# Domestic Homicide Review 10 – ‘Jason’ Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

**Background**

This review concerns the circumstances leading to the suicide of Jason, a 37 year old man from Telford in May 2023. As domestic abuse was known to have featured within his previous and recent relationships, this knowledge triggered the statutory requirement for a Domestic Abuse Related Death Review to take place

## Positive and Proactive Steps

The Telford and Wrekin Public Health Service have ensured that domestic abuse perpetrators and victims feature within their Suicide Prevention Strategy. The effectiveness of this will be monitored through the Domestic Abuse Forum, which has members with lived experiences alongside key agencies and partners. Escalations of concern can also be made to the Domestic Abuse Local Partnership Board.

The HM Coroners Service for Telford and Wrekin has now signed up to the ‘Real Time Suspected Surveillance System’. This allows us to track the number of suspected deaths by suicide in Telford in real-time, providing up-to-date information about suicide and helping to identify and implement support to prevent suicide in a timelier manner.

Work is ongoing between West Mercia Police and Mind to ensure that referral pathways are in place and all officers are aware of the requirement to offer a referral in cases where families are left bereaved following a suicide.

The Home Office accepted all three recommendations made to them and will take appropriate action on a national level.


## Process

Following receipt of the referral in early summer 2023 scoping information was requested which informed the decision to progress to a Domestic Homicide Review in late summer 2023. Immediate safeguarding actions were implemented and an independent author was sourced in early autumn 2023. The review panel was made up of practitioners involved with the case alongside managers from across the partnership and met formally three times throughout the process, with additional theme specific meetings taking place in between. Contact was made with family and friends to allow opportunity for them to contribute to the review if they wished. The report was submitted to the Home Office for their quality assurance feedback in November 2024 and their feedback was received in late May 2025.

## Recommendations and Learning

1. The Home Office to consider liaising with the Department of Health and Social Care and NICE to ensure that there is consistency across all clinical guidance for routine enquiry into domestic abuse for relevant health conditions potentially linked to domestic abuse, such as those for depression and anxiety specifically.
2. Telford and Wrekin Public Health to provide assurance to the Domestic Abuse Local Partnership Board that the domestic abuse pathway for primary care, which includes the social prescribers, is effective in identifying and responding to domestic abuse.
3. Telford and Wrekin Public Health Service to ensure that domestic abuse perpetrators and victims feature within their suicide prevention strategy
4. Telford and Wrekin Public Health to liaise with the Coroner and encourage local sign-up with the Real Time Suspected Surveillance System
5. Home Office to liaise with the chief coroner in respect of guidance to coroners to ensure that all coroners are part of Real Time Suspected Surveillance System (national recommendation)
6. West Mercia Police to provide assurance to the Partnership that families bereaved by suicide are systematically offered a referral to Telford Mind.
7. The Home Office to consider adding to their suite of leaflets for families and friends, leaflets specifically concerning domestic abuse related suicides.