NORFOLK COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Sarah

May 2021

Independent Chair and Author: Mark Wolski

Date of Completion: June 2022

Table of Contents

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Norfolk Community Safety Partnership (NCSP) in reviewing the circumstances of Sarah, a resident in Norfolk, who took her own life in May 2021.

1.2 The following pseudonyms have been used in this review to protect the identity of Sarah's partner, family and friends.

Table 1

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Sarah	Deceased	53	White British
Samuel	Partner	53	White British
Margaret	Daughter	u/k	White British
Janet	Friend	u/k	White British

1.3 The coronial process concluded on the 15th December 2021. The medical cause of death was recorded as 'Drug Toxicity' and the conclusion was one of suicide.

1.4 The NCSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The Home Office was notified on 6th July 2021.

1.5 Agencies that possibly had contact with Sarah and Samuel prior to the point of death were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies who had contact with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Sarah and Samuel.

2.2 The following agencies who had contact and their contributions are shown below.

Table 2

Agency	Trace of Sarah	Trace of Samuel	Input
Nottinghamshire Police (Mansfield)	Yes	Yes	Factual summary
Kingsmill Hospital – Sherwood Forest Hospital Trust (SFHT)	Yes	No	Chronology and IMR
Wensum Valley GP Practice	Yes	Yes	Chronology and IMR
Norwich City Council -Council Tax	Yes	Yes	Chronology
Integrated Care 24 (IC24) – NHS111	Yes	No	Chronology and IMR
Norfolk and Norwich University Hospital (NNUH)	Yes	No	Chronology and IMR
Norfolk and Suffolk NHS Foundation Trust (NFST) - Mental health	Yes	No	Chronology and IMR
Camborne Redruth Community Hospital	Yes	No	Factual summary
Norfolk Constabulary	Yes	Yes	Chronology and IMR
Norfolk County Council HR	Yes	No	Chronology and IMR
East of England Ambulance Service Trust (EEAST)	Yes	Yes	Factual summary

2.3 IMRs and factual reports were completed by authors who were independent of any prior involvement with Sarah and Samuel.

2.4 The authors and panel members assisted the panel further, with a number of one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Table 3

Name	Agency	Role
Mark Wolski	Chair	Independent Chair/Author
Amanda Murr	OPCC - Norfolk	Head of Community Safety
Liam Bannon	OPCC - Norfolk	Community Safety Officer
Richard Idle	SFHT	Named nurse, Safeguarding Adults
Ishbel Macleod	Notts Integrated Care Board (ICB)	Designated Professional for Safeguarding Adults
Maria Karretti	N&W ICB	Named GP for Safeguarding Adults
Rachael Wrapson	IC24 (NHS111)	Senior Safeguarding Lead
Gary Woodward	N&W ICB	Adult Safeguarding Lead
Rachel Swingewood	Norfolk Constabulary	Detective Sergeant, Safeguarding & Investigations Command
Pippa Hinds	Norfolk Constabulary	Detective Chief Inspector, Safeguarding & Investigations Command
Angela Johnson	NNUH	Named Nurse for Safeguarding children
Tristan Johnson	NNUH	Named Nurse Safeguarding Adults
Saranna Burgess	NSFT	Director of Nursing, patient safety and safeguarding
Sallie Rice	Norfolk County Council	Advice and Consultancy Manager
Lucy Lawrence	Norwich City Council	Specialist Support Team Leader
Sue Marshall	Public Health Norfolk	Safeguarding and Partnership Manager
Walter Lloyd-Smith	Safeguarding Adults Board	Safeguarding Adults Board Manager
Clive Evans	Sue Lambert Trust	Chief Executive Officer
Trudy Lock	Leeway Domestic Violence and Abuse Services	Residential Service Manager

3.2 The review panel met on four occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training, has attended subsequent Training by Advocacy After Fatal Domestic Abuse. (See Appendix A for full statement of independence)

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Norfolk's statutory agencies and Non-Government Organisations worked together in their dealings with Sarah and Samuel.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

5.3 Case specific lines of enquiry included the following

A. Analyse the **communication and co-operation** which took place within and between agencies regarding Sarah.
B. Analyse the opportunity for agencies to identify and **assess the risk of domestic abuse** or **self-harm**, including what would have enabled or hindered disclosure.
C. Analyse agency **responses to any identification of domestic abuse or self-harm** issues.
D. Analyse organisations' **access to specialist domestic abuse agencies**.
E. Analyse the **policies, procedures and training** available to the agencies involved in domestic abuse issues.
F. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**.
G. The extent to which **Covid-19** effected agency involvement with Sarah.
H. Consideration as to whether Sarah was an 'Adult at Risk' Definition in **Section 42 the Care Act 2014** and the response and signposting that did/did not take place:
I. **Equalities**: The Review Panel will consider all protected characteristics

5.4 The timeframe for this DHR was agreed as from June 2016 until Sarah's death in May 2021. This was agreed proportionate, covering an event where Sarah took an overdose prior to moving to Norfolk, and her engagement with local Norfolk agencies when she moved into the area to live with Samuel.

6. SUMMARY CHRONOLOGY

6.1 Sarah had lived in Norfolk with her partner Samuel in his flat for several years. No-one else lived with them. Sarah's two grown up children from a previous marriage lived elsewhere in England.

Family Perspective (Daughter - Margaret)

6.2 Margaret painted a picture of a mum who had become isolated from friends and family, a situation exacerbated by the Covid lockdown. She described examples of controlling behaviour, when Samuel would constantly phone Sarah, asking her to come home when out with Margaret, and of Sarah asking permission to do things. Matters got worse when Samuel drank, describing examples where she had fled to her mum or a friend and on one occasion Margaret had been present when he had smashed an expensive television and punched a hole in a wall. She was aware that Sarah had sustained injuries, though Sarah never said it was Samuel.

6.3 She believed that he had financially exploited her too, using Sarah's pension money to buy things for him, such as a motor scooter. She wasn't sure how much from memory, but believes her mum had tens of thousands of pounds from her pension.

6.4 Upon exploring, when matters had become problematic in the relationship, Margaret explained that soon after Sarah moved in, she had begun to feel isolated and had begun to self-harm. she attributes this to the strain of living with him and Sarah had begun to drink, a bottle of wine a day, and smoke cannabis which was out of character for someone against taking drugs.

6.5 Margaret summed up why she thought Sarah had taken her own life as "the weed, alcohol, control in the relationship, losing her job, and then, as covid restrictions were imposed, she became more isolated, as her volunteering role in a local charity shop was simply stopped."

Friend (Janet)

6.6 Janet explained that Sarah had known Samuel since she was fourteen. After Sarah's troubled first marriage, they had bumped into each other by accident. She provided an account of controlling behaviour, with Samuel coming out uninvited to a 'girls night out', and from telephone calls where she could not speak freely. In their conversations, Sarah had described being pushed and shoved, and on one occasion Janet had called the police. Janet explained that she had provided details of local organisations who support survivors of domestic abuse, but ultimately Sarah was too proud to admit or did not recognise that Samuel's behaviour was abuse and not love.

Sarah's voice

6.7 In a statement to the police in August 2020, she alleged having been physically and financially abused by Samuel, and draining her income from her lump sum and monthly pension payments. She alleged financial control extended to his monitoring what she spent.

6.8 Sarah left a note on taking her own life, that provides an insight into her thoughts at the time of taking her life.

"CAN'T BE AROUND ANYMORE, CAN'T START AGAIN WITHOUT HIM. AM 2 OLD AND HAD ENOUGH. AM SORRY. JUST WANT PEACE. HE DOESN'T CARE.HE WAS THE LOVE OF MY LIFE.AM NOT STRONG ENOUGH ANYMORE. TELL MY KIDS AM SORRY.BUT AM SO TIRED I DON'T WANT TO BE ALIVE ANYMORE. JUST WANT TO SLEEP AND NOT WAKE UP.

Sherwood Forest Hospital Trust

6.9 Sarah attended the hospital on one occasion in January 2017, following an overdose that she attributed to several issues, that included, having no heating, a burst pipe and having recently split up from her partner. She was discharged, stating an intention to go to Norfolk. She was not asked about domestic abuse, and the trusts Domestic Abuse Policy provided information 'if abuse was disclosed'. Whilst comprehensive, its last update was in 2017, suggesting an opportunity to bring up to date with current legislation and recent learning.

General Practitioner (GP)

6.10 On registering at her GP, a very detailed history was secured. Sarah had a diagnosis of anxiety, depressive illness, and asthma, with a history of repeated self-harm and suicide attempts. She attended numerous consultations with different clinicians regarding her mental health and was prescribed anti-depressant medication that was changed as required. She was signposted to counselling and referred to the specialist mental health team, but notes indicate she did not attend.

6.11 Sarah also attended her GP for physical complaints, that involved liaison with a number of secondary care specialists.

6.12 Presentations at her GP, related to a variety of matters including injuries, anxiety and self-harm/suicidal ideation that are cited within NICE guidelines as meriting enquiry.

NHS111/IC24

6.13 Sarah had a number of contacts with NHS111, some of which related to physical injuries, one in relation to injured ribs, and another two on same day related to spilling boiling water on her feet. She was not asked about how these incidents occurred, though it was apparent that she was not alone on some of these calls. The review identified there was no patient DA policy, though a section on abuse.

Norfolk and Norwich University Hospitals NHS Foundation Trust

6.14 Sarah had multiple contacts with the local hospitals trust, including accident and emergency (A & E), general surgery, day procedures, specialists such as oral, gastroenterology, and gynaecological specialists. Presentations at A & E, related to a variety of matters that provided opportunities for curiosity such as injuries to her ribs, abrasions to her arm, injuries to her hand (and overdose).

Norfolk and Suffolk Foundation Trust

6.15 Sarah first came to the attention of Mental Health Services as a routine referral from her GP. The presentation was described as one of anxiety, depression, panic attacks suicidality and self-harm. Following missed appointments, she was referred back to her GP. She next came to notice when seen by the Mental Health Liaison Team (MHLT) at the local acute hospital after an overdose of prescribed medication. She was discharged to care of her GP with a safety plan offered. The following day she was referred by GP as an urgent graded referral to the local Crisis Resolution and Home Treatment Team (CRHT) for ongoing care. The referral was reviewed and passed to the community team and after further assessment by the Community Mental Health team (CMHT), she was signposted to external agencies and discharged back to GP.

6.16 During her engagement with NSFT, she was asked about domestic abuse, and disclosed historic abuse from her father and ex-husband. (*Pre relevant period*)

Norfolk Constabulary

6.17 Norfolk Constabulary had two contacts with Sarah and Samuel. The first contact was on the 18th of August 2020 and the second was on the 22nd of May 2021. On both occasions Sarah contacted the police reporting being the victim of domestic abuse and on both occasions, Samuel was arrested. On the first occasion, she said there had been a history of abuse and his behaviour had caused her to take an overdose. She withdrew her allegation and the investigation concluded. On the second occasion, he was dealt with by way of a caution.

6.18 Whilst Samuel was arrested on both occasions, the review identified missed investigative opportunities such as listening to the 999 recording. However, Norfolk Constabulary have

introduced two initiatives a ‘Seven Point closure plan’, and Operation Investigate’ that now ensure comprehensive standards and peer review. These are noted as good practice.

Norfolk County Council HR

6.19 Sarah was employed by Norfolk County Council between 28 September 2015 and 12 June 2016 as an Outreach Practitioner. Her line manager had been aware of personal issues, and he had given her some time off to find alternative accommodation. On one occasion he had noted bruises on her hand, that she had commented on as being nothing to worry about, as she was no longer in that relationship. Sarah left the council and had explained this was owing to a decision to move to Nottingham. She subsequently applied for a deferred pension benefit.

6.20 It was noted colleague of Sarah who had said that she recognised her partner as being quite controlling, also described her as being ‘a strong northern woman’. As someone who did not disclose self-harming to her employer, the attribution of the generalised concept described, intersecting with her mental health risked having a disproportionate effect on Sarah

Occupational Health

6.21 As part of an application for deferred pension benefits/ill health retirement, Sarah was assessed by an occupational health specialist. This assessment is based upon letters received from her GP, previous referral for a deferred pension together with an interview with Sarah. The purpose of this assessment was to determine whether an individual is deemed more likely than not permanently incapable of discharging her local government employment because of ill health or infirmity of mind or body. It was determined that on the balance of probabilities, the criteria for ill health retirement were met.

7. KEY ISSUES AND LESSONS LEARNED

Recognition and Response, Professional Curiosity & Routine Enquiry

7.1 Sarah had contact with primary and secondary healthcare professionals and whilst she never raised concerns about domestic abuse and with the exception of NSFT, she was never asked about feelings of safety, nor did domestic abuse feature as part of routine screening or ‘induction’ to a new service.

7.2 Moreover, Sarah displayed health indicators associated with domestic abuse to primary and secondary care professionals that would have benefitted from greater professional curiosity and an investigative mindset. These indicators included her anxiety and depression, the fluctuations and deteriorations in her mental state, her suicidal ideation & self-harming, injuries, as well as fluctuations in her feelings of wellbeing/anxiety. Some of these same indicators were also apparent during her employment with the council, providing similar learning.

7.3 These learning opportunities identify three main lessons to be learned; - Ensuring that professionals are equipped with the knowledge to recognise indicators of potential abuse; - Ensuring professionals respond with an open mindset and professional interest to find out more; - Consider the extent to which routine enquiry should be described within policy expectations.

Domestic Abuse Policy

7.4 The ability to recognise and respond to domestic abuse is intrinsically linked to policies when dealing with patients/clients or in respect of staff.

7.5 This review demonstrated that organisations actively considered domestic abuse, by the fact of policy existence. Policies varied from being proactive such as for NSFT, with positive requirements to ask about domestic abuse, through to more passive policies that talk about where domestic abuse is" disclosed or identified."

7.6 The passive nature of policies that say 'if disclosed', aligned with the fact that Sarah presented with health indicators that could be indicative of domestic abuse, along with the fact that we know she lived with abuse, suggest that there were numerous missed opportunities to find out whether Sarah was experiencing abuse, by simply asking. It was suggested that the phrase 'duty to ask' summarises the lesson to be learned herein.

7.7 The panel also learned that Norfolk County Council staff had identified indicators of domestic abuse, and that staff /colleagues knew that Sarah had lived in a difficult relationship. The panel learned that there was a domestic abuse policy in place and following another DHR, the council had taken part in an 'Employers Initiative on Domestic Abuse.' However, at the time Sarah was employed the manager was unaware of the policy and on speaking to the panel representative, Human Resources and staff do not benefit from any enhanced training on domestic abuse. This suggests a need to reinvigorate the initiative and local DA policy.

7.8 The importance of robust policies was also recognised by NSFT when triaging referrals for support in respect of mental illness, having subsequently changed policies to ensure patients or referrers have been spoken to before closing cases.

Risk Assessment and Safety Planning for Suicide

7.9 Sarah did not disclose domestic abuse to any agency save NSFT, when she spoke about historic abuse, and the police when she called following domestic incidents. Therefore, the opportunity to risk assess in respect of domestic abuse was limited.

7.10 However, the subject and importance of risk assessment and safety planning in respect of self-harm was subject of considerable discourse. With regard to Sarah's case, the panel explored the general approach to risk assessment on deterioration of Sarah's mental health by exploring a lengthy chronology and numerous contacts with her GP practice. At times, the language used in the chronology was confusing, using terminology such as risk assessment, then mental state examination interchangeably. Upon exploration of the topic, the panel representative helped to clarify that risk assessments were completed, and these were based upon initial psychiatric training. On further examination, the chair shared numerous articles that described the conundrum of assessing risk of suicide, but it would be fair to say were not conclusive. Furthermore, the panel learned of; - the links between self-harm and suicide; - the links between self-harm and domestic abuse and from the local audit on suicide, a recommendation having been made around training and use of risk assessment tools. Furthermore, as the review was drawing to a close, the panel also learned of up-to-date NICE guidance, advising not to use suicide risk assessments. It seemed to the panel that there was an overarching point of learning to explore risk assessment with an opportunity to strengthen practice and safety planning.

Feedback Loop

7.11 Sarah had self-harmed throughout her adult life, and there was a reliance on prescription medication to manage her diagnosis in relation to anxiety and depression. A number of learning opportunities arose.

7.12 Sarah was signposted to counselling and other agencies for support. It is understood that she did not engage or approach them. The reasons for her not engaging are not known and no one asked her whether she had approached those agencies, and if not, why. In other words, an opportunity to close the feedback loop through improved professional curiosity.

Long-Term Treatment

7.13 It does not seem from records that alternative therapies such as CBT or DBT were formally considered or offered. The question arises as to whether this could be 'prescribed' and by whom. Whilst there are clear lines of responsibility between primary and secondary healthcare that meant Sarah was not accepted into secondary care, there is also guidance suggesting that mental health services should be responsible for the longer-term planning for those who self-harm. This suggests a learning opportunity in respect of the long-term care planning for patients such as Sarah.

7.14 Similarly, Sarah registered with a lead GP in primary care, and in the early months of her registration at the practice that GP was a consistent factor. However, over the years of treatment she saw around ten doctors that arguably compromised continuity of care and communication between doctor and patient. The panel agree that where possible it would be desirable for patients such as Sarah to see the same GP.

Factors relevant to cause and effect

Adverse Childhood Experience

7.15 The panel learned of Sarah's difficult upbringing, which may be interpreted as adverse childhood experiences. It is not possible to conclude her experiences as a child resulted in her depression, anxiety, and self-harming behaviour. However, the panel agrees that her case acts as a reminder to be alert to that possibility.

Alcohol

7.16 Alcohol was a significant factor in relation to impulsive overdoses. Whilst not evident in her final act, alcohol and wider substance misuse was not explored by health professionals and was subject to an individual agency recommendation by NSFT. Given that the Norfolk suicide audit found that alcohol was the second biggest factor for those taking their own lives, it is recognised as an important learning point from this review.

Menopause

7.17 Sarah was at an age where the menopause may have been a factor. The review learned of an increasing body of research linking menopause to suicide and in discussion cannot conclude it as being a factor in this review, it is concluded that it is important to keep in mind as a factor for those at risk of self-harm or suicide.

Interagency Communication – Pathways

7.18 Both the GP practice and NSFT in their IMRs identified an opportunity to streamline how a patient such as Sarah may be routed directly through to secondary mental healthcare services, following an attendance at a local emergency department for an overdose, as opposed to being required to back to the GP (primary care), and for them to make a referral. This has now been resolved.

Covid

7.19 It is apparent that Covid has had a significant impact on health services, with demands on GPs having risen, and the NNUH having been working under immense stress at times during the relevant period, though on only one occasion was an appointment with Sarah affected. The pandemic also affected the way NSFT were able to engage with Sarah, with no appointments taking place face to face. The extent to which agency interaction was hindered therefore varies from no impact, through to an unknown impact regarding NSFT.

7.20 The panel do however agree that there was a practical effect on Sarah, that was one of isolating her from her family, friends, and voluntary work at a local charity shop. This is a broad learning point, as opposed to one requiring a specific recommendation.

Equalities

7.21 The panel acknowledge the gendered nature of domestic abuse, where women are more likely to experience abuse. Conversely, the panel learned that men are more likely than women to die by suicide, though recent research has shown increases in women dying by suicide, within an age group associated with the menopause.

7.22 The panel noted Sarah had been considered a strong Northern woman working in an environment where help and advice was readily available. Such stereotyping risks the vulnerability of a person not being explored, and when overlayed with the reality of living in an abusive relationship, and with diagnosed mental health conditions, risks creating additional barriers to seeking help or being asked if everything is ok. The panel agree this is a timely reminder to guard against stereotyping people.

8. CONCLUSIONS

8.1 Sarah was a loving mother of two children who was keen to help others, working for the council dealing with young people who needed help, and then after retirement volunteering in a local charity shop.

8.2 It is understood from disclosures to occupational health and NSFT, that she left home aged 16 to escape a difficult home life, and married at a young age, and had her two children. It is understood that this first marriage of over twenty years was physically abusive.

8.3 Her friend Janet explained that Sarah and Samuel had a relationship when much younger, before she married and that the second relationship with Samuel began in around 2014. From Sarah's own words in a statement to the police, as well as corroborated by the account of her daughter, the relationship was typified by physical and financial abuse such as exploiting her in respect of her pension lump sum, and monitoring of how she spent her monthly pension. There are further accounts of how he controlled her in respect of contact with her children, be that by listening to her calls, or constantly phoning her when she visited her daughter.

8.4 Sarah had reportedly started to self-harm from the age of sixteen as a coping mechanism regarding her mental state that was later diagnosed as 'anxiety disorder' and 'low mood and depression'. She self-harmed through a variety of means including cutting, self-inflicting injuries, through blunt force to her ribs and on occasion through starvation. It is clear that her children and mum were protective factors, through phone calls, and fleeing to her parents at times of difficulty. Aggravating factors include consumption of alcohol, as apparent in presenting at hospitals with overdoses of medication that were described as impulsive episodes associated with what Sarah described as worries about previous relationships. Whether this was true is unclear, as except for NSFT, Sarah was not routinely asked about her current relationships, nor when she presented with health indicators/symptoms that are listed within NICE guidelines on domestic abuse as potential signs of abuse.

8.5 Sarah was treated for her diagnosed depression and anxiety with pharmacological prescriptions, and she was also signposted for alternative therapies. Enquiries with these agencies showed she did not avail herself of these alternatives, though research suggests these to be helpful as part of an overall holistic approach, especially for someone who may have experienced adverse childhood experience and subsequent trauma of domestic abuse.

8.6 Sarah's journey before taking her own life, was a lifetime of abuse from childhood, through an abusive first marriage, and a second long term relationship of abuse and control, where her

sense of isolation was exacerbated by covid restrictions that prevented her continued volunteering at a local charity shop as well as having contact with her children and mum. It is likely this isolation had a profound effect on her wellbeing.

8.7 The circumstances of her eventual death are intrinsically linked with an allegation of assault and damage that occurred the day before her death. Moreover, it is perhaps quite telling that Margaret had asked Sarah's mum whether there had been any indication of what was to come, and she said that Sarah asked her to post the flat keys back to Samuel as he wanted them back. In itself a final act of separation, and further isolation for her, a factor that is recognised as one of the most important risk factors for those who take their own lives.[1]

9. LESSONS LEARNED

9.1 The review identified a number of learning points that build upon agency IMRs. The list below summarises opportunities described above in section 7. Recommendations that follow, are relevant to particular agencies unless otherwise described, and have been considered against a background of agency and policy developments that has mitigated the need for more recommendations.

- Recognition and Response to Domestic Abuse (DA): with the exception of NSFT, Sarah was not asked about DA, showing opportunities to ensure professionals equipped to recognise and respond to DA within an appropriate policy framework.
- Risk Assessment: The review showed opportunities to strengthen the approach to managing the risk of self-harm / suicide.
- Feedback Loop: Sarah did not engage with third sector agencies that she was signposted to, but no-one asked whether she had approached them and sought feedback:
- Long- term treatment: Sarah saw multiple GPs suggesting an opportunity to improve consistency in primary care, and guidance in respect of the role of mental healthcare professionals suggests an opportunity to strengthen the approach to treating suicidal ideation.
- Cause and Effect: The review identified a number of potential links to self-harming behaviour including; adverse childhood experience, alcohol as a feature of impulsive overdoses and that the menopause is a potential risk factor.
- Inter-agency Communication: Primary and secondary healthcare identified opportunities to streamline the referral pathway to secondary mental healthcare.
- Covid: The lockdown period exacerbated Sarah's feelings of isolation, including her being prevented from volunteering at a local charity shop.
- Equalities: The risks of stereo-typing a woman as a 'strong Northern' woman, created additional barriers to Sarah seeking help or being asked if everything is ok.

10 GOOD PRACTICE

10.1 This review has identified several areas of good practice that are summarised here:

GP Practice
- Domestic Abuse Policy in place
- Domestic Abuse Champions

IC24
- Domestic Abuse Policy for staff

NSFT
- Did not attend policy.
- Domestic Violence and Abuse policy that is unambiguous about routine enquiry.
- Supporting staff through domestic violence and abuse

[1] Source: Suicidal thoughts and behaviors and social isolation: A narrative review of the literature - PubMed (nih.gov) (Accessed July 2022)

- Suicide Prevention Strategy
- Menopause champion

Police

- Good evidence of secondary supervision
- Police officer ensuring an original note is signed in pocketbook.
- Innovative leaflet with full details of support agencies
- Trial of 'Cautions and Relationship Abuse initiative for perpetrators
- 'Operation Investigate' and '7 point closure plan' for domestic abuse investigations

Other

- DA Champion Network across Norfolk established in 2015 that has over 800 individuals that are trained how to ask questions, how to respond, to risk assess and signpost. It is intended to further develop this network.

11. RECOMMENDATIONS

11.1 Local IMR Recommendations

IMR authors identified recommendations that should be implemented internally. If an agency is not listed, then no recommendations were made.

GP Practice

- Ensure appropriate information sharing with patient consent between smoking cessation advisors and the GP surgery to ensure there is an awareness of co-morbidities and medication that might impact on medication prescribed for smoking cessation.
- Ensure robust communication pathways exist between primary and secondary care in the event of deterioration of a patient's clinical presentation.

NNUH

- To review information, contained within the level 3 training package (face to face and e learning) around Professional Curiosity and how to ask the questions around DA and, embed any additional information that is required to facilitate an increase in staff knowledge and understanding.
- To review current DA policy and review policy to ensure that there is enough information contained within the policy to enable the identification of DA and to increase practitioners' knowledge around professional curiosity.
- To review self-discharge flow charts A review of the process related to self-discharge should be undertaken to ensure safeguarding, DA/V and Mental Health concerns are embedded within the pathway.
- Review pre operation assessment paperwork alongside surgical governance teams, to add additional trigger questions to ask all patients about DA and Safeguarding concerns / do you feel safe are you concerned?
- Review recording on symphony electronic system to add in additional trigger questions to ask all patients about DA and Safeguarding concerns / do you feel safe are you concerned?
- Share Key points of learning following publication of DHR.

NSFT

- Explore the possibility for MHLT to refer directly to CMHT.
- Raise issue of signposting to specialist substance misuse/ alcohol

11.2 Overview Report Recommendations

The following recommendations have been agreed by the panel.

R1	Sherwood NHS Trust to Review and refresh the Domestic Abuse Policy in accordance with legislative and best practice developments.	**Sherwood Hospital Trust**
R2	Improve the ability of clinicians to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse. *(Training on health indicators, routine enquiry and associated policy changes – mental health, suicidal ideation*	**GP**
R3	The ICS' Suicide Prevention Partnership, led by Public Health, works together to support primary care to improve recognising and managing risk including safety planning for suicidal patients.	**Public Heath**
R4	Ensure that alcohol misuse is considered/addressed as a risk factor for all patients who self-harm or express suicidal thoughts and ensure patients treated/signposted accordingly.	**GP**
R5	To seek to raise awareness and the ability to recognise and respond to the risk of suicide associated with the menopause.	**GP**
R6	Work in Partnership to ensure that people who self-harm are in receipt of appropriate care and support.	**Norfolk and Waveney ICS Suicide Prevention Partnership led by Norfolk County Council**
R7	Improve the ability of staff to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse. *(With an up-to-date policy that mandates domestic abuse training).*	**Norfolk Council**
R8	Seek to reduce the risks of stereotyping that risks the true vulnerability of those living with domestic abuse having confidence to disclose.	**Norfolk Council**
R9	The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide and all the learning opportunities raised.	**NCSP**
R9a	The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide and all the learning opportunities raised, that for primary care includes. *-using consistent terminology regarding risk assessment.* *-opportunities to close the feedback loop with patients by asking how referrals had progressed.* *-recognising the potential benefits of seeing the same GP*	**GP**

Appendix A – Statement of Independence

The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training, has attended subsequent Training by Advocacy After Fatal Domestic Abuse and is a Home Office approved chair for Offensive Weapon Homicide Reviews.

Mark is a former Metropolitan police officer with 30 years operational service, retiring in February 2016. He served as a uniformed officer, holding the role as Deputy Borough Commander across several operational command units. Following retirement from the police he has acted as a consultant in the field of community safety and has experience of leading the strategic response to violence against women and girls, including the commissioning of VAWG services and development of strategy across a number of authorities. He has also had a number of DHR's published from across England.

Mark has no connection with Norfolk or any agencies involved in this case.

APPENDIX B: GLOSSARY

Abbreviation / Acronym	Full meaning
AAFDA	Advocacy After Fatal Domestic Abuse
ACE	Adverse Childhood Experience
BMJ	British medical Journal
CARA	Cautions and Relationships Abuse
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning group
CDSS	Clinical Decision Support System
CMHT	Community Mental Health Team
CRHT	Community Resolution and Home Treatment Team
CSEW	Crime Survey England and Wales
DA	Domestic Abuse
DARA	Domestic Abuse Risk Assessment
DASH	Domestic Abuse Stalking & Honour based violence
DHR	Domestic Homicide Review
EIDA	Employers' Initiative on Domestic Abuse
GP	General Practitioner
HEAR	Help Educate Awareness Respond'
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advocate
MARAC	Multi Agency Risk Assessment Conference
MHLT	Mental health Liaison Team
NCC	Norfolk County Council
NCSP	Norfolk Community Safety Partnership
NNUH	Norwich and Norfolk University Hospitals NHS Foundation Trust
NPCC	National Police Chief Council
NSFT	Norfolk and Suffolk Foundation Trust
OH	Occupational Health
OPCC	Office Police and Crime Commissioner
PHQ	Patient health Questionnaire
SPOA	Single Point of Access
SFHT	Sherwood Foundation Hospital Trust

Appendix C

1. Domestic Homicide Review

Norfolk Office for Police Crime Commissioner commissioned this DHR following Sarah taking her own life in May 2021

2. Case Summary

Sarah was aged 53 at the time of her death. In May 2021, police were called to an incident at Sarah and Samuel's home address. On arrival they found evidence of damage to the property. Samuel was arrested and admitted causing damage and was subsequently dealt with by way of a police caution. That evening, Sarah travelled by taxi from Norfolk to her parents address in Cornwall, arriving early the following afternoon. Sarah said to her parents that she wanted to sleep, and she went to bed. Her parents checked on her during the afternoon and didn't get a reply. When they checked her again later, she was found unresponsive, and her parents called an ambulance. Under her the bedding were empty packets of prescribed medication and a suicide note.

3. The Facts – an overview

Sarah was one of two children who had become estranged from her brother over time. Her parents moved to Cornwall around thirty years ago, and still live in that area.

Sarah had two children from her first marriage and moved to Norfolk, living with Samuel from around 2016.

Previously been employed in Nottingham, as a senior social worker, she took on the role of an outreach worker when moving to Norfolk.

Sarah had a difficult childhood, described to health professionals as being physically and emotionally abusive. It is understood that she left home aged 16 to escape her home life, married at a young age and had her two children. It is also understood that this first marriage of over twenty years was physically abusive.

She started to self-harm from the age of sixteen as a coping mechanism regarding her mental state later diagnosed as 'anxiety disorder' and 'low mood and depression'. Self-harming included cutting, blunt force to her ribs and on occasion through starvation. She was treated for her depression and anxiety with pharmacological prescriptions, was referred into secondary mental healthcare but not admitted for ongoing treatment. She was also signposted for alternative therapies that she did not engage with.

Her relationship with Samuel began in around 2014, and from Sarah's words in a statement to the police, was typified by physical and financial abuse such as exploiting her in respect of her pension. There are further accounts of how he controlled her in respect of contact with her children and best friend.

4. Learning Points

Recognition and Response to Domestic Abuse (DA): with the exception of NSFT, Sarah was not asked about DA, showing opportunities to ensure professionals equipped to recognise and respond to DA within an appropriate policy framework.

Risk Assessment: The review showed opportunities to strengthen the approach to managing the risk of self-harm / suicide.

4. Learning Points (continued)

Feedback Loop: Sarah did not engage with third sector agencies that she was signposted to, but no-one asked whether she had approached them and sought feedback:

Long- term treatment: Sarah saw multiple GPs suggesting an opportunity to improve consistency in primary care, and guidance in respect of the role of mental healthcare professionals suggests an opportunity to strengthen the approach to treating suicidal ideation.

Cause and Effect: The review identified a number of potential links to self-harming behaviour including; adverse childhood experience, alcohol as a feature of impulsive overdoses and that the menopause is a potential risk factor.

Inter-agency Communication: Primary and secondary healthcare identified opportunities to streamline the referral pathway to secondary mental healthcare.

Covid: The lockdown period exacerbated Sarah's feelings of isolation, including her being prevented from volunteering at a local charity shop.

Equalities: The risks of stereo-typing a woman as a 'strong Northern' woman, created additional barriers to Sarah seeking help or being asked if everything is ok.

Nature of abuse: The panel acknowledge the hidden nature of controlling behaviour and financial abuse requiring ongoing awareness raising across professionals and communities.

5. Good Practice (see 17.3.1 of report for full details)

GP: DA Policy and DA champions

IC24: DA Staff Policy

NSFT: DA policy that is unambiguous about routine enquiry, suicide prevention strategy & menopause champion.

5. Recommendations

R1: Sherwood NHS Trust to Review and refresh the Domestic Abuse Policy in accordance with legislative and best practice developments.

R2:(GP) Improve the ability of clinicians to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse.

R3: (Public Health) The ICS' Suicide Prevention Partnership, led by Public Health, works together to support primary care to improve recognising and managing risk including safety planning for suicidal patients.

R4: (GP/ICB) Ensure that alcohol misuse is considered addressed as a risk factor for all patients who self-harm or express suicidal thoughts and ensure patients treated/signposted accordingly.

R5: (GP/ICB) To seek to raise awareness and the ability to recognise and respond to the risk of suicide associated with the menopause.

R6: (Public Health) Work in Partnership to ensure that people who self-harm are in receipt of appropriate care and support.

R7:(Norfolk County Council) Improve the ability of staff to identify signs of domestic abuse and respond with appropriate professional interest that provides opportunities for survivors to disclose abuse. (With an up-to-date policy that mandates domestic abuse training).

R8: (Norfolk County Council) Seek to reduce the risks of stereotyping that risks the true vulnerability of those living with domestic abuse having the confidence to disclose.

R9: (NCCSP) The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide and all the learning opportunities raised.

R9a: (GP) As above, but referencing: - *consistent use of terminology about risk assessment, - opportunities to close the feedback loop with patients, - recognising benefits of seeing the same GP*