Learning Brief

Derbyshire Community Safety Partnership

Domestic Abuse Related Death Review (DARDR)
DHR2023-2 Operation Mula – Death of "Erin" (a pseudonym)

The Domestic Abuse Related Death Review Panel that considered this case would like to offer their sincere condolences to the family of Erin whom they have lost in such tragic circumstances. Professionals involved in this review are committed to learning from Erin's experiences to improve the system-wide response to victims and survivors of domestic abuse.

Purpose

To highlight **key learning and practice improvements** from the Domestic Abuse Related Death Review into the death of Erin, to strengthen **early identification, safeguarding, and multi-agency responses** to domestic abuse and vulnerability.

Case Overview

- Erin was a **24-year-old woman** who tragically lost her life during the Summer of 2023.
- Having met her partner as a young woman, the last six years of Erin's life were overshadowed by **coercive control and physical, financial and emotional** abuse.
- Multiple agencies had contact with Erin and her partner over several years.
- Erin had a **significant health challenges** which limited her mobility and increased her isolation, and she had lived with alcohol and substance use within the relationship.
- Despite warning signs, the **risks to Erin were not sufficiently recognised** or responses coordinated across agencies.

Key Learning for Practice

1. Identifying and responding to domestic abuse and coercive control

- Indicators of domestic abuse were often **missed by agencies, not fully understood or responded to in isolation**.
- Erin's reluctance to support police action or engage with domestic abuse support services were frequently accepted without sufficient consideration of **coercive control** or the challenges she experienced.
- **Cumulative risk** (repeat incidents, third-party concerns, history) was not adequately recognised by police, local authority or health professionals.

Learning: Absence of disclosure of abuse and a failure to join up cumulative risk indicators. Patterns matter.

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2. Safeguarding adults with complex needs

- No **Adult Social Care referral** or multi-agency safeguarding response occurred, and Erin was not identified as an adult at risk under the Care Act 2014.
- The combination of limited agency contact, isolation from family and limited mobility meant that Erin's **capacity for action was extremely limited** however this was not noticed or acknowledged by any agency.
- No consideration was made of a **carer's assessment** for Erin's partner, missing further opportunities to understand how safe Erin was at home.

Learning: Poor physical health and abuse **compound vulnerability** and should be considered collectively to fully explore opportunities to safeguard.

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3. Health and primary care response

- Erin had life limiting health conditions which should have prompted **professional curiosity** and further contact from health agencies to assess her risk, care and support needs.
- Health contact focused narrowly on presenting symptoms and didn't fully consider the **cumulative impact** on Erin's health and wellbeing.
- There was limited exploration of **home circumstances, safety or support networks** and despite alcohol and substance use being identified, no referrals were made to specialist support.

Learning: Healthcare settings provide important opportunities to ask about safety and coercive control; medical staff should remain professionally curious and alert to substance use and potential abuse.

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4. Housing and anti-social behaviour

- Housing responses focused primarily on **anti-social behaviour**, with no explicit consideration of domestic abuse as a potential contributing factor.
- Repeated neighbour reports and family concerns did not translate into appropriate **safeguarding** enquiries.

Learning: Anti-social behaviour and noise complaints may be **signs of domestic abuse** and should be considered by housing and community safety practitioners as part of their response.

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5. Police risk assessment and information sharing

- Risk was frequently graded **standard or medium**, despite cumulative reports of abuse and repeat incidents, which meant missed opportunities for multi-agency risk assessment conference (MARAC) level intervention.
- There was **limited triangulation of intelligence** and third-party information which could have better reflected the risk to Erin and the barriers she may face to reporting.
- Challenges with cross-force information sharing hampered the full understanding and context of risk.

Learning: Risk assessment must reflect **history, context and repeated nature of abuse**, not isolated incident data alone.

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6. Family, friends and community awareness

- Family and neighbours were aware of the abuse Erin was experiencing but faced challenges reporting their concerns and/or a **lack of confidence** that reports would result in positive action.
- There was limited awareness of the role of the **Domestic Abuse Helpline** in supporting concerned family members.

Learning: Families and communities play an important role in safeguarding, with support available through the local DA helpline.

What Good Practice Looks Like

- Pattern-based risk assessment across agencies which appropriately consider cumulative risk and vulnerability
- **Professional curiosity** where abuse is repeatedly denied, allegations are retracted and/or appointments are missed
- Early Adult Social Care referral where disability and potential abuse intersect
- **Routine enquiry** about safety and risk in health settings
- Evidence-led police approaches where victims face challenges engaging with criminal justice
- Clear routes for **concerned others** to seek advice and report safely

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Key Reflective Questions for Professionals

- Would we recognise this person as an adult at risk?
- Do we understand the whole picture as experienced by this individual, or just our part?
- What might be preventing disclosure, retraction and/or a lack of confidence in reporting abuse?
- Have we considered cumulative risk and escalation?

This Learning Brief should be shared with frontline staff, supervisors and safeguarding leads to inform continuous improvement in domestic abuse and safeguarding practice.