had introduced alternative coping strategies in the place of cannabis, and he did not have any ongoing psychosocial support to support him in his long-term recovery.

7.7. These stressors, and the burden placed on Robbie, should be viewed through the lens of the trauma he had been experiencing from childhood.

## 8. Lessons to be Learnt

8.1. Probation Officers and staff must ensure that they record the rationale for decisions made, ensuring they have made defensible decisions, and record keeping is robust.

8.2. There are male DA services available in the local area. This is an excellent resource, however many male victims require gradual exploration and curiosity, as well as ongoing support, to access these services.

8.3. Since the scoping period services, such as CHCP Talking Therapies, are making plans to upskill staff with DASH training. Agencies are recommended to consider some level of DASH

training with their service, if this is appropriate. This has been identified as learning to be raised, but is not a formal recommendation from the review.

8.4. Agencies are reminded to consider how risk is fluid, but also that the best ways to assess risks of suicide with a holistic and person-centred approach, which comes from building rapport, asking questions and using professional curiosity, then fully recording discussions to enable a review of circumstances as situations change.

8.5. A Think Family approach should be adopted at all times: when assessing risk, for safety planning, during transitions between services and when closing cases and ending support. Consideration should always be given to how each person's risk may exacerbate other family members' risks, along with the impact of the cumulative risks. It is important that risks should be constantly assessed, and where a risk has increased, the systems around the family should be adapted to respond to the fluidity of the risk.

8.6. As a trauma informed city, it is important that all services, and the wider system in Hull considers how the ending of support, and transitions to different areas and levels of support, can be achieved in a trauma informed way.

## 9. Recommendations

9.1. The Review Panel makes the following recommendations from this DARDR:

A. Each agency involved in this review to provide assurance that they have considered where their services could be enhanced by introducing Think Family approaches. At a minimum, this would include providing details of how many staff have completed Think Family training,

B. Each agency involved in this review to provide assurance that they have considered where their services could be enhanced by introducing trauma informed practices. At a minimum, this would include providing details of how many staff have completed the trauma informed practice training, available through Public Health.

C. Robbie's story will be developed into a case study which can be used a resource within trauma informed training and to assist with learning around the need for a trauma informed approach. Highlighting that Hull as a Trauma Informed City. This will include access to trauma informed training and resources. For all agencies to use as appropriate.

D. The Hull Domestic Abuse Board will consider the need for services to support children as direct victims of domestic abuse, during the upcoming re-commissioning of domestic abuse services.

E. A learning briefing will be developed to share reflective learning around identifying risks within family units, including risks of suicide.

F. GP Practice A will use the case study referenced in Recommendation C, at a learning event which is specific to the practice staff.

G. To support safer, high-quality care, the Humber Teaching Trust will launch a campaign focused on improving the accuracy, completeness, and timeliness of patient contact entries in SystmOne, ensuring they fully reflect the care delivered and decisions made by healthcare professionals.