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Elizabeth Died November 2024

Domestic Abuse Related Death Review

David Blain – Independent Author/Chair

June 2026

CONDOLENCES

DTK Safeguarding Associates and the review panel members would like to offer their deepest condolences to Elizabeth and family members on their sad loss of a precious mum, daughter, sister and friend.

FOREWORD AND TRIBUTE BY THE FAMILY OF Elizabeth

Elizabeth was the 2nd of 3 girls, being the middle child, she loved mischief.
As long as I can remember all she wanted was a happy family unit, she loved being a mum and a home maker.
School was not her favourite place, and the sad thing is she could have achieved so much had she put her mind to it. Dad always said she was the clever one.

When she became pregnant for the first time she was over the moon. She would have done anything for her children well in fact, if you were lucky enough to be loved by her, she would do anything for you, she would love fiercely for those closest to her.

She suffered for years with her mental health and just never seemed to get the help she really needed.

Over the years she loved more than anything making memories with her children and would constantly paper over the cracks that we could see quickly appearing.
She kept going back to her family unit as she believed a family should be together but, in the end, she realised this is not how life should be, and she was worth more. Elizabeth was extremely traumatised and further distressed when her beloved children were placed with her abuser, a perpetrator of domestic abuse and coercive control, she was feeling left to fight alone. A battle she didn't believe she was strong enough to win.

We lost a precious mother, sister, auntie and friend. I am not sure our lives or hearts will ever be the same again.

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1. THE REVIEW PROCESS

This summary outlines the process undertaken by the Hull Community Safety Partnership (CSP) Domestic Abuse Related Death Review (DARDR) panel in reviewing the death of Elizabeth who was a resident in their area.

There are currently no criminal proceedings associated with this review and no coroner's hearing has taken place so far.

The process began with an initial meeting of the CSP on 29/01/2025 when the decision to hold a domestic homicide review was agreed and the Home Office notified. All agencies that potentially had contact with (victim/perpetrators) prior to the point of death were contacted and asked to confirm whether they had involvement with them. Correspondence requesting an extension was sent to the Home Office on 03/06/2025 due to the large amount of information being submitted and reviewed by the panel.

26 of the agencies contacted confirmed contact with the victim and/or perpetrators and children involved and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

- Hull Domestic Abuse Partnership x2 (DAP) - Chronology, IMR and Information
- Humber Teaching Foundation Trust (HTFT) - Chronology, IMR, Information
- Hull University Teaching Hospitals (HUTH) - Chronology, IMR and Information
- General Practitioner (GP) - Chronology, IMR and Information
- Humberside Police (HP) - Chronology, IMR and Information
- Yorkshire Ambulance Service (YAS) – Chronology and Information
- Humberside Fire and Rescue Service (HFRS) - Information
- Neighbourhoods and Housing Hull City Council (N&H) - Chronology, IMR and Information
- Together Housing - Chronology, IMR and Information
- Renew Substance Misuse Services (Renew) - Chronology, IMR and Information
- Schools x2 - Chronology, IMR and Information
- Children Social Care 1 (CSC) - Chronology, IMR and Information
- Children Social Care 2 (CSC) – Chronology, IMR and Information

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- Adult Social Care Safeguarding Team (ASC) – Information
- City Health Care Partnership (CHCP) - Chronology, IMR and Information
- Humber and North Yorkshire Integrated Care Board (ICB) – Information
- Blue Door - Chronology, IMR and Information
- Preston Road Women's Centre - Chronology, IMR and Information
- National Probation Service – Chronology and IMR
- Hull City Council Public Health Team – Chronology and Information
- Hull and East Yorkshire MIND – Information
- The pharmacy of Elizabeth – Information
- East Riding County Football Association – Information
- The National Football Association – Information
- Grass roots football team manager/coach - Information

DARDR panel members confirmed the independency of IMR authors for each respective agency.

A total of 5 panel meetings were completed during the period of the review. All agendas included reference for confidentiality and the requirement for panel members to be independent of involvement with the subjects of the review, non-supervisory of professionals/practitioners involved with the family, or authors of their agency's reports.

3. AUTHOR OF THE OVERVIEW REPORT

The independent chair/author is an independent safeguarding consultant with 42 years' experience in the health sector prior to NHS retirement in 2021. A paramedic by clinical background, but the past 27 years working in child and adult safeguarding, also domestic abuse roles within various NHS organisation's Quality, Assurance and Risk Directorates. This included acute trusts, numerous ambulance services, Clinical Commissioning Groups, Primary Care and regional/national roles within NHS England/Improvement. One of these roles was as a Designated Safeguarding Lead with the former now non-existent NHS Hull Clinical Commissioning Group between 2014 - 2018.

The independent chair/author has completed the Home Office/Advocacy After fatal Domestic Abuse (AAFDA) domestic homicide chairs training online and attended the AAFDA Raising the Standard of Domestic Homicide Reviews workshop on 21/10/22.

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The independent chair/author completed the Home Office approved DHR chairs training in June 2024 (Certificate 9852406). The independent chair/author is also a current member of the AAFDA DHR national network and has attended numerous CPD events provided by the network, x5 in 2025 so far.

The independent chair/author is totally independent from the CSP and all other agencies involved in the review with no existing personal, professional, financial or other conflicts of interest. The independent chair/author's appointment was cognisant of previous local relationships in the city.

4. TERMS OF REFERENCE FOR THE REVIEW

Terms of Reference (ToR) for the review were developed based on the current Home Office DHR/DARDR national guidance. The ToR were reviewed and updated against information supplied by agencies upon completion of each chronology and other associated information. The time period for searching contacts with the subjects of the review was dictated by the marked escalation in incidents and concerns during the stated period between 01/11/2021 to 06/11/24. Authors were also requested to include any relevant or significant information outside of this time frame if considered to be important.

This review will;

- Include and consider the events leading up to the death of Elizabeth, including a full chronology of all contacts within the above time frame and outside of this where relevant.

- Include all available and relevant information relating to the subjects of the review and other individuals if required.

- Review practices by all agencies and consider whether these were sensitive to the 9 protected characteristics within the Equality Act 2010. Require authors to consider the issue of intersectionality and whether this was considered to have an impact on risk assessments or establish any barriers to the services provided.

- Require the agencies involved to secure and review all documentation, case notes, clinical records, and any other relevant sources of information pertaining to the subjects of the review.

- Review the quality of information sharing between professionals, agencies, other relevant services, and identify if actions were commensurate with current protocols to support and protect the subjects of the review.

- Review the reported substance misuse and any potential impact this may have had on wider engagement with services.

- Include and capture the lived experiences of any children involved and review any information relating to this in the event of non-engagement.

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- Consider any references to the alleged/reported domestic abuse, and whether subsequent actions by professionals were in accordance with current policies/procedures to report and escalate to the necessary support required.

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

- Highlight any examples of good practice so that these may be used to improve future standards of care and support for victims and perpetrators of domestic abuse.

- Include all key findings and produce specific and relevant recommendations to improve future domestic abuse practice.

In accordance with the statutory guidance, these terms of reference were subject to review by the review panel and updated as the DARDR progressed.

5. SUMMARY OF CHRONOLOGIES

The subjects of this review were known to many agencies and professionals in the city due to numerous contacts and requests for help with physical, and mental health, criminal offending/behaviour, housing and social care. The review also reached out to peripheral agencies once their involvement was known. The data above taken from 21 agency chronologies, demonstrates in combination, a total of 1250 entries and pieces of information with all the subjects of the review within the ToR and date scope. Agencies shared many more pieces of information outside of the scope which was also considered to inform the review when relevant by the independent chair/author.

Many chronology entries for Elizabeth were for the responses to the verbal and physical abuse she suffered, perpetrated by Adult J and Adult R. These included the after effects of physical injuries and psychological challenges caused by the traumatic impact of the events and the abuse.

Entries for Adult J were minimal, mostly for when emergency services attended the address following incidents of domestic abuse. Adult J had minimal engagement with the schools until he became the primary carer. Adult J's only real engagement with professionals was when he reported Elizabeth as a perpetrator of domestic abuse. He attended local domestic abuse support services and was recorded as a victim following procedures. Adult J did not respond to communication attempts by the independent chair/author to be involved in the review.

Adult R had a long history of substance abuse and mental health issues. Appropriate agencies were involved to support Adult R with these issues prior to and during the period of the review. Adult R would also perpetrate domestic abuse against Elizabeth. There were chronology entries relating to incidents involving Adult R when suffering mental health crises and expressing suicide ideation associated with overdoses. Adult R was also known to the police and National Probation Service (NPS) following criminal activity and offending behaviour.

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6. KEY ISSUES ARISING FROM THE REVIEW

The wider impact of domestic abuse on family members and children living in the home.

The challenge for professionals when dealing with counter allegations and resistance violence when partners are recorded as both victims and perpetrators.

Lack of awareness of the domestic abuse suicide timeline.

Seeing domestic abuse victims through an adult safeguarding lens.

The significant contribution that education has when keeping children and adults safe from abuse and neglect.

The need to improve trauma informed care.

Raise further awareness of the link between domestic abuse, mental health and suicide.

The presence and guises of controlling and coercive behaviour.

7. CONCLUSIONS

Following completion of this review, there has been the opportunity for equal contribution from everyone involved and has been impartial whether professionals, family, friends, neighbours, providers or commissioners of services. Findings of fact and general conclusions indicate that there is no doubt that the information shared for this review demonstrates the amount of traumatic situations and experiences that all the subjects been exposed to during childhood and adulthood.

It is essential that all professionals and front-line staff are aware of how pervasive the risks and vulnerabilities of domestic abuse, mental health and substance misuse are linked in households where present.

Information provided demonstrated that both Adult J and Adult R had grown up in a households where domestic abuse, alcohol misuse and mental health issues were factors, and this appears to have continued into and throughout their relationships with Elizabeth and other partners. There needs to be more focus and consideration by all agencies of the wider impact of domestic abuse and how this also affects other family members, not just perpetrators and primary victims. This was also a concern highlighted by the family of Elizabeth and a local recommendation is made to address this.

> *Non-physical forms of domestic abuse like coercive control have a significant impact on children and professionals focused on physical acts of violence may fail to understand the daily experience of victims and children, how it is affecting them, and the level of risk posed by perpetrators.*

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(Home Office 2021)

As Elizabeth appeared to progress on a journey to a stage of hopelessness and helplessness, the frequency of events and incidents increased, ultimately leading to the fatal incident when Elizabeth sadly died. The complex life and relationship experiences that Elizabeth described and disclosed to many professionals, was indicative of a life filled with physical and emotional abuse and trauma. The reported coercive control and abuse perpetrated by Adult J and Adult R appears to have further subjected Elizabeth to a long, historical period of verbal, emotional and physical abuse. It is not possible to confirm that the abuse or coercive control would happen every day during the relationships, the information provided may only be potentially suggestive that this review only captures a small understanding of the amount of mental and physical trauma that was involved. Further emphasising the importance for all professionals to undertake a trauma informed approach when engaging with and supporting vulnerable people and families.

Adult R would also become a vulnerable individual due to his lifestyle choices, substance misuse, mental health challenges and relationship difficulties. Especially when relationships were breaking down appears to have been a trigger for some behaviours and actions.

It is essential that front line professionals, supervisors and senior managers are aware of the domestic abuse suicide model and the 8 stages of behaviour and escalation when assessing risk and supporting vulnerable individuals. With more understanding of this model, practitioners and professionals will be assisted to improve the quality of domestic abuse risk assessments, especially in situations where victims of abuse decline support, do not engage or refuse conveyance to a place of safety. A local recommendation is made to address this issue.

Although the suicide of Adult R is not in response to being a known victim of domestic abuse. It is still important to capture the impact that a partner's suicide may also have on a victim of domestic abuse that is also experiencing suicidal ideations.

There were many cries of pain made by Elizabeth that were recorded and captured by professionals whilst in contact with Elizabeth, but the emphasis appears to have been focussed on assessment, treatment and risk management, rather than a more holistic approach to establish a complete understanding of the trauma symptoms The victimised voice of Elizabeth was evident in many contacts with agencies, and this should have prompted deeper professional curiosity and consideration of what she had experienced and been subjected to. The current and historical abuse being perpetrated by Adult J and Adult R was shared, and this impacted on Elizabeth's mental and physical health. It is essential that professionals, staff and volunteers do not view domestic abuse incidents in singularity or isolation, and that any type of assessment is cognisant of the many components that perpetrators utilise to coercively control victims.

Following events and incidents, Elizabeth repeatedly shared with professionals and agencies, how she felt anxious, afraid, emotionally unregulated, and having suicidal thoughts. The family of Elizabeth shared that the death of their mother may have had

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a significant and traumatic impact during the period of this review, apparently causing further problems with Elizabeth's wellbeing, alcohol use and presentation. It was also shared by friends, family and neighbours that Adult J would attend the home address of Elizabeth's mother to demand money for gambling addictions and make threats causing further distress to Elizabeth. It is not referenced in any agency reports, so maybe this was something that Elizabeth kept to herself and didn't disclose to professionals.

It appears that the abuse by Adult J continued towards Elizabeth once the relationship with Adult J had ended and they had separated.

> *Suspected victim suicide and intimate partner homicide in many ways have very similar risk profiles. A history of domestic abuse, non-fatal strangulation and attempts to separate are all indicators of coercive and controlling behaviour and they are risk factors for both intimate partner homicide and suspected victim suicide.*
>
> *(Home Office/NPCC 2021)*

It is essential that professionals and staff must carefully consider potential suicidality when anyone is disclosing such trauma and domestic abuse, as it appears that Elizabeth may have reached the feeling of hopelessness which potentially led to the fatal incident.

> *Those trapped by domestic abuse can feel so hopeless that they believe the only way out is suicide*
>
> *(Refuge and Warwick Law School 2018)*

Elizabeth left a series of notes prior to her death. The notes are specific when relating to the rationale to her death by suicide and the reasons why. Although not for inclusion in this review, there is reference to the abuse and trauma she had suffered in her relationships and the impact of Adult R's recent death by suicide.

The link between mental health, suicide ideation and domestic abuse does not appear to be fully embedded in practice throughout many of the contacts that inform this review. This is also consistently being highlighted within other current DARDRs being completed and published around the United Kingdom. This needs to change, and a local recommendation is made by this review to continue to address this issue and improve practice by professionals and staff in this issue.

> *The psychological impact of domestic abuse can be so severe that it leads to suicide ideation and attempt. The severity and time span of the abuse, and existing mental health needs of the victim, may be specific risk factors.*
>
> *(Home Office 2022)*

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It does also not appear that some professionals were aware of or gave consideration to the higher risk of suicide of Elizabeth identifying as a female who had disclosed mental health and a long history of domestic abuse including coercive control.

> *Women who have experienced abuse from a partner are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse.*
>
> *(Agenda Alliance 2023)*
>
> *The findings show that the nature and extent of prior coercive control are severe in situations which culminate in a victim dying by suicide, which reinforces the importance of identifying, recording and charging for controlling or coercive behaviour in a timely and accurate manner.*
>
> *(Home Office 2022)*

Elizabeth had suffered greatly in her life with Adult J and Adult R due to the long-term abuse and being coercively controlled. On occasion, there would be inconsistent accounts and information shared, and sometimes it would be selectively shared, but this is expected due to the impact of trauma, substance misuse and mental health issues that Elizabeth was suffering from. When having suicidal thoughts, it appears Elizabeth would always reach out to someone, whether family or professionals in agencies for help. However, adult safeguarding does not appear to be a significant feature of the response by agencies, nor does consideration of the MEAM or VARM/MARM processes available at the time. These omissions did not sufficiently identify or fully share the levels of concerns and risks despite lots of information being available to agencies and professionals. The application of contextual safeguarding principles may have provided further professional support from the local adult safeguarding team and partner agencies

To conclude, the city and its organisations must continue to develop a community of practice towards progressing the utilisation of trauma informed care and practice for its professionals and citizens. Very little evidence was highlighted in agencies reports to demonstrate that front line professionals were familiar with the 6 key principles of trauma informed practice of safety, trust, choice, collaboration, empowerment and cultural consideration.

The current working definition for trauma informed practice provided by the Office for Health Improvement and Disparities (OHID) offers the following,

> *Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being.*
>
> *(OHID November 2022)*

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8. LESSONS TO BE LEARNED

Nationally domestic abuse related suicides have recently overtaken intimate partner homicides and professionals need to be aware of this statistic.

> *"The number of suspected victim suicides following domestic abuse has overtaken intimate partner homicides for the first time."*
>
> *(National Police Chiefs Council 2024)*

As seen in this review for Elizabeth, there is a need to continually promote and enhance professionals and organisations understanding of the link between domestic abuse, mental health, suicide risks and the traumatic effect these can have on individuals and families. There are a multitude of references to mental health by agencies in reports, but it appears there is still not enough connection or curiosity by professionals linking this to domestic abuse, vulnerabilities and suicide/suicide ideation, this requires ongoing and further urgent actions to address this.

Suicide and suicide ideation remains a big challenge for professionals and agencies in the area. Local suicide data and reports published in 2024 was shared with the independent chair/author by the local Public Health Team. Hull has the 5th highest suicide rate in Yorkshire and the Humber area averaging 33 deaths by suicide each year in the past two years. The Public Health report demonstrates that key risk factors are known mental health problems, previous suicide attempts, suicide ideation, self-harm, worklessness, substance misuse; relationship breakdown; physical health problems and domestic abuse. The Public Health report also identified that 68% of the suicides recorded hanging as the method. Elizabeth and Adult R were both also found suspended by ligatures. All of these factors are also captured and highlighted in this review and organisations in the city need to continue to raise awareness of these issues and the impact they have on vulnerable individuals. A local recommendation is made to continue to address this issue and ensure strong links with domestic abuse continues to be embedded within assessments, systems and process for suicides and suicide ideation.

> *'findings uncovered by Agenda Alliance have led to fresh calls for midwives, dentists, probation, Jobcentres and all professionals across healthcare, justice, education and welfare sectors to be trained to better understand and respond to women at risk of both domestic abuse from their partner and of suicidal thoughts and suicide attempts.'*
>
> *(Agenda Alliance 2023)*

Alcohol use is also reported as a factor in the majority of reported incidents/events and the services provided to Elizabeth. Elizabeth did engage very well with substance misuse services at Renew and attended many face to face and group appointments for her drinking challenges. Elizabeth was open regarding her consumption and disclosed on some days to drinking 10 cans plus amounts of gin and vodka. During this time Elizabeth declared she had not used any drugs nor did completed tests reveal the presence of such substances.

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Only one of the agencies involved could demonstrate that professionals and staff involved with the subjects of the review, were aware of the 8-stage domestic abuse suicide timeline when assessing risks posed to Elizabeth by Adult J and Adult R. Therefore, a local recommendation is also made to address this issue highlighted in this report to improve practice and services provided to local citizens.

This review places a large emphasis on learning lessons from the death of Elizabeth and how the impact of domestic abuse, coercive control, substance misuse, mental health, suicide ideation were key factors. It is essential that the learning from this review is disseminated widely amongst all professionals and agencies providing services in the city of Hull. The learning must also be utilised to inform the progress and development of the Domestic Abuse, Suicide Prevention and Trauma Informed strategies.

> *'Organizations learn only through individuals who learn. Individual learning does not guarantee organizational learning. But without it no organizational learning occurs'*
>
> *(Senge 1990)*

9. RECOMMENDATIONS FROM THE REVIEW

Local Recommendations

1. The CSP will reconvene this DARDR panel in 6 months to reflect on panel/organisational learning, and to provide evidence/assurance that agency action plans are being implemented and completed. Assurance will also be provided to the family of the progress of the associated action plan.

2. Within 6 months agencies working directly with individuals that are classified as both perpetrators and victims of domestic abuse and coercive and controlling behaviour, will consider ways to share information and practice to further understand the dynamics of the relationships and agree management principles together.

3. Within 3 months, the themes, outcomes and recommendations from this review will be shared with the academy sponsors of the two schools involved.

4. Over the next 12 months, the local education safeguarding officer in Hull will present the outcomes and learning from this review to all Designated and Assistant Designated Safeguarding Leads (DSL/ADSL) within all schools in the local area as part of safeguarding Continual Professional Development (CPD) events.

5. Over the next 12 months, the local education safeguarding officer in the East Riding will present the outcomes and learning from this review to all Designated and Assistant Designated Safeguarding Leads (DSL/ADSL)

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within all schools in the local area as part of safeguarding Continual Professional Development (CPD) events.

6. Within 6 months, all involved agencies to review and update policies, practice and educational resources where required, to include the link between mental health, domestic abuse and suicides/suicide ideation.

7. Within 6 months, all involved agencies will review and update educational resources and policies, to include resistance and bi - directional violence theories and the potential impact on risk assessments.

8. Within 6 months involved agencies will review and update educational resources and policies, to include the suicide 8 stages of the Domestic Abuse Suicide Timeline.

9. Within 1 month a referral will be completed to the East Riding Safeguarding Adult Board (ERSAB) to consider Adult R for a Safeguarding Adults Review (SAR).

10. Within 6 months, YAS will review and update policies and systems for non-conveyance and clinical safety netting, including further reference to domestic abuse and coercive and controlling behaviour.

11. Within 6 months, CSC agencies will review and update procedures to further involve schools in all relevant multi-agency meetings, especially when domestic abuse and coercive and controlling behaviour is reported.

12. Within 3 months, the ERCFA will further promote and re-inforce with club welfare officers for dissemination, safeguarding responsibilities of all local grassroots teams and the impact of domestic abuse. This will be completed via various communication methods and CPD events.

13. Within 6 months, the two local CSPs will review and update their domestic abuse educational resources to enhance further inclusion of the impact of Coercive and Controlling behaviour and the wider impact on all family members.

14. Within the next 6 months, all involved agencies will internally promote access and referral to the VARM/MARM/MEAM processes available for professionals.

National Recommendation

There are no national recommendations to be made from this review.

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Action Plan

(The Action Plan is subject to change as recommendation are implemented)

Recommendation	Scope: Local or Regional or National (L,R,N)	Action to Take	Lead Agency / Person	Key milestones achieved in enacting recommendation	Target Date	Evidence To Demonstrate Completion and Implementation	Completion Date and Outcome
1. The CSP will reconvene this DARDR panel in 6 months to reflect on panel/organisational learning, and to provide evidence/assurance that agency action plans are being implemented and completed. Assurance will also be provided to the family of the progress of the associated action plan.	L	Reconvene DHR/SAR panel	Hull CSP	Meetings arranged and agencies in attendance.	August 2026	Agendas published Meetings minutes agreed, approved and circulated Agency action plans submitted with associated evidence	TBC
2. Within 6 months agencies working directly with individuals that are classified as both perpetrators and victims of domestic abuse and coercive and controlling behaviour, will consider ways to share information and practice to further understand the dynamics of the relationships and agree management principles together.	L	To arrange meetings with relevant agencies and produce improved networks, arrangements and processes.	Hull DAP	Leads and Teams aware and involved in developing the process	August 2026	Meetings arranged and minutes completed Event agendas and outcomes developed/ published	TBC

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3. Within 3 months, the themes, outcomes and recommendations from this review will be shared with the academy sponsors of the two schools involved.	L	DARDR report and outcomes to be shared with academies involved	Hull CSP	Documents sent and received	May 2026	Evidence of learning outcomes being shared, emails etc	TBC
4. Over the next 12 months, the local education safeguarding officer in Hull will present the outcomes and learning from this review to all Designated and Assistant Designated Safeguarding Leads (DSL/ADSL) within all schools in the local area as part of safeguarding Continual Professional Development (CPD) events.	L	Outcomes, lessons and themes to be included in all education safeguarding CPD events	Hull Education Safeguarding Officer	CPD events arranged and circulated	February 2027	Educational AV Resources reviewed and updated Evidence of events and attendance /completion by DSL/ADSLs and staff	TBC
5. Over the next 12 months, the local education safeguarding officer in the East Riding will present the outcomes and learning from this review to all Designated and Assistant Designated Safeguarding Leads (DSL/ADSL) within all schools in the local area as part of safeguarding Continual Professional Development (CPD) events.	L	Outcomes, lessons and themes to be included in all education safeguarding CPD events	ER Education Safeguarding Officer	CPD events arranged and circulated	February 2027	Educational AV Resources Reviewed and Updated Evidence of events and attendance /completion by DSL/ADSLs	TBC

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6. Within 6 months, all involved agencies to review and update policies, practice and educational resources where required, to include the link between mental health, domestic abuse and suicides/suicide ideation.	L	Policies and Training Resources Reviewed and Updated	All Involved Agencies	Work on documents and training resources completed	August 2026	Reviewed, Updated and Approved Policies Educational resources reviewed, updated and actively delivered in events	TBC
7. Within 6 months, all involved agencies will review and update educational resources and policies, to include resistance and bi - directional violence theories and the potential impact on risk assessments.	L	Policies and Training Resources Reviewed and Updated	All Involved Agencies	Work on documents and training resources completed	August 2026	Reviewed, Updated and Approved Policies Educational resources reviewed, updated and actively delivered in sessions	TBC
8. Within 6 months involved agencies will review and update educational resources and policies, to include the suicide 8 stages of the Domestic Abuse Suicide Timeline.	L	Policies and Training Resources Reviewed and Updated	All Involved Agencies	Work on documents and training resources completed	August 2026	Reviewed, Updated and Approved Policies Educational Resources Reviewed and Updated	TBC
9. Within 1 month a referral will be completed to the East Riding Safeguarding Adult Board (ERSAB) to consider Adult R for a Safeguarding Adults Review (SAR).	L	Complete referral to SAR processes	Hull CSP	SAR Referral documentation completed	March 2026	Referral documentation shared as evidence of completion	TBC

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10. Within 6 months, YAS will review and update policies and systems for non-conveyance and clinical safety netting, including further reference to domestic abuse and coercive and controlling behaviour.	L	Policy and system to be reviewed and updated	YAS	Evidence of discussions with clinical leads in YAS Date arranged for discussions at clinical governance committee/group	August 2026	Reviewed, updated and approved documentation and pathway	TBC
11. Within 6 months, CSC agencies will review and update procedures to further involve schools in all relevant multi-agency meetings, especially when domestic abuse and coercive and controlling behaviour is reported.	L	Policies to be reviewed, updated and approved	CSC	Meetings arranged with CSC and education safeguarding leads	August 2026	Agreed, updated and approved multi-agency information sharing agreement and processes /arrangements	TBC
12. Within 3 months, the ERCFA will further promote and re-inforce with club welfare officers for dissemination, safeguarding responsibilities of all local grassroots teams and the impact of domestic abuse. This will be completed via various communication methods and CPD events.	L	Communication via various methods throughout local grassroots football	ERCFA	Communications completed via available methodologies CPD sessions arranged	May 2026	Evidence of correspondence /communications Delivery of CPD sessions Links with ERCFA White Ribbon accreditation	TBC

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13. Within 6 months, the two local CSPs will review and update their domestic abuse educational resources to enhance further inclusion of the impact of Coercive and Controlling behaviour and the wider impact on all family members.	N	Review, update and agree contents of AV educational resources	Chairs of Hull/ER Community Safety Partnerships	Evidence of training sessions being arranged for both organisations	August 2026	Correspondence between Hull and East Riding CSPs Copy of AV resources utilised in training delivery	TBC
14. Within the next 6 months, all involved agencies will internally promote access and referral to the VARM/MARM/MEAM processes available for professionals.	L	Internal communication processes utilised to convey and promote referral mechanisms	All Involved Agencies	Resources developed to convey promotional messages.	August 2026	Evidence of methodologies utilised in the promotion of messages and the systems used.	TBC

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10. GLOSSARY OF TERMS

AAFDA – Advocacy After Fatal Domestic Abuse

ADSL – Assistant Designated Safeguarding Lead

CPD – Continual Professional Development.

CPOMS – Child Protection Online Management System

CSP – Community Safety Partnership

DARDR - Domestic Abuse Related Death Review

DHR – Domestic Homicide Review

DSL – Designated Safeguarding Lead

ERCFA – East Riding County Football Association

ERSAB – East Riding Safeguarding Adults Board

FA – The England Football Association

IMR – Individual Management Reviews

MAPPA – Multi Agency Public Protection Arrangements

MARAC – Multi Agency Risk Assessment Conference

MARM - Multi Agency Risk Management

MEAM - Making Every Adult Matter

SAR – Safeguarding Adults Review

ToR – Terms of Reference

Hull City Council

Your Ref: 20250129/0
My Ref: CSP/TH
Web: hull.gov.uk
Email: tracy.harsley@hullcc.gov.uk
Tel: 01482 625022
Date: 29th May 2025

GHRENQUIRIES@homeoffice.gsi.gov.uk

Dear Sir/Madam

Title: DARDR ADULT CAW- 20250129/0

Following my letter dated 29th January 2025 to notify you of the Community Safety Partnerships intention to start a DARDR, I write to inform you that the family are now engaging in the DARDA process.

Additionally, more latterly, Individual Management Reviews completed have identified additional agencies to become involved in the review, which is inevitably going to impact on the DARDR timeline and completion of the Overview Report. Because of these factors more time has been provided for the independent chair to support family members and enable newly identified agencies to complete an IMR.

If you have any queries then please do not hesitate to contact me or Vicki Paddison, Strategic Domestic Abuse Services Manager, (Tel: 01482 318759; Email: vicki.paddison@hullcc.gov.uk who has been dealing with this Review.

Yours sincerely

Tracy Harsley
Chair – Safer Hull - Community Safety Partnership

Home Office

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Vicki Paddison
Community Safety,
33 Witham,
Hull,
HU9 1BY

05 June 2026

Dear Vicki,

Thank you for submitting the Domestic Homicide Review (DHR) report (Elizabeth) for Hull Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 22 April 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board

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