OPEN

Scrutiny Committee

Date: 04 September 2025

Domestic Homicide Review: EMMA

Report of: Helen Charlesworth May Exec Director – Adults Health and Integration

Report Reference No: SC/04/25-26

Ward(s) Affected: All

For Decision or Scrutiny: Scrutiny

Purpose of Report

1 The purpose of this briefing report is to inform Scrutiny Committee Members, about the Domestic Homicide Review following the suicide of Emma who died in September 2021. The Review was commissioned by the Safer Cheshire East Partnership in April 2022, signed off by SCEP on 27/4/23 and approved by the Home Office on 22/5/25. The Report is now ready to be published on the Councils Safer Cheshire East Partnership (SCEP) Website.

2 The purpose of a Domestic Homicide Review is to:

3 Establish what lessons are to be learned from the domestic homicide, regarding the way in which local professionals and organisations work individually and together to safeguard victims.

4 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

5 Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

6 Contribute to a better understanding of the nature of domestic violence and abuse; and highlight good practice.

7 A DHR is not an inquiry into who is culpable, this is for the court or coroner to decide.

8 One of the objectives of the Councils Corporate Plan is for Cheshire East to be a place where a “Everyone feels safe and secure, difference is celebrated, and abuse and exploitation not tolerated”. Therefore, it is important to look in depth at the circumstances leading to this tragedy and the lessons learned and what has been implemented since the Review.

Executive Summary

9 The full Domestic Homicide Review Report is found in the supporting documentation. It will be published on the SCEP Website and should be read in conjunction with this Briefing Paper.

10 Emma was 30 when she died and had 3 children. Emma had been struggling with her mental health. Her father had taken his own life a few years previously. In November 2021 the Police were called to the home address by a former partner who had found Emma deceased having committed suicide.

11 Statutory Guidance produced in 2013 defines the criteria for undertaking a Domestic Homicide Review as follows:

12 Under section 9(1) of the 2004 Act, domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by— (a) a person to whom he2 was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

13 To note that the scope and definitions relating to DHRs is currently under review and will become known as Domestic Abuse Related Death Reviews. This is due to the high numbers of cases involving suicide, where a person has been subject to Domestic Abuse and has taken their own lives because of the abuse.

14 It is important to hear the voice of family members and friends who contributed to the Review and some of the comments are quoted below:

"Our *Emma was bubbly and confident and always there for everyone."*

"*Emma was fun-loving, bubbly, kind and caring, and he stated she was my best friend."*

"Emma was bubbly and lucky and would talk about college, excited about her future."

15 The DHR Review panel met 5 times to consider how Agencies worked with Emma. The Review made 8 recommendations which will be highlighted later, together with the actions that have been completed since the conclusion of the Review.

RECOMMENDATIONS

The Scrutiny Committee is recommended to:

Scrutinise and note the learning and recommendations from the EMMA – Domestic Homicide Review.

Background and Context:

16 Key findings from the Home Office analysis of domestic homicide reviews: September 2021 to October 2022 Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK considered 129 completed DHR's referred to the Home Office Quality Assurance Panel, involving 132 victims.

17 In the 129 DHRs reviewed there were 132 victims: 24% had a familial relationship with the perpetrator(s), for 50% the relationship with the perpetrator was partner or ex-partner. Twenty-six per cent were victims who died by suicide.

18 The average age of familial abuse victims was 55 years, older than the average age of familial perpetrators which was 35 years. Intimate partner victims were on average younger (38 years) and younger than

preparators (43 years). The average age of victims who died by suicide was 36 years.

19 Where victims were in an intimate partner relationship or who had died by suicide, 86% and 88% respectively were female. This was different where there was a familial relationship where 53% of the victims were female.

20 Considering nationality, 69% of familial victims were British; 80% of intimate partner victims were British and where the victims died by suicide 91% were British.

21 The number of cases which have met the criteria for a DHR to be undertaken in Cheshire East has increased in recent years with the majority of cases identifying suicide resulting from domestic abuse being the factor.

22 In 2024 SCEP commissioned a Thematic Review of DHR's resulting in Suicides to understand the learning from the circumstances involved.

23 The Thematic Review highlighted a number of key themes for agencies and partners to consider in their dealing with those at risk of domestic abusive relationships.

24 To break the cycle of domestic abuse, women and girls need access to essential resources and support.

25 Collaboration between statutory agencies and local organisations is crucial to addressing emotional, legal, and financial needs. When victims have readily available information and know where to turn for help, they are empowered to seek assistance, helping society break the silence around domestic abuse and promoting awareness.

26 Establishing age-specific and comprehensive support systems is crucial to addressing the needs of domestic abuse survivors and reducing the risk of suicide.

27 Effective collaboration among domestic abuse organisations, mental health services, and statutory agencies is essential for providing adequate support to vulnerable individuals.

28 Victim-survivors of domestic abuse may experience a heightened risk of suicide when they lose custody or contact with their children.

29 The complexity of custody disputes in domestic abuse cases requires a thorough understanding of abuse dynamics and the specific risks to children

30 Increasing awareness of the interplay between mental health and domestic abuse is vital for fostering informed communities and encouraging intervention

31 A copy of the full Thematic review approved by SCEP in April 2025 and is attached to this report for further information.

32 The key themes which emerged from Emma follow those highlighted in the Thematic Review. However, each set of circumstances are unique and the impact on families and friends and professionals cannot be underestimated.

33 Emma was one of seven siblings, with her mum having four children from a previous relationship. After six months together, Emma's siblings moved to their father's home, leading to minimal contact. Emma and her two sisters, were raised by her parents, who lived outside Cheshire

34 Emma’s childhood was unstable due to her dad's heroin addiction and his domestic abuse towards her mum. Despite the abuse and her troubling experiences, including visiting crack homes, Emma defended and loved her dad and viewed the experiences as the norm. a family memebr believed that children's services, which were aware, should have intervened but left them in a dangerous environment.

35 Emma was accommodated in supported housing at fifteen or sixteen after telling her mum about her stepfather's abuse, prompting her mum to tell her to leave.

36 Emma moved to Cheshire in 2009 to be closer to her dad, with whom she maintained a close relationship and who would offer her emotional support. In 2019, her dad died by suicide. Emma's family and friends reported that she continued to experience prolonged grief until her death in November 2021.

37 Emma met Ian in 2019; he relocated to Cheshire to live with her and her three children

38 Emma’s family and friends were aware that she would self-harm, a behaviour that had intensified since her dad's death. They urged her to seek support from services, and she would inform them that she had seen her and discussed this with her GP and was prescribed antidepressants.

39 Ian returned to Emma's home in the early hours of the morning the day before she died. He used a ladder to climb into the bathroom, entered Emma's bedroom, and was reportedly aggressive towards her.

40 The police arrested Ian for harassment and possession of a bladed article after they located him in the shed with a knife among his possessions. The following day, he was released on police bail, with the condition that he does not contact Emma or visit her home

41 Emma had told her friends and family about Ian's relationship, describing him as controlling and verbally aggressive. She had instructed him to leave but let him stay in the shed because he had nowhere else to go. However, he continued interacting with her via Alexa and monitored her coming and going from the house via the Ring doorbell. She was encouraged to seek support from her family and friends, but they were unaware of any additional ways in which they could intervene or provide support.

42 Coercion and control is referenced in Part 6 of the Domestic Abuse Act 2021, emphasising the need for agencies to be aware of this as domestic abuse. Women's Aid emphasises that domestic abuse is not always physical, as is commonly believed by victims/survivors. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.

43 Controlling and coercive behaviour is a high-risk factor and is highlighted in the suicide and homicide timeline. It is, therefore, essential to identify this critical risk factor and empower victims/survivors with the understanding that coercion and control is a crime and to improve the collective response of agencies that engage with victims/survivors.

44 Recommendations: The Review made several multi agency recommendations which can be seen at the end of the full Report and in the 7-minute briefing. These include the following.

45 Training for officers focused on recognising indicators of coercion and control.

46 To provide their staff access to the review to facilitate their responses and raise awareness of the use of coercion and the various strategies employed by perpetrators.

47 When self-harm or suicidal ideation is identified in individuals experiencing domestic abuse, services should have established protocols/resources to support the response to the disclosure.

48 To identify familial suicide as a risk factor for self-harm and suicide and to share the assessment/information with appropriate partners to facilitate a coordinated response.

49 Suicide Awareness – including its impact

50 Actions: The Safer Cheshire East Partnership seeks assurances from Partner Agencies about their responses to the learning from DHRs and oversees Action Plans. Whilst the Home Office approved the publication of this DHR in May 2025, the following actions have already been put into place.

51 The SCEP commissioned Professor Jane Monckton Smith a respected specialist in the file of Domestic Abuse to provide Training to partner professionals in November 2024 on the Suicide Timeline.

52 Engagement with victims of Domestic Abuse to ascertain details of their journey and experiences in dealing with the effectiveness of partner agency support.

53 Training has been introduced by several partner agencies to spot the signs of Domestic Abuse together with Controlling and coercive behaviour.

54 The introduction of Suicide Prevention Training available to professional staff within Cheshire East Council every 4/6 weeks.

55 The Domestic Abuse Strategy is being refreshed.

56 The Panel and Cheshire East wishes to record its condolences to the family of Emma for their loss.

Consultation and Engagement

57 No consultation is required for this report

Reasons for Recommendations

58 This Report sets out the learning and recommendations from the Domestic Homicide Review to ensure that service delivery is improved and to prevent further incidents of harm. The Safer Cheshire East Partnership will oversee the Action Plan.

Other Options Considered

59 There are no other options to consider as the Safer Cheshire East Partnership has met its Statutory Duties to undertake a Domestic Homicide Review and to share the learning.

Option	Impact	Risk
The Domestic Abuse Act places statutory duties on public bodies to identify and report Domestic Abuse in order to protect victims and pursue and prosecute offenders.	Domestic Abuse impacts 1 in 4 adults in the UK. The numbers of Suicides related to Domestic Abuse is increasing and we hold a Corporate Duty to see Safeguarding as Everyone's Business	Without conducting Domestic Homicide Reviews, the risk to victims will increase and services will fail to improve.

Implications and Comments

Monitoring Officer/Legal/Governance

60 Under Section 9 (1) of the Domestic Violence, Crime and Victims Act 2004 a Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has or appears to have resulted from Domestic Abuse. It is held with a view to identifying the lessons to be learnt from the death.

61 The Safer Cheshire East Partnership (SCEP) is responsible for commissioning DHRs under the Domestic Violence, Crime and Victims Act 2004.

62 The report ensures compliance with the statutory duties placed on SCEP.

Section 151 Officer/Finance

63 There are no financial implications or changes required to the MTFS because of the recommendations in this report. Implementation of learning from this review will be carried out by the service within existing resources.

Human Resources

64 There are no HR resource implications for this report.

Risk Management

65 There are no Risk Management Implications for this report. The learning from the DHR is being shared via the Safer Cheshire East Partneship, and forms part of the Suicide Prevention and Domestic Abuse Strategy.

Impact on other Committees

66 There are no impacts on other committees.

Policy

67

Commitment 1: Unlocking prosperity for all	**Commitment 2: Improving health and wellbeing**	**Commitment 3: An effective and enabling council**

Equality, Diversity and Inclusion

68 The learning from the DHR is applicable to all.

Other Implications

69 The learning from the DHR is applicable to all communities.

Consultation

Name of Consultee	**Post held**	**Date sent**	**Date returned**
Statutory Officer (or deputy) :			
Ashley Hughes	S151 Officer	18/06/25	21/08/25
Janet Witkowski	Acting Monitoring Officer	Click or tap to enter a date	Click or tap to enter a date

Legal and Finance			
Nikki Woodhill	Finance Manager	18/06/25	24/06/25
Roisin Beressi	Principal Lawyer	18/06/25	29/07/25
Other Consultees: *Executive Directors/Directors*			
Helen Charlesworth May	Executive Director Adults Health and Integration	04/08/25	27/08/25

Access to Information	
Contact Officer:	Richard Christopherson – Locality Manager Richard.christopherson@cheshireeast.gov.uk
Appendices:	Appendix 1 – Cheshire East DHR – Emma – Summary Report Appendix 2 – Learning Brief Cheshire – EMMA
Background Papers:	Key findings from analysis of domestic homicide reviews: September 2021 to October 2022 (accessible) - GOV.UK