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Elizabeth Died November 2024

Domestic Abuse Related Death Review

Executive Summary

David Blain – Independent Author/Chair

September 2025

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.

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.

2. CONTRIBUTORS TO THE REVIEW

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

3. THE REVIEW PANEL MEMBERS

The following people were core members of the panel in attendance at meetings;

- David Blain – Independent Chair/Author

  DTK Safeguarding Associates

- Vicki Paddison – Strategic Domestic Abuse Commissioning Manager

  City Safe/Public Health

- Vicky Macklin – Tesm Leader

  Hull Domestic Abuse Partnership (DAP)

- Chloe Greechan – Safeguarding Practitioner

  Humber Teaching Foundation Trust (HTFT)

- Jayne Wilson – Named Nurse Safeguarding Adults

  Hull University Teaching Hospitals (HUTH)

- Rebecca Holmes – Detective Inspector Safeguarding Governance Unit

  Humberside Police

- Andrea Wilkinson – Senior Probation Officer

  National Probation Service (NPS)

- Lauren Woodall – Practice Management Officer

  Neighbourhoods and Housing Hull City Council (N&H)

- Sue Lewis – Assistant Director Supported Housing and Neighbourhood Safety

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- Sarah Allen – Designated Safeguarding Lead/ Think Family Team Leader

  Renew Substance Misuse Services (Renew)

- Designated Safeguarding Lead – School 1

- Headteacher - School 2

- Alexandra Campbell – Head of Safeguarding Localities

  Children Social Care (CSC 1)

- Stuart Crabb – Independent Reviewing Service Manager

  Children Social Care (CSC 1)

- Donna Smalley - Head of Strengthening and Supporting Families
  Children Social Care (CSC 2)

- Ann Clarkson – Chief Executive

  Preston Road Women's Centre (PRWC)

- Stephanie Price – Chief Executive Officer

  The Blue Door Support Service CIC

- Phillipa Morgan – Operational Safeguarding Manager (Adults)

  Hull Adult Social Care Safeguarding Team (ASC)

- Mags Shakesby – Named Nurse Safeguarding Adults, MCA Lead & Integrated, Safeguarding Team Manager, City Health Care Partnership (CHCP)

- Rachel Sharp – Designated Professional for Safeguarding Adults

  Humber and North Yorkshire Integrated Care Board (ICB)

- Sally Barlow – Public Health Lead (Communities and Partnerships)

  Public Health Team Hull City Council

- Lyndsey McClements – Director of Operations

  Hull and East Yorkshire MIND

- Andrea Wilkinson – Senior Probation Officer

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National Probation Service (NPS)

- Sanjedah Zaro – Named General Practitioner (GP) for Safeguarding Adults

  Humber and North Yorkshire Integrated Care Board (ICB)

  The following people were core members of the panel not in attendance at meetings;

- Lindsey English – Specialist Domestic Abuse Practitioner, Yorkshire Ambulance Service (YAS)

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.

4. 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. 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.

5. 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:

- 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.

- 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.

6. KEY ISSUES ARISING FROM THE REVIEW

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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, often with children present to witness and experience these traumatic and distressing events. Almost all of the agencies involved in this review were aware of the domestic abuse and coercive controlling behaviour in the home where Child 1 and Child 2 were living and had lived with this since birth. 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.

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, having suicidal thoughts and was very fearful of losing her children. The family of Elizabeth shared that the death of their mother may have had 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. Primarily around the property and then it is also reported via text messages from Child 1 and Child 2.

> *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)*

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.

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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)

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.

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

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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.

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.

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