NORFOLK COMMUNITY SAFTY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

Report into the death of Sarah.

May 2021

Independent Chair and Author: Mark Wolski

Date of Completion: July 2023

Norfolk Community Safety Partnership

The Domestic Homicide Review Panel and the members of the Norfolk Community Safety Partnership would like to offer their sincere condolences to the family and friends of the victim for whom this Review has been undertaken.

Sarah was a much-loved mother and daughter who will be greatly missed by all their family and friends.

This review has been undertaken in order that lessons can be learned from this situation, and we appreciate the support provided by the family and a close friend who were able to shine a light on her life.

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1. INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) were established under Section 9(3), Domestic Violence, Crime and Victims Act 2004.

1.2 This report of the DHR (hereafter 'the review') examines agency responses and support given to Sarah, a resident in Norfolk before the point of her taking her own life in May 2021.

1.3 The day before she took her life, the police had been called to an incident at Sarah's home address in Norfolk. Her partner Samuel was arrested for causing criminal damage. She then travelled to her parents in Cornwall and said she wanted to sleep. Later that afternoon, they checked on her and found her to be unresponsive. They called an ambulance, and on their arrival found a note along with empty packets of prescription medication under the bed.

1.4 This review was commissioned by the Norfolk Community Safety Partnership (NCSP) to consider agencies contact/involvement with Sarah and Samuel from **June 2016 to May 2021** (around the time of Sarah's death) In addition to agency involvement, the review will also examine the past to identify any relevant background or trail of abuse before Sarah's suicide, whether support was accessed within the community and whether there were any barriers to accessing support.

1,5 The period was selected to encompass her presentation at a hospital following an overdose prior to her moving to Norfolk, and her engagement with local Norfolk agencies when she moved into the area to live with Samuel. Where appropriate, information outside of this time period is included to provide context and to explore noteworthy events before the relevant period.

1.6 The primary purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person has or appears to have died as a result of domestic violence and abuse. In this case, where Sarah had taken her own life, a domestic incident occurred on the day before Sarah's death. Records showed she had experienced a history of domestic abuse, which gave rise to a concern that a review should be undertaken, even though no one was charged with homicide. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand the circumstances leading up to Sarah's death, what happened when agencies were involved with her during the relevant period, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.7 This review process does not take the place of the criminal or coroner's court, nor does it take the form of a disciplinary process.

1.8 The review also reflects the views and thoughts of some of Sarah's family who contributed to this review. The Panel wishes to express their sincere condolences to them and all of Sarah's family.

2. TIMESCALES

2.1 The NCSP commissioned this review in accordance with 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'. The Home Office were notified of the decision in writing on 6th July 2021.

2.2 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. There was an initial delay as the commissioner of reviews undertook two rounds of advertising before a suitable chair was appointed in September

2021. The Home Office have been kept appraised of subsequent delays in progressing the review. In this case, the main reason has been to establish effective communication with Sarah's family (May/June 2022) and a close friend (July/August 2022). Please see section 6.

3. CONFIDENTIALITY

3.1 Details of confidentiality, disclosure and dissemination were discussed and were agreed between Panel Member Agencies at the first Panel Meeting.

3.2 All information discussed was agreed as strictly confidential and was not disclosed to third parties without the agreement of the responsible Agency's Representative.

3.3 All Agency Representatives agreed to be personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

3.4 NCSP provided a secure information platform for the purposes of sharing information.

3.5 To protect the identity of family members, with the agreement of family members, the following anonymised terms and pseudonyms have been used throughout this review.

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

4. TERMS OF REFERENCE

4.1 The full terms of reference are set out at **Appendix A**. This review aims to identify the learning from the suicide, and for action to be taken in response to that learning with a view to preventing homicide (and people taking their own life) and ensuring that individuals and families are better supported.

4.2 The Review Panel comprised of agencies from the Norfolk area, as Sarah and her partner were living in that area at the time of her death. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation, and the need to secure their records.

5. METHODOLOGY - REVIEW PROCESS

5.1 Legal Framework

5.1.1 The Review has been conducted in accordance with Statutory Guidance under S9(3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

5.2 Methodology Overview, Panel Meetings, Individual Management Reviews (IMRs) and Chronologies

5.2.1 Following the decision to undertake a DHR, NCSP agencies were asked agencies to check for their involvement with any of the parties concerned and secure their records. The

approach adopted was to seek chronologies initially, followed by IMRs for all the organisations and agencies that had contact with Sarah and Samuel.

5.2.2 Agencies who had contact with Sarah and Samuel are summarised 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
Norfolk County Council -Council Tax	Yes	Yes	Chronology
Integrated Care 24 (IC24) – NHS111	Yes	No	Chronology and IMR
Norfolk and Norwich University Hospital	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

5.2.3 An integrated chronology produced by NCSP was reviewed at the first panel meeting on 1st December 2021 that enabled a draft Terms of Reference to be agreed. This was kept under review throughout the review process.

5.2.4 The chair gave a bespoke IMR briefing to authors, providing an overview of the DHR process, and writing an IMR, in line with Home Office guidance (Home Office 2016).[1]

5.2.5 In addition to the IMRs, documents reviewed during the review process have included:

- Norfolk County Council Domestic Abuse Policy
- Norfolk and Suffolk NHS Foundation Trust
  - ➢ *Suicide Strategy 2017-22*
  - ➢ *Domestic Violence and Abuse Strategy*
  - ➢ *Supporting Staff through Domestic Violence and Abuse Strategy*
  - ➢ *'Did not Attend' Policy*
- Norfolk Constabulary
  - ➢ *Signposting Leaflet*
  - ➢ *Supervisor 7 Point Closure Plan*
- GP
  - ➢ *CCG (now ICB)/GP Safeguarding Policy*
- NCSP Domestic Abuse Strategy
  - ➢ *Norfolk Domestic Abuse Strategy 2022 -2025*

5.2.6 In addition to panel meetings (summarised at 8 below), the chair also held individual meetings with panel representatives to explore technical details and seek clarification on several matters.

[1] Source: DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

5.2.7 The chair would also like to thank Public Health who met with the chair outside panel meetings, to provide an overview of the work being undertaken in respect of suicide prevention, and for adopting recommendations that were suited for public health oversight.

6. FAMILY INVOLVEMENT

6.1 Sarah was one of two children who grew up in the Midlands. She had not spoken to her brother for several years, and it has not been possible to obtain his contact details. She had two children from her first marriage.

6.2 Norfolk Community Safety Partnership wrote to Sarah's mother, son and daughter advising them that a review was being undertaken in September 2021, along with information about reviews and details of support agencies including Advocacy After Fatal Domestic Abuse. The chair wrote to family members in October 2021, and followed up with initial telephone conversations and has ensured that the family were aware of the available support by AAFDA, providing information in his letter and when speaking to them. A schedule of contact is detailed at **Appendix B.**

6.3 Following an initial conversation with Sarah's mother, he learned that she was caring for her husband (Sarah's father). She made it clear that she did not wish to take part in the review or talk about Sarah's relationship with Samuel. The chair decided at that point not to continue to engage further with Sarah's mother until the review was nearing completion. Sarah's father was not able to participate owing to his health condition.

6.4 The chair made further attempts to speak to Sarah's daughter and son, and it wasn't until July 2022 that he was able to speak to her daughter, Margaret and gain some perspective about the relationship between Sarah and Samuel. Margaret also provided details of a friend of Sarah's (Janet) and had attempted to speak to her on several occasions, before being able to have a conversation in with her in July and August 2022.

7. CONTRIBUTORS

7.1 IMRs or Factual Reports were requested from agencies as shown at table 2 above, as being proportionate to the purposes of the review.

8. REVIEW PANEL

8.1 The Review Panel consisted of:

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 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

8.2 The review panel met a total of four times, with the first meeting 1st December 2021 and subsequent meetings on the 2nd March 2022, 13th May 2022, and 1st September 2022.

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

8.4 The chair of the review wishes to thank everyone who contributed their time, patience and co-operation during this review.

9. AUTHOR AND INDEPENDENT CHAIR

9.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended subsequent Training by Advocacy After Fatal Domestic Abuse.

9.2 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.

9.3 During and since his MPS service Mark has had no personal or operational involvement with NCSP.

10. PARALLEL REVIEWS AND RELATED PROCESSES

Coronial Proceedings

10.1 The inquest into Sarah's death took place in December 2021. The medical cause of death was recorded as 'Drug Toxicity'. The conclusion as to the cause of death was suicide.

11. EQUALITIES AND DIVERSITY

11.1 The nine protected characteristics as defined by the Equality Act 2010 have all been considered; they are age, disability, sex, sexual orientation, gender reassignment, marriage and civil partnerships, pregnancy and maternity, race, religion or belief and sexual orientation.

11.2 At the first meeting of the Review Panel, it identified that the protected characteristics of Sex and Disability were pertinent to this review.

Sex

11.3 Sarah was female, and Samuel was male. An analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with females representing the majority of victims and males representing most perpetrators. [2] Women's aid report, "There are important differences between male violence against women and female violence against men, namely the amount, severity, and impact. Women experience higher rates of repeated victimisation and are much more likely to be seriously hurt (Walby & Towers, 2017; Walby & Allen, 2004) or killed than male victims of domestic abuse (ONS, 2020A; ONS, 2020B)".[3]

11.3 The ONS reports that males accounted for three quarters of suicide deaths in 2020[4], the most recently published report. Therefore, males are more likely to take their own lives with the ONS reporting that 'since around 1990, men have been at least three times as vulnerable to death from suicide as women'.[5]

Disability

11.4 Disability was considered as it was apparent that Sarah lived with mental illness that the panel learned prevented her from sustaining her employment. The Human Rights Act 2010 definition of disability states "A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities".[6]

11.5 The panel agreed Sarah meets the Human Rights definition and in so doing recognise the importance of the Equalities Act and the duty on public authorities to.

- remove or reduce disadvantages suffered by people because of a protected characteristic.
- meet the needs of people with protected characteristics.
- encourage people with protected characteristics to participate in public life and other activities [7]

11.6 The panel has paid due regard to these requirements and whether intersectionality was apparent, that is the theory that various social identities contribute to systemic discrimination.[8] The panel note the reported association between having mental health problems and being a victim of domestic abuse,[9] that along with the gendered nature of domestic abuse makes intersectionality a relevant topic to this review.

12. DISSEMINATION

12.1 Once finalised by the Review Panel, the Executive Summary and Overview Report will be presented to the Domestic Abuse and Sexual Violence Group and Norfolk Community Safety Partnership (NCSP) for approval and thereafter will be sent to the Home Office for quality assurance.

12.2 The Executive Summary and Overview Report will be shared by the Office of the Police and Crime Commissioner for Norfolk with the following.

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[2] Source: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf (Accessed October 2021)

[3] Source: Domestic abuse is a gendered crime - Womens Aid (Accessed October 2021)

[4] Source: Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (Accessed February 2022)

[5] Source: Who is most at risk of suicide? - Office for National Statistics (ons.gov.uk) (Accessed June 2022)

[6] Source: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics#disability (Accessed February 2022)

[7] Source: https://www.citizensadvice.org.uk/law-and-courts/discrimination/public-sector-equality-duty/what-s-the-public-sector-equality-duty/ (Accessed February 2022)

[8] Source: https://www.dictionary.com/browse/intersectionality (Accessed February 2022)

[9] Source: Spotlight 7 - Mental health and domestic abuse.pdf (safelives.org.uk) (Accessed February 2022)

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- Sarah's family
- Norfolk Police and Crime Commissioner
- Chief Constable, Norfolk Police
- Chief Executive, Norfolk County Council
- Chief Executive, Leeway
- Chief Executive Officer, Norfolk and Waveney Clinical Commissioning Group (now N & W Integrated Care Board)
- Chair, Norfolk Health and Wellbeing Board
- Independent Chair, Norfolk Safeguarding Adults Board
- Sarah's GP practice

12.3 The action plan will be monitored by NCSP Domestic Abuse and Sexual Violence Group. The Community Safety Team will be responsible for monitoring the recommendations and reporting on progress".

13. BACKGROUND INFORMATION - THE FACTS

13.1 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.

The Events of Sarah's death

13.2 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.

13.3 Sarah travelled by taxicab 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 that describe her reflections that Samuel didn't care and of her feeling tired, wanting to sleep and not wake up.

13.4 Devon and Cornwall Constabulary conducted a comprehensive investigation into the circumstances of Sarah's death that included interviewing and taking statements from friends and family. As there was no evidence of third-party involvement, the matter was passed to the coroner who concluded in December 2021 that the death was by way of suicide.

13.5 The review was commissioned based on the events the day prior to her taking her own life and owing to a previous domestic incident in August 2020 and other historic domestic incidents recorded in a different county.

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14. CHRONOLOGY

14.1 Background History of Family

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

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

14.1.3 She had previously been employed at Nottingham City Council as a senior social worker, before moving to Norfolk and taking on a role as an outreach worker.

Children

14.1.4 The chair contacted Margaret in October 2021, and it wasn't until June 2022 that she felt comfortable to talk in greater depth about her mum.

Margaret painted a picture of a mum who had become increasingly isolated from friends and family, a situation exacerbated by the Covid lockdown. This had resulted in her not seeing her mum in the five months before she took her own life.

On exploring the sense of isolation before the 'lockdown', she described the controlling behaviour (Margaret's words), of Samuel with examples such as; when Sarah was with her, Samuel would constantly call asking her to come back; Sarah would whisper on the phone so as not to disturb Samuel, and not to be overheard; when Margaret had suggested coming to get her mum, she replied, I'll have to ask Samuel

She suspected that her mum hid a lot of what was happening at home, but recalls that matters got worse when Samuel drank, describing examples where she had fled to her mum or a friend. On one occasion Margaret had been present when he had smashed an expensive television and punched a hole in a wall. She continued, that she was also aware that her mum had injured her ribs, and though Sarah never said it was him who caused the injury, she did know that the night before, Sarah and Samuel had had a massive argument.

Margaret had over time, taken several calls from Sarah during the night, when Samuel had been abusive, and she knows that her mum had on occasion called the police, but suspected that on many occasions she had not called the police.

She believed that he had exploited her, and financially abused her too, using money from her pension 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.

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 cut herself. The cuts were not deep, and she attributed this to the strain of living with him. It was at this time, that Sarah had begun to drink, a bottle of wine a day, and smoke cannabis, that she found very strange as her mum had been so against taking drugs.

On exploring the mater of self-harming/suicidal ideation, Margaret had not known much about these episodes until the coroner's inquest, when she learned that about a year before she died, when she learned of an episode where Sarah had taken some Tramadol along with a large quantity of Vodka.

On describing Sarah's upbringing, she understood that Sarah had a very strict upbringing, from her dad in particular who was ex-military. She described what in today's term would be classified as abuse (Margaret's words), with the use of force, typified using a belt and slipper. She had left home fairly young.

The chair explored what may have helped, and Margaret said that she was personally concerned about the frequent changes in medication that took place. Margaret explained that she works as a nurse in a hospital where patients are sectioned and therefore has an awareness of the side effects of some medication, such as depression. When asked about other help, such as counselling or therapies, she said that her mum had never mentioned such support and was unlikely to have accepted such assistance.

Margaret had learned of her mum taking her own life a few days after the event. Whilst they had not spoken on the phone, Sarah had texted her and said that she was on the way to Cornwall. The understanding was that they would talk later that day. It therefore came as a shock to her when she was told of the incident.

Margaret had asked her grandmother whether there had been any indication or threat that Sarah was going to take her own life, and the only thing she could recall, was that her mum had after arrival

at her grandmothers, gone to her bedroom, and when came out and said that Samuel wanted his keys back. Sarah gave her the keys and asked her to post them to Samuel. Margaret believes this was owing to a communication between Sarah and Samuel, after she had arrived in Cornwall.

Upon exploring why this tragedy had occurred, she said, in a bullet point fashion: 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.

14.1.4 It has not been possible to speak to Sarah's son, although the opportunity to participate in the review has been communicated on a number of occasions.

Friends Voice

14.1.5 The chair was able to speak to Sarah's best friend Janet, who had been a friend since childhood.

Janet explained that she had known Sarah since she was fourteen, both having been modettes.[10] *Sarah had been and remained passionate about the fashions of that era, and associations with motor scooters. (Relevant in this case). She described how infatuated Sarah had been with Samuel during her teenage years, as he was also a keen 'mod', phoning him every Friday night.*

Janet recalls Sarah's upbringing as being very strict but does not recall any further details.

She also recalls that Sarah's first marriage had been troubled and commented that she seemed attracted to that type of relationship. On enquiring how she had become reacquainted with Samuel, she explained they had literally bumped into each by accident when at an event. She recalls how Sarah had travelled to meet with Samuel in Norfolk and that when she arrived at his house, Samuel's mum had said that he had gone fishing, and believes this was a sign of how he treated her.

She believes that the relationship was controlling, explaining that when they had arranged to meet up for a girl's night out, Samuel would come with her. It seemed from calls that she could not speak freely and made maintaining the relationship difficult.

She recalls having said to Sarah "that's not love", when being told about him pushing and shoving her. Sarah had been very slight in build and could have been blown over by a strong wind. Indeed, Janet had called the police one evening, when Sarah had phoned her and told her about Samuel's behaviour. (This is cross referenced within the chronology)

Asked why she became involved with him again, she explained a lot related to their joint interest in mods and modettes, and associated memorabilia, and films such as Quadrophenia. Indeed, this led to another element of abuse, where Sarah paid for many of Samuel's fashion accessories, and a new scooter.

On asking about whether Sarah would have sought any help from anybody, she 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

14.1.5 In August 2020, Sarah provided a statement to the police, as evidence in supporting criminal proceedings in relation to Samuel. This has been provided to the chair and provides an insight into her lived experience and an assault.

- *Sarah describes a relationship of around six years with Samuel, approximately half of which is when they lived in Nottingham, and the other half in Norwich. She said that he had abused her for all that period, verbally and physically causing thousands of pounds of damage.*
- *She describes an incident reported to Mansfield police, along with the incident on the 19th August2020.*

[10] A female mod into the '79 British mod revial. Source: Slang Define: What is Modette? - meaning and definition

- *In between, she alleges that she was financially abused, 'draining' her income including three lump sums from her pension and a regular monthly pension. She described having paid for his flat furniture almost entirely, using her. She further explained that he used to monitor her spending.*

14.1.6 Sarah also provides a perspective on an incident where she suffered from scald injuries that are detailed in the chronology and agency analysis.

- *She explained that she had been subject to verbal abuse all night, and the following day, whilst trying to cook the tea, she became upset and frustrated, and on draining the potatoes, spilled boiling water on her feet. She said that whilst he had not inflicted the injury, she considered him responsible because of abuse on her.*

14.1.7 Sarah then continued with her statement describing the incident resulting in police being called.

- *Sarah explained that both had been drinking and that his mood just switched. She explained that she had been in previously abusive relationships, and she recognised that the situation would escalate. She tried to leave, and he prevented her leaving injuring her arm and finger. Eventually he unlocked the door and let her leave the flat, and police spoke to her, taking a photo of her inured finger.*

14.2 Narrative Chronology – Key Contacts with Agencies

Prior to the 'relevant period'

14.2.1 In November 2009 police were called to a verbal argument. No offences were disclosed, and her former husband left.

2016

14.2.2 Sarah was recruited into Norfolk County Council as an 'Outreach Practitioner' in July 2015, working for a little under a year until she resigned in June 2016.

14.2.3 ***Nottinghamshire Police***: On 28th December, police were called to a verbal argument between Sarah and Samuel at their home address. Both had been drinking and Samuel was removed to prevent a breach of the peace. The risk was assessed as being standard.

2017

14.2.4 **Summary***:* In 2017, Sarah was seen on a number of occasions regarding her mental health, and she also presented at hospital following a deliberate overdose and regarding an injury to her ribs. There was also a note that she moved in with Samuel and Norwich City Council also visited the home address on a number of occasions for routine repair matters.

14.2.5 ***Sherwood Forest Hospitals NHS Trust***: On 6th January, Sarah attended hospital after a deliberate overdose of tramadol and vodka. She was assessed by the 'Rapid Response Liaison Psychiatry.' She denied any suicidal intent and reported no intention to harm herself further. She described recent stressors in her life as her boiler not working on Christmas eve and a relationship breakdown on 28.12.16. She reported that she and her partner had resolved their issues the previous evening and he plans to collect her from the hospital today and they will spend the week at his home address in Norfolk. Blood tests were completed, and she was reported as being at low risk. It was unclear if she was asked about domestic abuse, and none was disclosed.

14.2.6 ***GP:*** On 1st February she attended her GP having registered the week before. The events of the 6th January were explored and described as being triggered by a relationship breakdown and financial worries. It was noted she had slit a wrist in 2009 and had taken an overdose in 1986. Sarah said she was living with a friend and thought trauma always pushed her towards stress and suicidal thoughts. She was referred for counselling and prescribed anti-depressants with the intention to review in two weeks.

14.2.7 ***GP:*** Further appointments were kept on the 22nd February and 8th March, when her 'low mood' was reviewed and unrelated medical matters were explored. Whilst Sarah described thoughts of self-harm by cutting having been stopped by ringing her mum, she did not indicate active suicidal ideation or intent. The dosage of anti-depressant was increased.

14.2.8 ***GP:*** On 31st March, an 'Employment and Support Allowance Form (ESA)' was completed, and her diagnosed condition was recorded as low mood and depression.

14.2.9 ***NHS111 and Norfolk and Norwich Hospital***: On 2nd April Sarah called 111 saying she had fallen over and hurt her ribs. She described having breathing difficulties and was advised to attend accident and emergency (A & E). On attending the hospital, she was diagnosed with a probable closed rib fracture and given pain relief. There is no note of an x-ray or her being asked how the injury occurred.

14.2.10 ***GP:*** On 4th April, the GP conducted a home visit. She explained she had a fall whilst decorating at home and fractured her rib. She was advised regarding pain control and a follow-up was scheduled for two days later (6th April), when a telephone review took place. The dosage of anti-depressant was increased at her request and a risk assessment was completed.

14.2.11 ***NHS111 and GP***: On 7th April, she called 111 regarding her rib pains and was advised to speak to her GP. She saw her GP five days later (12th April) and she said the pain had improved and she was issued with a not fit for work certificate for 2 months.

14.2.12 ***GP:*** On 11th May, the pain from her ribs had improved, but it was noted on reviewing her mood that worried about issues from the past. A risk assessment was completed, and she was signposted to a local counselling service.

14.2.13 ***GP:*** Sarah was seen intermittently throughout 2017(21st June 7th July6th September,11th and 23rd October) regarding her painful ribs. She was prescribed stronger pain control, referred to neurologist and sent for x-rays. She was also seen by her GP regarding unrelated physical matters (see below)

14.2.14 ***GP & Norfolk and Norwich Hospital:*** On 21st July, Sarah attended her GP regarding irregular bleeding during intercourse over a period of 2 years. She was seen by the gynecology department at hospital in September, and further assessment and investigation did not identify cause for concern.

14.2.15 ***GP:*** On 13th September, the GP conducted a home visit as she had a fever and chesty cough. She was treated for suspected pneumonia and her partner said he would keep a close eye on her.

14.2.16 ***Council Tax IT systems***: On the 13th October, Samuel phoned and reported that Sarah had moved in with him. A council officer called him 4 days later (17th October), and he said that she was now not moving in, and therefore his single person discount for council tax was re-opened.

14.2.17 ***GP:*** Sarah was next seen by her GP on the 22nd November when she was in a depressed mood and tearful, talking about issues with her ex-partner. It was noted she was not suicidal, and a decision was taken to change her anti-depressant with a planned review three weeks later. The planned review took place, and it was noted she was doing better on the new medication.

2018

14.2.18 **Summary**: In 2018 Sarah was seen on a number of occasions by her GP regarding her mental health and Norfolk and Norwich Universities Hospitals Foundation Trust (NNUHT)

regarding unrelated medical matters. Norwich City Council also visited the home address on a number of occasions for routine repair matters.

14.2.19 ***GP:*** Sarah attended her GP on the 1st February and a mental state examination and a medication review took place, and the dose of anti-depressant (*Venlafaxine)* was increased. Three weeks later (22nd February), a further review was undertaken, and she requested a change of medication. The medication was changed to *Sertraline* and a review scheduled for a week later. This review took place on 1st March, where it was noted that she was suffering from nausea and vomiting as a side effect of sertraline, and her diagnosis was recorded as "anxiety disorder and depressive symptoms". Another change in the prescribed anti-depressant medication took place. (*Duloxetine*).

14.2.20 ***Norfolk County Council – Human Resources and Clinical Commissioning Group***: On 6th March Sarah began the process to access deferred pension benefits from the local government pension scheme. A consent form was sent to her, that was returned and forwarded to Occupational Health. This process involved the Clinical Commissioning Group and a consultant occupational physician releasing medical information to support the application for release of preserved pension benefits. Later in the year, Occupational Health completed an assessment and determined that the criteria for ill health retirement had been met. Sarah was informed that she was entitled to access her deferred pension benefits and Norfolk Pension Fund made the arrangements for this to happen.

14.2.21 ***GP***: Sarah was seen on the 27th April and a month later on 30th May, feeling occasionally suicidal. On both occasions the GP conducted a mental health risk assessment. Sarah explained that her children were a protective factor, and said that she," could not do that to them." She presented as being well kempt and exhibiting normal behaviour.

14.2.22 ***NNUH:*** On 23rd September when attending the Gastroenterology Day Procedure Unit, Sarah said that she did not want her partner present when discussing her discharge. The reason for this request was not explored by professionals.

14.2.23 ***GP and Norfolk and Suffolk Foundation Trust (NSFT):*** Sarah attended her GP on the 7th November and described her panic attacks and anxiety getting worse. She was afraid to go out and was self-harming, trying to cut a lump out of her neck and cutting her wrists. The referral to the mental health services was received and an appointment letter was sent for the 14th December, that she did not attend. A letter was sent to her offering another appointment and this was copied to her GP. She then attended her GP again on the 21st December. She saw a different doctor to the one who had referred her to mental health services on the 7th November. On this occasion it was noted she was having trouble sleeping. This was the last occasion a GP saw her for five months.

2019

14.2.24 **Summary**: In 2019, Sarah was seen on several occasions by her GP regarding her depression and by NNUH regarding unrelated medical concerns. Towards the end of the year, she attended NNUH A & E regarding breathing difficulties. There was one visit by Norwich City Council for a routine repair matter.

14.2.25 ***GP***: On 9th May Sarah requested a change to her anti-depressants to one she had previously taken, as she had occasional suicidal thoughts. This request was agreed to, with a plan to review in 4 weeks' time. She was also provided with contact details for Samaritans. She was next seen on the 4th July and on the 19th September. The dose of anti-depressant was adjusted on both occasions as her mood had dipped.

2020

14.2.26 **Summary**: In 2020 Sarah was seen on numerous occasions by her GP regarding her mental health and other medical matters. She was also seen by a number of departments

within Norfolk and Norwich University Hospital, including A & E for burns to her feet and an overdose. Other contacts with the hospital related to other medical conditions that, whilst unremarkable in the context of shining a light on potential abuse, show the frequency of contact with medical professionals. These are not all detailed below. She also had contact with Norfolk and Suffolk Foundation Trust mental health department via A & E and following referral by her GP. There was one reported domestic incident to the police.

14.2.27 ***GP:*** On 16th January, a medication review was conducted by a pharmacist, when it was noted, she had reduced her dose of anti-depressant herself and it was also noted that "her partner looks after all meds".

14.2.28 ***GP:*** On 28th January, she attended her GP and spoke to a smoking cessation advisor. This was the first of a number of appointments following admissions to hospital (15th October and 18th December 2019) with breathing difficulties. A subsequent appointment at her GP by a practice nurse took place on 18th February when she attended for an asthma review, and it was noted she was on champix a drug used in adults to help them stop smoking[11]

14.2.29 ***GP:*** On 20th February, Sarah was seen at the practice, and an examination of the roof of her mouth and a disclosure of mouth cancer in the family resulted in urgent referral to NNUH outpatients. She saw specialists on the 28th February and 6th March respectively and had a final telephone consultation on the 4th May. She was given advice regarding dental hygiene and medication.

14.2.30 ***NNUH (Chest Medicine*)**: On 2nd March following the admittances to A & E regarding breathing difficulties, she attended the specialist clinic and was diagnosed as most likely having COPD secondary to smoking. The notes stated 'no significant past medical history or major illnesses recorded.

14.2.31 ***GP:*** Sarah attended two appointments, on 4th and 23rd March with a smoking cessation advisor that resulted in a recommendation to continue the use of 'Champix' and a letter stating, "I have assessed this patient's suitability for Champix and have identified no contraindications on the information I have been supplied". Thereafter the pharmacists at the GP medical centre prescribed champix (Varenicline) without further patient contact.

14.2.32 ***NNUH (A & E)***: On 31st March, she attended hospital, describing arm pain, following a fall onto her arm. Following x-rays, she was discharged with a diagnosis of soft tissue injury.

14.2.33 ***NNUH (A & E) and NSFT:*** On 12th April, the ambulance service attended to Sarah at home, following a deliberate overdose of medication and alcohol. Upon conveyance to the hospital, she was found not to have capacity owing to temporary impairment through intoxication. The notes record that there were no safeguarding concerns highlighted. She was treated for the overdose and referred to mental health liaison.

14.2.34 Whilst at hospital, an assessment of her mental health was conducted over the telephone by a registered nurse from NSFT owing to Covid. The nurse noted previous input from community mental health team (CMHT) in 2018. Sarah stated she has always had mental health issues and her GP referred her to CMHT last year and was still on the waiting list. She reported taking an overdose of her anti-anxiety medication with vodka, saying this was an impulsive act and she told a friend soon afterwards who called an ambulance. She felt embarrassed and ashamed she did this. She stated she is always anxious. States she had cut her wrists 7 years previously but no deliberate self-harm since. She denied active suicidal ideation or plans. She reported only drinking alcohol at weekends. Assessor stated when drinking alcohol and getting upset there is a risk that she may take an overdose. She was referred back to her GP, with a recommendation to chase up mental health referral. She was provided with a number for Samaritans and MIND Crisis line.

[11] Source: Champix: Uses, Side Effects, Benefits/Risks | Drugs.com (Accessed December 2021)

14.2.35 She later discharged herself, against medical advice, but following another mental capacity act assessment. It was noted that she was not actively suicidal and understood the worries and concerns medical practitioners had.

14.2.36 ***GP:*** On 13th April, Sarah saw her GP following episodes of vomiting blood. A risk assessment was completed, and she denied having active suicidal or self-harm thoughts. She was advised to attend A & E and her prescriptions were changed to weekly owing to the recent overdose. An internal task was sent to chase the mental health referral. On the following day (14th April), a review was undertaken. She had not attended A & E and she was deemed to have the capacity to make decisions. It was noted that the mental health referral in 2018 had been closed owing to her not attending. As a result, she was re-referred to mental health.

14.2.37 ***NSFT (Mental Health):*** On 21st April, Sarah was assessed and discharged back to GP with advice re; medication and signposted to Sue Lambert Trust. It was noted that her anxiety was linked to a previous abusive relationship with her ex-husband. A letter was sent to the GP to advise them of the outcome.

14.2.38 ***GP:*** On 30th April she discussed with her GP starting a new anti-depressant. She explained she had support from her family, talking to them regularly on the phone.

14.2.39 ***GP:*** On 22nd May Sarah was seen regarding ongoing elbow pain. She was referred to physiotherapy, but she did not make contact within the allocated timeframe and was discharged from that care pathway.

14.2.40 ***GP:*** On 9th July, the pharmacist conducted a medication review. Notes state "is very happy on medications- they are doing the trick. Sounded well and chatty on the phone- happy will be seeing her son and daughter this weekend."

14.2.41 ***NHS111 and NNUHT (A & E);*** On 18th July Sarah phoned 111 having dropped a pan of boiling water on to her feet. As a result, she attended A & E for treatment and was later discharged.

14.2.42 ***Camborne Redruth Community Hospital l***: On 21st July, Sarah was registered with a GP in Cornwall for 15 days. Five days later, she attended the hospital, where she had dressings to her scalded feet changed. She was asked about how the accident had happened and she refused to disclose.

14.2.43 ***Norfolk Constabulary***: On 18th August police attended Sarah's home address and she alleged that Samuel had caused criminal damage over a period of years and assaulted her. She was assessed as medium risk, and this was agreed in secondary safeguarding by the DAST. No further action was taken following a withdrawal of support by Sarah, no supporting evidence and a 'no comment' interview by Samuel.

2021

14.2.44 Sarah was seen at the GP practice on five occasions in 2021 (25th February 18th and 30th March, 8th and 22nd of April prior to her taking her life. She also attended NNUH on two occasions (14th January and 22nd April). Each of these contacts related to physical ailments that were not trauma related and with no reference to her state of mind.

14.2.45 ***Norfolk Constabulary***: On 22nd May, police attended Sarah's mother-in-law's house, where she alleged that Samuel had damaged property after consuming alcohol at their home address. She also alleged an assault. Police then attended the home address and found evidence of criminal damage. Samuel admitted causing the damage, was arrested, and received a caution for criminal damage. The investigating officer updated Sarah, who had travelled by taxi to her parents in Cornwall.

14.2.46 ***Devon and Cornwall Police***: On 23rd May, police were notified by the ambulance service of Sarah's death. The death was assessed as non-suspicious, and the circumstances were reported to the coroner by a local officer.

15. OVERVIEW

The summaries below relate to agencies with whom which she had significant contact during the relevant period and have completed IMRs or a factual report.

15.1 Sherwood Forest Hospitals NHS Trust

15.1.1 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.

15.2 General Practitioner (GP)

15.2.1 Sarah had been registered at a few GP practices during the relevant period. Between March 2015 and June 2016 at a GP practice in Norfolk, then a GP in Nottingham in June 2016, before re-registering in Norfolk in January 2017. She also registered at a GP practice in Cornwall during this period, albeit for 15 days only

15.2.2 She had a diagnosis of anxiety, depressive illness, and asthma, with a history of repeated self-harm and suicide attempts:

- Aged 17 years she took an overdose of pain relief medication.
- In 2009 she slit her wrist following marital divorce
- in January 2017 she took a deliberate overdose of pain relief medication (tramadol) triggered by a relationship breakdown and financial worries whilst living in Nottinghamshire.

When she registered at the GP practice in 2017, she explained that she thought a traumatic life episode always pushed her towards stress and suicidal thoughts. On several occasions she reported that her family were a protective factor in her mental illness.

15.2.3 She was reviewed regularly at the GP surgery, having forty consultations with clinicians at the Norfolk GP practice. The majority related to her mental health, and she was prescribed anti-depressant medication that was changed as required. She was signposted to counselling on two occasions (February and May 2017) and on one occasion (November 2018) the GP referred her to the specialist mental health team, but notes indicate she did not attend. On a subsequent occasion in April 2020, following attendance at A&E, she was referred back to the specialist mental health team following an impulsive overdose.

15.2.4 Sarah was supported by her GP for several physical complaints, including conditions related to her bowels, a lump on her face, gynaecological matters, and asthma. This involved liaison with a number of secondary care specialists.

15.2.5 The GP also provided pain treatment for a fractured rib over a period of months in 2017.

15.2.6 It has been clarified that there is no evidence from medical records that the practice was aware that Sarah and Samuel were a couple.

15.3 NHS111/IC24

15.3.1 The NHS111 service is provided by Integrated Care 24 (IC24) a social enterprise organisation serving the locality and other parts of England.

15.3.2 The NHS 111 had six contacts with Sarah due to variety of ill health concerns. These varied from physical injuries including broken ribs following a fall, scalding her feet, through to breathing difficulties. These contacts resulted in advice and being signposted to either her GP or secondary healthcare.

15.4 Norfolk and Norwich University Hospitals NHS Foundation Trust

15.4.1 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 gynecological specialists.

15.4.2 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). Attendance at other specialists presented opportunities for more curiosity, such as at the plastics clinic where historic swelling to her jaw were apparent.

15.5 Norfolk and Suffolk Foundation Trust

15.5.1 Sarah first came to the attention of Mental Health Services as a routine referral (to be seen within 28 days) through the NSFT Single Point of Access (SPOA) by her General Practitioner (GP). The presentation was described as one of anxiety, depression, panic attacks suicidality and self-harm. Following 2 missed appointments she was referred back to her GP. She next came to notice (12/04/20) when seen by the Mental Health Liaison Team (MHLT) at the local acute hospital (NNUH) following 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 be seen within 120 hours) to the local Crisis Resolution and Home Treatment Team (CRHT) for ongoing care. On 15/04/20 the referral was reviewed and passed to the community team. Sarah was contacted on 16/04/2020 and it was agreed she did not meet the criteria for an urgent assessment, an appointment was agreed for 21/04/2020. Further assessment took place by Community Mental Health team (CMHT) a week later, after which she was signposted to external agencies and discharged back to GP.

15.6 Norfolk Constabulary

15.6.1 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.

15.6.2 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.

15.6.3 On the second occasion, he was dealt with by way of a caution.

15.7 Norfolk County Council HR

15.7.1 Sarah was employed by Norfolk County Council between 28 September 2015 and 12 June 2016 as a 5-19 Outreach Practitioner. The purpose of this role was to engage with hard-to-reach young people and those at risk of poor outcomes to build relationships to influence aspirations and behaviours that improve outcomes in health, education, employment, reduce anti-social behaviour.

15.7.2 Her line manager was aware of personal issues, and he had given her some time off to find alternative accommodation. 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.

15.7.3 Sarah left the council and had explained this was owing to a decision to move to Nottingham. She subsequently applied for a deferred pension benefits and this did not conclude until 2018.

15.8 Occupational Health

15.8.1 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.

15.8.2 This assessment provides a unique insight into Sarah's life.

16. ANALYSIS

The analysis of this review explores the reasons why events occurred, how and whether information was shared and, subsequently, whether the sharing informed decisions and actions taken. This section is broken down into three parts, the definition of domestic abuse, an analysis overview, and a detailed analysis of agency involvement against the lines of enquiry.

16.1 Domestic Abuse Definition

16.1.1 This review is undertaken in accordance with Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

16.1.2 The government definition of domestic abuse within that guidance is: - Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited, to the following types of abuse: psychological, physical, sexual, financial, emotional.

16.1.3 Controlling behaviour is defined as: - A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

16.1.4 Coercive behaviour is defined as: - An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

16.1.5 In April 2021, the Domestic Abuse Act received Royal assent and provided a statutory definition of domestic abuse that is shown at appendix A, but otherwise summarised as: - *Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if A and B are each aged 16 or over and are personally connected to each other, and the behaviour is abusive. Behaviour is abusive if it consists of any of the following; (a) physical or sexual abuse, (b) violent or threatening behaviour, (c) controlling or coercive behaviour, (d) economic abuse, (e)psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.*

16.2 Analysis Overview

16.2.1 In order to try and understand why this tragic event took place, the review panel first considered events from the perspective of Sarah's lived experience, from her childhood experience of abuse, through experience of abuse with her first marriage, evidence of an

abusive relationship with her partner Samuel, the extent of/history of self-harming and then links between suicide and domestic abuse. This overview summarises some of the matters arising, before moving on to the detailed agency analysis against key lines of enquiry.

Childhood Experience

16.2.2 When assessed by Norfolk and Suffolk Foundation Trust (24.04.2020) she disclosed emotional and physical abuse as a child that amounts to adverse childhood experiences, which may be helpful to understand Sarah. A report entitled Welsh Adverse Childhood Experiences (ACE) Study[12] supports this, saying "the prevalence of being a victim of violence was over nine times higher in participants who had recorded an ACE count of four or more than those who had been exposed to no ACEs". The same articles describe the long-term negative impacts of ACEs on a person's life such as "Children raised in environments where violence, assault and abuse are common are more likely to develop such traits themselves as these behaviours are seen as normal (i.e., normalised); leaving them more likely to both commit violent acts and/or be the victim of such acts in adulthood.".

16.2.3 Other articles suggest means of addressing the effects of ACE's, such as an article 'Adverse Childhood Experiences: Impact, Prevention, and Treatment' that reported " A comprehensive analysis of systematic reviews published in 2020 found that the most effective psychotherapeutic approach for treating people who have experienced ACEs is cognitive-behavioural therapy rather than broad support interventions, parental training, or other psychotherapeutic approaches".[13] The analysis of agency responses does not indicate that CBT was considered by agencies as part of an holistic response to Sarah's condition.

Domestic Abuse

16.2.4 During her assessment by NSFT, Sarah reported that she had entered marriage to escape her father. She explained that this relationship that lasted 25 years was also abusive, supporting the comments made above.

16.2.5 During the relevant period, the chronology showed that there were three reports of domestic abuse, but the analysis will show that routine enquiry and opportunities to identify signs of domestic abuse were not acted upon consistently across agencies, nor was she asked. In effect missed opportunities to show professional curiosity and opportunities to strengthen policies around routine enquiry.

Financial Abuse

16.2.6 Whilst it is not clear from the information 'reported' to agencies that events were part of a pattern of controlling, coercive and abusive behaviour perpetrated by Samuel, the accounts of Sarah's daughter and friend both indicate financial abuse during their relationship. The hidden harm of financial abuse is highlighted in an article by the FCA (Financial Control Authority) that reported, "*One in five women and one in seven men has suffered some form of financial abuse typically at the hands of their partner. Like all domestic abuse it is a hidden crisis that goes on behind closed doors, and lockdown, however essential for public health, will have made matters worse for many victims*." [14]

Self-Harm

16.2.7 The chronology clearly shows a history of self-harm and the report by an occupational health (OH) specialist in 2018, provides detail of what she reported at that time, which provided the panel an insight of her 'lived experience'. The account given by Sarah included the following.

- She developed symptoms of mental illness in her teenage years when she adopted the coping strategy of self-harm.

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[12] Source: 2016_01_adverse_childhood_experiences_and_their_impact_on_health_harming_behaviours_in_the.pdf (ljmu.ac.uk) (Accessed March 2022)

[13] Source: Adverse Childhood Experiences: Impact, Prevention, and Treatment - The Human Condition (Accessed March 2022)

[14] Source: The hidden harm of financial abuse | FCA Insight (Accessed February 2024)

- That she self-harmed during her working career, but that she did not divulge this to her employers as she was aware that this would result in consideration of her suitability to continue in her career.
- She summarised that she believes nine separate medication approaches have been trialed to control her mood, but she feels these have not been successful. She indicates that she has attempted significant self-harm nine times this year and this has included using a metal toolbox to break her ribs. As recently as last week she used the knife on herself. Currently she is taking high-dose antidepressant and beta-blocker.
- She told me that last week she was referred to a psychiatrist and will be placed on a waiting list to see them.
- She referred to anticipated waiting times to see a specialist.
- That she would not be able to leave the house on 3 or 4 days out of 7 and that she further self-harmed by starving herself

16.2.8 These incidents of self-harm were varied in nature, and it would seem possible from the account above, that some injuries reported to health professionals, such as the injury to her ribs were incidents of self-harm. Indeed, when considering her scalding injury, and a report 'Suicide and Self Harm by the Mental Health Foundation that noted, 'A survey of women who self-injured found that 90% had cut themselves and a third had inflicted blows or scalded themselves'[15], one may contemplate three possibilities, accident, assault, or self-harm. This reminds us of the need for professionals to be professionally curious and have an investigative mindset. Moreover, the panel learned that self-harm is an increasingly recognised phenomenon and one of the strongest predictors of suicide, which continues to be one of the leading causes of death.[16]

Suicide and Domestic Abuse

16.2.9 In 2018, Refuge and The University of Warwick published research that investigated the link between domestic abuse and suicide that was commissioned to fill gaps in the knowledge about factors that might predict, contribute to or mitigate against the risk of victims taking their own lives.[17] The findings of this review provide a useful lens from which to consider Sarah's situation and the agency analysis against the terms of reference. The report's key findings were.

- Damaging *gaps and delays* were observed by staff who referred clients to community services.
- Short term *risk management* approaches were often cited as inadequate to address suicidality, particularly when facilitating its disclosure.
- Limitations of existing *tools* to assess risk of harm from the client to herself particularly over a broad timescale were highlighted.
- The need for *trauma-informed approaches* to practice, for clients and for the workforce were identified.

16.2.10 Whilst an examination of an academic report risks the counsel of perfection that is hindsight bias, it is unavoidable that the information about Sarah's lived experience, and her interaction with agencies may be cross referenced with some of the above report's findings. For example.

- (Gaps and delays) the analysis below will show that she was referred to various services and yet does not appear to have taken up these referrals, and was referred to specialist secondary health care on two occasions, the first occasion being typified by not attending, and the second occasion being referred back to GP and given information around other sources of help;
- (Risk management approaches) risk management focusing on symptoms, rather than underlying causes, though it is fair to say secondary healthcare did identify historic

[15] Source: *suicide-self-harm.pdf (mentalhealth.org.uk) Accessed April 2022
[16] Source: Self-harm & Suicide - ACAMH (Accessed April 2022)
[17] Source: WRAP-Domestic-abuse-and-suicide-Munro-2018.pdf (warwick.ac.uk) (Accessed January 2022)

domestic abuse from a former partner, though adverse childhood experiences were not disclosed to medical professionals.

- (Risk assessment tools) when considering risk management, the tools for assessment will be shown as being unclear and that linked care planning could be improved.
- (Trauma informed approaches) the analysis will show that whilst Sarah was signposted to organisations for counselling, arguably the focus was on pharmacological treatment.

16.2.11 The scale of the challenge is further illustrated by Safelives who quote. “It is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse and every week three women take their own lives”.[18]

Suicide and Isolation

16.2.12 Sarah’s daughter described several contributory factors, describing her isolation by virtue of the control exercised in the relationship, but also by virtue of losing her job, then losing her wider contact with people through volunteering at a local charity shop owing to the lockdown restrictions during the covid pandemic. In an article, “Women and suicide: the dangers of social isolation”, a number of points are made, including; “Studies already show that the pandemic is having a profound effect on many people’s mental health. Ongoing research from the University of Essex indicates this has particularly been the case for women, whose mental wellbeing has declined by twice as much as men’s during this time” and “Having less social contact was shown to have the strongest influence on women’s wellbeing – more so than caring and family responsibilities or work and financial pressures”.[19]

Introduction to analysis of agency involvement

16.2.13 The following sections deal with the analysis of agency involvement with regard to lines of enquiry. Where learning opportunities are identified, these will be highlighted, and for each learning opportunity an appropriate response will be put forward, in the form of options that include an individual agency recommendation and/or an overview report recommendation. If learning opportunities do not necessitate a recommendation, the rationale will be summarised, and the learning opportunity highlighted in an overall recommendation around sharing the learning of this review.

16.3 Sherwood Forest Hospitals NHS Trust

Line of Enquiry (LoE1)– Communication and Co-operation between agencies

16.3.1 Sarah came to the attention of the hospital on one occasion only (06/01/2017). The emergency department promptly consulted with liaison psychiatry to ensure appropriate assessment and follow up of potential mental health/self-harm concerns. A discharge note was also sent to the GP on her discharge.

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

16.3.2 Sarah had called for an ambulance herself as she realised after drinking heavily and taking painkillers, she was feeling unwell. The trust encourages enquiry about domestic abuse by including a prompt ‘is this presentation related to domestic abuse’. This is recognised as positive, though it is not mandatory to ask a patient about domestic abuse.

16.3.3 Whilst it was not clear from the records whether she was specifically asked about abuse, it is apparent that she neither volunteered or was asked about the circumstances that had brought her to hospital and she spoke about recent ‘stressors’ including a boiler breakdown

[18] Source: How widespread is domestic abuse and what is the impact? | Safelives (Accessed July 2022)
[19] Source: Women and suicide: the dangers of social isolation (theconversation.com) (Accessed June 2022)

and a relationship breakdown, stating that they had resolved their issues and would be returning to his address in Norfolk.

16.3.4 On considering routine enquiry in greater depth the panel explored several contradictory reports on the efficacy of routine enquiry. Whilst the Cochrane report found a two-fold increase in identification of Domestic Abuse, it also found that there was no increased uptake in accessing specialist provision and concluded there was insufficient evidence to justify implementation of IPV screening for all women in healthcare settings.[20] However, the British Journal of General Practice reports "evidence suggests that routine or universal healthcare screening for DA improves levels of victim identification in primary care settings".[21]

Line of Enquiry (LoE3) – Response to domestic abuse – self harm issues

16.3.5 Sarah was not identified as having needs associated with domestic abuse, and she declined any signposting to other services, but accepted contact information before she was discharged. There was no further information available to provide information at this one presentation that suggested a need for other proactive measures, and it is noted, she had said the overdose was impulsive and she did not intend to harm herself, hence calling an ambulance when she felt unwell.

16.3.6 Having arrived at 10.22am, she was seen promptly by liaison psychiatry service at 11.35am. she declined referrals to local mental health services, but was provided with the contact information, before being discharged at 12.20pm. In effect, she was assessed swiftly regarding her physical and mental health, deemed to have capacity, and left the hospital with appropriate information.

Line of Enquiry (LoE4) – Access to specialist agencies

16.3.7 The Trust has a specialist nurse for domestic abuse in post. This has progressed now so that a specialist IDVA is contracted in from Nottinghamshire Women's Aid. This recognised as good practice.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.3.8 The trust reported that there are specific policies in place to support awareness of domestic abuse and that training is mandatory for all staff in relation to domestic abuse and additional specialist training is also available.

16.3.9 A copy of the Trust's patient Domestic Abuse Policy (2014) was provided and provides a useful reference point for staff and requirements.

16.3.10 The policy specifically cites that all frontline emergency staff will have level 2 training and be able to provide an initial response and complete a risk identification checklist. The policy continues that the domestic abuse specialist nurse will receive advanced training at level 4. This graduated approach to training is recognized as good practice.

16.3.11 The policy has a section on 'enquiry', with useful guidance about lines of enquiry, what to ask and recording of information. The policy includes flow diagrams for the emergency department and other departments separately, and whilst the panel representative confirmed that there are standard questions to ask regarding safeguarding and domestic violence, the second diagram describes 'if domestic abuse is disclosed,' suggesting a more passive approach. Whilst acknowledging the demands upon clinicians, the panel also reflected on a report by Safelives, "We only do bones here", that found 'Survivors have experienced a lack of understanding, awareness and support from the health system,

[20] Source: Source: Screening women for intimate partner violence in healthcare settings | Cochrane/ (Accessed February 2022)
[21] Source: Routine screening for domestic abuse | British Journal of General Practice (bjgp.org) (Accessed February 2022)

perpetuating the impact on their physical and mental health'.[22] The panel agreed there was an opportunity to encourage greater professional curiosity in the case of Sherwood Hospital, as there would be other health settings within this review.

16.3.12 Notwithstanding the policy being comprehensive, it was noted as having been last updated in 2017 and would benefit from a review given the evolution in knowledge around abuse and to include a section on types of domestic abuse such as inter-familial abuse. Given that the Domestic Abuse Act is now in place, this would seem a timely opportunity.

(LO1) Learning Opportunity: To bring the domestic abuse policy up to date and strengthen the approach to routine enquiry that affords survivors the chance to disclose domestic abuse. **Recommendation 1**: Sherwood NHS Trust to Review and refresh the Domestic Abuse Policy in accordance with legislative and best practice developments. (In line with Domestic Abuse Act)

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

16.3.13 Sarah's presentation at this hospital and trust was a 'one off'. Notwithstanding the points in respect of routine enquiry, we know that she spoke about stressors at home including a relationship breakdown. Whilst this may have prompted further professional curiosity to understand whether there was anything about the relationship, in isolation, the panel agree does not require further exploration.

Line of Enquiry (LoE7) – Impact of Covid

16.3.14 The contact with Sarah took place outside the period of the pandemic.

Line of Enquiry (LoE8) – Consideration as to Sarah being an adult at risk

16.3.15 This was a one-off presentation, where Sarah called the ambulance herself. This shows a presence of mind, and a capacity to make decisions that continued during her short visit to the hospital. There was nothing overt, nor disclosed suggesting broader care and support needs, or being an adult at risk.

Line of Enquiry (LoE9) - Equalities

16.3.16 There is no indication that any of the protected characteristics impacted upon the delivery of care.

Good Practice

16.3.17 The panel recognises that there appears to be a broad approach with a local patient policy, a domestic abuse nurse and more recently a locally commissioned IDVA working at the hospital.

16.4 General Practitioner (GP)

16.4.1 Sarah had around fifty contacts with her GP practice, including forty contacts with clinicians that followed her registration with the Norfolk GP practice in 2017. The practice was attentive and responsive to her mental and physical health needs ensuring timely specialist referral to secondary services and supported her. The practice showed itself to be patient led, specifically regarding changes to medication that is discussed below. The analysis below reflects key lines of enquiry that are not mutually exclusive.

Line of Enquiry (LOE1) – Communication and Co-operation between agencies

[22] Source: 'We Online Do Bones Here' - Why London needs a whole-health approach to domestic abuse_0.pdf (safelives.org.uk) (Accessed September 2022)

16.4.2 Sarah was seen by the surgery in relation to several physical ailments and her mental health. The practice made referrals to secondary care regarding her mental health appropriately and signposted her to counselling services on two occasions. Please see LOE3 for details of learning opportunities arising, that relate to feedback loops from counselling, and the extent to which services worked together regarding her mental health.

16.4.3 Communication and referral from the GP to secondary healthcare regarding physical ailments was appropriate to the nature of presenting conditions and it was also apparent that the GP was alerted to attendances at the emergency department following overdoses.

Line of Enquiry (LOE2) – Risk Assessment for domestic abuse and self-harm

16.4.4 On registering at the practice, the senior partner recorded an initial history that followed Sarah's admission to a hospital in Nottinghamshire following an overdose one month previously. This provided an early indicator of what triggered episodes of self-harm. She described historic events of an overdose in 1986, the slitting of her wrists following a divorce in 2009 and describing her most recent overdose following a relationship breakdown and financial worries. In her own words, she had said "Thinks trauma always push her towards stress and suicidal thoughts". This shows she was very self-aware of the triggers for her harmful behaviour.

Routine Screening & Risk Assessment for Domestic Abuse

16.4.5 This initial disclosure of relationship difficulties in February 2017, does not appear to have been probed further, raising a discussion point in respect of routine enquiry. There is a significant body of evidence suggesting the benefits, such as an article by the British Journal of General Practice that says "Evidence suggests that routine or universal healthcare screening for DA improves levels of victim identification in primary care settings".[23] Whilst it may be argued it is not practical to ask every patient about abuse, an examination of the chronology identified further opportunities to identify 'triggers' or 'flags' that merited improved professional curiosity and an opportunity to ask her about her current relationship;

- April 2017, when the GP carried out a home visit. Sarah said she had hurt her ribs following a fall whilst decorating at home which given her history may have been an opportunity to enquire further, though it has been confirmed the GP did not observe anything concerning at the home.
- Similarly, during a follow up call on 11th May, she said that she was worrying about issues from the past that could have prompted a question as to why she was reflecting on the past and asked her about her current safety and relationship, though she was signposted to wellbeing services as an adjunct to the medication.
- In July and September of 2017, she saw her GP with regards to unexplained bleeding following sexual intercourse. Whilst subsequent medical procedures did not find a cause, the phenomenon of rough sex that is 'sexual activity in which one or both participants risk bodily harm'[24] is not documented as having been considered.
- In November 2017 Sarah was in a depressed mood, with "lots of issues going on with ex- partner", that provided an opportunity to explore issues further with her.

16.4.6 During panel discussions, the chairs attention was drawn to Quality Standard [QS116] of the NICE guidelines that deals with asking about domestic violence and abuse. Helpfully, this highlights a range of potential indicators including symptoms of depression, suicidal tendencies, or self-harming and traumatic injury.[25] However, on none of these occasions was she asked about abuse.

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[23] Source: Routine screening for domestic abuse | British Journal of General Practice (bjgp.org) (accessed February 2022)

[24] Source: Rough sex | definition of rough sex by Medical dictionary (thefreedictionary.com) (Accessed March 2022)

[25] Source: Quality statement 1: Asking about domestic violence and abuse | Domestic violence and abuse | Quality standards | NICE (Accessed March 2022)

16.4.7 The panel therefore agree that there were opportunities to identify 'triggers' or 'flags' and on occasion demonstrate improved professional curiosity and make a routine enquiry. A suggestion made at the panel was to adopt the phrase, a 'duty to ask'.

(LO2) Learning Opportunity: To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse. **Recommendation 2:** Seek to 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. *(Parameters include training on health indicators, routine enquiry, and associated policy review)*

Adverse Childhood Experience

16.4.8 Risking the counsel of perfection that is hindsight bias, the panel also reflected on Sarah's history before what she disclosed to the GP. When assessed by Norfolk and Suffolk Foundation Trust (24.04.2020) she disclosed emotional and physical abuse as a child that amounts to adverse childhood experiences, that may have been helpful for the GP to understand her. A report entitled Welsh Adverse Childhood Experiences (ACE) Study supports this, saying "the prevalence of being a victim of violence was over nine times higher in participants who had recorded an ACE count of four or more than those who had been exposed to no ACEs". The same articles describe the long-term negative impacts of ACEs on a person's life such as "Children raised in environments where violence, assault and abuse are common are more likely to develop such traits themselves as these behaviours are seen as normal (i.e., normalised); leaving them more likely to both commit violent acts and/or be the victim of such acts in adulthood.". Other articles suggest means of addressing the effects such as an article 'Adverse Childhood Experiences: Impact, Prevention, and Treatment' that reported " A comprehensive analysis of systematic reviews published in 2020 found that the most effective psychotherapeutic approach for treating people who have experienced ACEs is cognitive-behavioural therapy (CBT) rather than broad support interventions, parental training, or other psychotherapeutic approaches".[26] It was therefore suggested that an even more comprehensive history may alert practitioners to the risk and vulnerability of patients, being more alert to potential triggers, but also consider where and who to signpost and refer patients to.

16.4.9 The panel explored how a more comprehensive history may be secured, including adapting the registration process, but learned that this is now carried out online, and that not all new patients would be seen by a GP at registration. The panel agreed it was not appropriate to consider asking about childhood experiences online, that risked re-traumatising patients, but there was a need to ensure sufficient awareness of ACEs within primary care that would encourage professional curiosity. Moreover, it seems that the concept of assessing ACEs to target treatment remains unclear. An article by the Association for Child and Adolescent Mental health notes, "The potential of using measures of ACEs to target treatment or as a screening tool has also been criticised. Others suggest ACEs are an 'indicator of risk' rather than a risk factor for poor mental health ".[27] It is not suggested that in this review a substantive recommendation is made, rather that the possibility of connection between childhood experience and adult health is kept in mind and is shared as broader learning.

(LO3) Learning Opportunity: Recognition that adverse childhood experiences can/may have an effect on long-term health and well-being. **Response:** The learning opportunity/observation will be shared with clinicians as part of broader learning from this review, and links with recommendation 9.

16.4.10 The senior partner maintained significant contact with Sarah in 2017, and she saw six other GPs that same year. During the remainder of the relevant period, contact was with several GPs, seeing six GPs once each in 2020. In Sarah's case this may have been important, in ensuring that the practice was aware of her history and triggers to harmful behaviours. The

[26] Source: Adverse Childhood Experiences: Impact, Prevention, and Treatment - The Human Condition (Accessed March 2022)
[27] Source: Links between adverse childhood experiences and self-harm - ACAMH (accessed May 2022)

BMJ reported “Patients who see the same GP are less likely to be admitted to hospital for certain conditions, researchers at the Health Foundation have found”.[28] After all, it may be argued that seeing one GP enables a patient to build up trust, not having to repeat their story and feeling safe talking to the same doctor. And conversely, one may argue that seeing different GPs, inadvertently creates barriers to sharing information and concerns.

16.4.11 In an attempt to look for any temporal sequencing, it appears that the volume of contacts was at its peak in 2017 with around 20 contacts, dipping in 2018 to around 9, with very few contacts in 2019, before 2020 when there were around 12 contacts and finally four contacts in first five months of 2021. It is therefore difficult to identify trends when Sarah’s mental health was deteriorating. Indeed, it is noted that none of the contacts in 2021 related to or mentioned mental health concerns, that may suggest a period of stability in her life.

Risk assessment for Self-Harm

16.4.12 Sarah had a history of self-harm and suicidal ideation and was diagnosed with anxiety disorder (1.3.18). the NHS helpfully describes anxiety as “a feeling of unease, such as worry or fear, that can be mild or severe” and continues to explain that general anxiety disorder is “a long-term condition that causes you to feel anxious about a wide range of situations and issues, rather than one specific event”.[29]

16.4.13 The link between suicidal ideation, suicide and domestic abuse is well recognised, with several reports describing the link. A report by Refuge in conjunction with Warwick University entitled ‘Domestic Abuse and Suicide’ highlighted a number of points including;
- almost a quarter (24%) of refuge’s clients felt suicidal at one time or another.

16.4.14 Other reports provide important information, such as the statistical link between self-harm and suicide. A national strategy ‘Preventing Suicide in England’ notes that groups at high risk of suicide are people with a history of self-harm and at least half of people who take their own life have a history of self-harm’.[30] Sarah fell into this category.

(LO4) Learning Opportunity: Recognition that self-harm and suicidal ideation are potential indicators of patients experiencing domestic abuse.
Recommendation 2: Seek to 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. *(Parameters include training on health indicators, routine enquiry, and associated policy review)*

16.4.15 The panel representative explained that if a patient presents for the first time with suicidal thoughts or if a GP is already familiar with a patient and they present with a deterioration in their mental health the expectation would be a risk assessment is conducted which is an enquiry for a patient’s active suicidal thoughts or ideation. If these are expressed, the suicidal thoughts are explored further including any plans, previous suicide attempts and, previous mental health admissions. The practical questions that are asked may include; *Do you feel your life is not worth living? Have you made any attempts to hurt yourself or end your life? Further exploratory questions may include; Was this planned? Did you leave a suicide note?* At this point, the GP may then refer to specialist mental health services if appropriate. It was clarified that a mental health review is a more routine, non-urgent encounter, such as at a follow up consultation in response to changing medication. *(1st February 2018, 22nd February 2018, 27th April, 2018, 30th May 2018)*

16.4.16 Analysing the chronology for deterioration/changes in mental health, there are clear notes of risk assessments being completed by the senior partner (GP1) on these occasions.

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[28] Source: Seeing same GP is linked to fewer hospital admissions | The BMJ (Accessed March 2022)
[29] Source: Overview - Generalised anxiety disorder in adults - NHS (www.nhs.uk) (Accessed March 2022)
[30] Source: *Preventing suicide in England - A cross-government outcomes strategy to save lives (publishing.service.gov.uk) (Accessed March 2022)

However, there were occasions when it was not clear whether a risk assessment was completed.

- On 22.11.17 Sarah had depressed mood and was tearful with 'lots of issues going on with ex-partner' The IMR author notes this as a missed opportunity to explore psychological issues further
- On 27.4.18, she reported occasionally feels suicidal, no risk assessment noted, but a mental health review conducted.
- On 7.11.18, it was noted "afraid to go out- self-harming- tried to cut out a lump in her neck and cutting wrists". However, she was referred to mental health team.

16.4.17 This was explored by the panel representative who confirmed that risk assessments were completed on these occasions, suggesting a need to remind clinicians use terminology consistently. The panel also noted that Sarah had not presented to medical professionals with concerns about her state of mind, and depression since April of 2020, around 1 year prior to her death, thereby obviating the need to make a recommendation in these specific circumstances.

(LO5) Learning Opportunity: To ensure consistent use of terminology regarding risk assessment and mental health reviews. **Response:** The learning opportunity/observation will be shared with clinicians as part of broader learning from this review dealt within recommendation 9 & 9a that describe how the learning from this review will be shared.

16.4.18 The panel representative also explained, that when a patient presents with a new mental health presentation or worsening of a current mental health illness, a brief "mental state examination" can be completed. This is often completed in more detail by mental health services. It covers the following areas[31]:

- *Appearance and behaviour: appearance, motor behaviour and attitude to situation and examiner.*
- *Speech: rate, volume, quantity of information; disturbance in language or meaning. Mood and affect: mood (e.g., depressed, euphoric, suspicious); affect (e.g., restricted, flattened, inappropriate).*
- *Content of thought: delusions, suicidal thoughts, amount of thought and rate of production, continuity of ideas.*
- *Perception: hallucinations, other perceptual disturbances (derealisation; depersonalisation; heightened/dulled perception)*
- *Cognition: level of consciousness, memory (immediate, recent, remote), orientation (time, place, person), concentration: serial 7s, abstract thinking.*
- *Insight: extent of the individual's awareness of the problem.*

16.4.19 It should be noted that not all aspects of the mental state examination may be relevant for example cognition is only assessed if there is a concern about memory impairment.

16.4.20 On considering the available tools for assessing risk, the panel learned that risk assessment in relation to self-harm and suicidal ideation is problematic, with the BMJ reporting "Risk assessment is challenging for several reasons, not least because conventional approaches to risk assessment rely on patient self-reporting and suicidal patients may wish to conceal their plans. Accurate methods of predicting suicide therefore remain elusive and are actively being studied"[32] Conversely, the department of Health in its publication 'Best Practice in Managing Risk'[33] cites 6 tools for assessing risk of suicide.

16.4.21 The panel also explored the use of the PHQ9 tool (patient health questionnaire) that is used to both diagnose depressive illness and to assess its severity. In discussion with the panel

[31]Source: https://patient.info/doctor/psychiatric-assessment#nav-1 (Accessed October 2022)

[32] Source: studied Suicide risk assessment and intervention in people with mental illness | The BMJ (Accessed February 2022)

[33] Source: Best Practice Managing Risk Cover (publishing.service.gov.uk) (accessed March 2022)

representative, it was learned there had been a requirement historically to use this tool, but this is no longer the case, and it is not deemed as a risk assessment tool.

16.4.22 The conundrum of assessing risk is perhaps informed by a BMJ article that summarises, “Suicide is a behaviour and not a diagnosis. Suicide cannot be predicted accurately in any given individual at a single point in time. Suicide usually occurs as a result of a multifactorial process, where vulnerability to suicide may be generated over several weeks, months, or years”[34] The summary continues “Clinicians, patients, and their carers (supporters) are calling for a paradigm shift in suicide risk assessment that moves away from “characterising, predicting, and managing risk’ towards ‘compassion, safeguarding, and safety planning” In the meantime, clarification has been provided by the panel representative at (see 16.4.15/16) as to the general approach and questions regarding assessing suicide risk that were used in Sarah’s case. This forms part of basic psychiatric training for GPs.

16.4.23 The challenge of assessing risk was subject of further discourse outside the panel meetings with Public Health, and the chair was signposted to a recent Public Health Audit regarding Suicide in Norfolk.[35] The report found that “*A significant percentage were being supported with their mental health problems by their GP or receiving a prescription for antidepressants. Some did not meet the threshold for specialist intervention with mental health issues or may have refused to go to specialist agencies for mental health or substance misuse support. GPs are therefore sometimes responsible for supporting people at significant risk of suicide”.*[36] The report makes several recommendations one of which relates to the implementation of the ‘SAFEtool’[37] that culminates in identifying and maximising strengths, assets, and protective factors with the co-production of a safety plan for patients.

- Consideration could be given to the ‘Connecting with People’ Training and Suicide Assessment Framework E Tool (SAFEtool or other local developed risk assessment tools.

16.4.24 The chair met with the GP panel representative outside the panel, who was unaware of the audit recommendation, nor SAFEtool. Moreover, when reviewing requirements of the SAFEtool, it was observed this would require completion of a safety plan and a ‘my wellbeing action plan’. On balance, the representative does not believe this would be practical within the timeframes allowed within ten-minute patient consultations. In other words, a significant practical problem to the systemic change to assessing suicide risk. In panel discussions, it was learned there are 105 GP practices within the locality, that would present a considerable logistical challenge for the Integrated Care Board to recommend wholesale change across the system.

16.4.25 As the review was concluding, the chairs attention was drawn to recently published NICE guideline (NG225) regarding ‘Self-harm: assessment, management and preventing recurrence’[38]. This article provides clear advice as to the use of risk assessments, clarifying what had been an ambiguous position for the panel, with section 1.6 of this article specifically stating, “*Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm*”.

16.4.26 Whilst the panel does recognise the potential to make improvements to suicide risk assessment, it would seem the first step would be to ensure that the suicide audit recommendation is subject to discourse between Public Health and Integrated Care Boards who commission GP practices. The chair met with representatives from public health who agreed they were best placed to pursue this learning opportunity and recommendation below.

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[34] Source: Suicide risk mitigation - Symptoms, diagnosis and treatment | BMJ Best Practice (Accessed April 2022)

[35] Source: Microsoft Word - Norfolk Suicide Audit 2019 vFINAL 3 (norfolkinsight.org.uk) (Accessed July 2022)

[36] Source: *Microsoft Word - Norfolk Suicide Audit 2019 vFINAL 3 (norfolkinsight.org.uk) (Accessed July 2022)

[37] Source: Training-and-suicide-assessment-framework.pdf (healthylondon.org) (Accessed July 2022)

[38] Source: Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE (Accessed April 2023)

(LO6) Learning Opportunity: An opportunity to strengthen and/or standardise the approach to suicide risk management and safety planning.
Recommendation 3: The Integrated Care System (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.

Line of Enquiry (LOE3) – Response to domestic abuse – self harm issues

Domestic Abuse

16.4.27 Domestic abuse was neither identified nor asked about, and therefore the response to Sarah's presentation of domestic abuse is limited save to reflect on the learning opportunities identified above.

Self-Harm

16.4.28 The national strategy 'Preventing Suicide in England' has 6 key areas for action, that includes; - reducing the risk of suicide in key high-risk groups; - tailor approaches to improve mental health in specific groups; - reduce access to the means of suicide; - providing information and support to those bereaved or affected by suicide; - support the media in delivering sensitive approaches to suicide and support research, data collection and monitoring. Whilst these may be seen as high-level strategic aims, it does provide helpful information such as referencing factors that would have been apparent in Sarah's case, as being at heightened risk of suicide; - those with a history of self-harm; - that violence and abuse can lead to a number of psychosocial problems associated with suicide; -and untreated depression can heighten the risk of suicide; - smoking and nicotine dependence are associated with suicidal behaviour (though there is no evidence to suggest that smoking cessation increases suicide risk)

Medicine – Pharmacological Treatment

16.4.29 The chronology provides clear evidence of treatment by way of medication, and of being very responsive to Sarah, and working with her in changing her medication when it did not agree with her, or in adjusting medication dosage (in February, March and May) Upon discussion, the GP panel representative acknowledged that this common, and in her case appears to be patient led, but is consistent with NICE guidelines that say, "patients should be reviewed every 1–2 weeks at the start of antidepressant treatment. Treatment should be continued for at least 4 weeks (6 weeks in the elderly) before considering whether to switch antidepressant due to lack of efficacy. In cases of partial response, continue for a further 2–4 weeks (elderly patients may take longer to respond)." [39]

16.4.30 In January 2020, a smoking cessation advisor recommended a medication called champix (varenicline) to reduce the nicotine cravings. The IMR author reported that the British National Formulary advises to use with caution in "history of psychiatric illness (may exacerbate underlying illness including depression)". However, a study by the Medicines and Healthcare Regulatory Agency (MHRA) found no clear evidence that varenicline was associated with an increased risk of fatal or non-fatal self-harm.[40] However, the IMR author has made a specific recommendation regarding this learning point.

(LO7) Learning opportunity: Raising awareness of co-morbidities and medication that may impact on use of medications used for smoking cessation.

[39] Source: Antidepressant drugs | Treatment summary | BNF content published by NICE (Accessed March 2022)
[40] Source: Varenicline and suicidal behaviour: cohort study provides some reassurance - GOV.UK (www.gov.uk) (Accessed March 2022)

Single Agency recommendation: 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.

16.4.31 More broadly, we know that Sarah took her own life by means of an overdose of medication. The review identified that the practice had prescribed a range of medications in respect of pain relief (14.2.13), and a variety of medications in respect of her mental health (14.2.19). On considering this, the chair explored the work of the local Public Health department who explained that they are currently undertaking a piece of work around anti-depressant prescribing in Primary Care, the aims of which are.

- *To review primary care guidance, good practice and recommendations relating to suicide prevention and anti-depressants, considering that a local suicide prevention audit highlighted numbers of people who took their own lives, having been prescribed anti-depressants, but what little guidance is available suggesting this is not effective.*
- *To undertake a research paper on the effective treatments of depression to prevent suicide, including non-clinical interventions at the primary and pre-primary care level, that can create pathways into the suicide prevention action plan.*

16.4.32 The panel cognisant of observations made by Sarah's daughter in respect of changes in medication (14.1.3) welcome this local project, that may be informed by a case such as Sarah's.

Specialist therapy, Mental health, and multi-disciplinary working

16.4.33 During the relevant period, in February and May 2017, Sarah was signposted to a Norfolk Wellbeing Service, a local counselling service for self-referral. This in accordance with NICE guidelines that state, "Patients with generalised anxiety disorder, a form of chronic anxiety, should be offered psychological treatment before initiating an antidepressant." [41] Subsequent entries show no further reference to these self-referral opportunities, such as asking her how she had got along with those referrals or whether she had followed them up. The panel representative agreed it would be best practice for clinicians to follow up with patients on subsequent attendance. The panel did consider whether system change was required, but balancing the learning opportunity as an observation, the panel agree a proportionate response that this observation be highlighted to clinicians as part of the broader learning of this review.

(LO8) Learning opportunity: For the practice to close the feedback loop with patients and ask how referrals had progressed.
Response: The learning opportunity/observation will be shared with clinicians as part of broader learning from this review dealt within recommendation 9 & 9a that describe how the learning from this review will be shared.

16.4.34 In 2018, Sarah continued to report low mood and suicidal ideation. Managed through medication, her panic attacks increased, her anxiety described as getting worse with reported cutting of wrists. Whilst she was referred to secondary mental health care (November 2018), several matters arose in discussion. Firstly, there was no evidence of her being asked why her anxiety was worsening, in other words looking for any potential trigger. This links with point 16.4.15 above.

(LO9) Learning opportunity: Through improved professional curiosity understand why people's anxiety/depression fluctuated.
Recommendation 2: Seek to 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

[41] Source: Antidepressant drugs | Treatment summaries | BNF | NICE (Accessed June 2022)

16.4.35 Secondly, whilst NSFT closed the feedback loop by informing the GP she had not attended appointments, there was no subsequent evidence of her being asked why she had not attended when she saw her GP in late December 2018. Indeed, when she attended A&E on 12th April 2020, she reported that she was still on the waiting list, indicating a breakdown in communication between health care and patient. In discussion with the panel representative, the records do not reflect receipt of the letter from NSFT informing them of her not attending. This raised several matters including, how such communications are handled, how they are triaged, and information passed to the GP and who performs this role, administrative staff, or secretaries. In discussion with the panel representative, two possibilities arise, the first being no evidence of a letter being received, the second if received, not scanned to records. Whilst it is not for the review to determine the solution, matters such as task check lists were discussed. However, the panel agree that without evidence to show what had happened to the letter, such as not received, or received and not filed, it is problematic to suggest a remedy. The only means of the GP knowing if Sarah had attended referrals would be to contact that agency. This, the panel agree would not be proportionate, given the volume of patients who are referred from GP practices.

(LO8) Learning opportunity: For the practice to close the feedback loop with patients and ask how referrals had progressed. **Response:** The learning opportunity/observation will be shared with clinicians as part of broader learning from this review, and links with recommendations 2 & 9

16.4.36 In April 2020 Sarah presented to NNUH Accident and Emergency department having taken an impulsive overdose of her prescribed anti-anxiety medication (propranolol) with vodka after her son left home to live with his new partner taking on a big mortgage. She was referred to and assessed by the liaison mental health team by telephone due to covid-19 restrictions. Following assessment, she was discharged back to the GP surgery without planned follow up. This required the GP to make a new mental health referral on 14.04.2020. The IMR author reflected this was a potential missed opportunity for the mental health specialist to provide ongoing care, making an individual agency recommendation regarding this point. A similar observation is made by the author of the NSFT IMR suggesting a need to jointly review the communication pathways.

(LO10) Learning opportunity: To improve/streamline the communication and referral pathways between primary and secondary healthcare. **Response:** This has been resolved, with the liaison team in the acute trust being able to directly re-refer back to secondary mental health services

16.4.37 Later, in April (30th), a GP discussed a review of Sarah's medication. She was also seen on 22nd May, 9th July, 30th November. In addition, given that she had been signposted by NSFT to the Sue Lambert Trust, The Harbour Centre and The Survivors Trust, the panel agree that it would have been useful to discuss with her whether she had followed up this information, and if so, how they had helped. This adds weight to the learning opportunity cited above (LO10) but also suggest an opportunity to explore how partners work together in such cases.

16.4.38 On considering care plans, and long-term management, NICE guidelines (CG133) suggest that care plans should be reviewed with the patient, describing the aims of treatment, and be revised at agreed intervals of not more than one year.[42] Care plans are not documented or referred to within the chronology. The guidance goes on to recommend that 'Care plans' should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers, or significant others. Care plans should:

- identify realistic and optimistic long-term goals, including education, employment, and occupation.
- identify short-term treatment goals (linked to the long-term goals) and steps to achieve them.

[42] Source: Source: 1 Guidance | Self-harm in over 8s: long-term management | Guidance | NICE (accessed March 2022)

- identify the roles and responsibilities of any team members and the person who self-harms.
- include a jointly prepared risk management plan (see below) be shared with the person's GP.

16.4.39 This guidance suggest that mental health services should generally be responsible for the longer-term assessment, treatment, and management of self-harm. In these circumstances, this may create a gap, for patients such as Sarah, as the panel learned that care planning is only done for those accepted into secondary mental health care and she never met the threshold for ongoing mental health services. However, it is known that during the relevant period, the practice signposted her to counselling twice in 2017, to mental health services once and were invited to re-refer to mental health services on a second occasion. We also know that NSFT signposted to other agencies and yet she did not engage with these agencies. We also know that Sarah's capacity was never questioned, save at time of crisis when intoxicated, and that her daughter said that she was unlikely to have sought other help. One may therefore argue that any additional tactics relying on Sarah heeding advice/referrals may not have resulted in engagement with other services. Once again, the point arises in relation to the benefit of enquiring how a patient has progressed with referrals.

Patient & Carer involvement

16.4.40 The national strategy 'Preventing Suicide in England' noted above suggests that risk assessment should be an integral part of clinical assessment, not a separate activity, and service users (and their carers) should be given a copy of their care plan, including crisis plans and contact numbers. What is clear from records (checked by the panel representative), was that Sarah was involved in formulating a plan. The correspondence from NSFT from 24th April 2020 has a heading "interim care and safety plan" which states she would like to try alternative medication and would be signposted for support. A further letter addressed to Sarah and copied to the GP provides written information signposting her to the Sue Lambert Trust, Harbour Centre and Survivors Trust and asks the GP to add in another antidepressant. In this letter NSFT advised her to ask the GP to refer her again if she "requires our service in the future. This shows that there was effective communication with the GP, as well as involving Sarah in treatment by NSFT. It is noted that the research carried out by NCSP shows that the aforementioned agencies have no records of contact with Sarah.

Alcohol and Substance Misuse

16.4.41 Upon further examination of previous presentations at emergency departments regarding. Sarah overdosing, it is apparent that events took place under the influence of alcohol. Whilst not raised within the body of the IMR, it is clear from Sarah's daughter that alcohol and substance misuse played a big part in her life. This is also a factor that NSFT have identified as a learning opportunity, (16.7.11) without having had the benefit of Margaret's insight. Whilst in Sarah's final act, there is nothing to suggest that alcohol played any part, the panel's attention was drawn to articles that suggest, 'There is a strong association between alcohol misuse (either chronic or acute) and suicidal thoughts, suicide attempts, and death from suicide' and 'Alcohol can lower a person's inhibitions enough for them to act on suicidal thoughts. It suppresses activity in parts of the brain associated with inhibition. Any warning signals that may have kicked in if a person was sober are unlikely to work, which can lead to actions they might not otherwise have taken – including self-harm and suicide.'[43] In Sarah's case, it seems that there may have been an opportunity for improved professional curiosity as to the circumstances of previous impulsive overdoses, that may have enabled signposting to Norfolk's alcohol and drug behaviour service, 'Change, Grow, Live'. Alcohol misuse was also found to be the second largest factor in Norfolk's recent suicide audit.

[43] Source: Alcohol and suicide | Drinkaware (Accessed July 2022)

(LO11) Learning opportunity: Recognition of alcohol misuse as a factor requiring exploration for those experiencing suicidal ideation.
Recommendation 4: 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.

Line of Enquiry (LOE4) – Access to specialist agencies

Domestic Abuse

16.4.42 Notwithstanding commentary above regarding routine enquiry, at no point was there evidence in the records that Sarah was the victim of domestic abuse or violence and therefore she would not have been signposted to specialist services such as the 'Leeway DA helpline'.

16.4.43 Where DA is identified a comprehensive safeguarding policy (see comments under KLOE5), does signpost professionals where support is available.

Self-Harm

16.4.44 Sarah had been signposted by primary and secondary care to other organisations. Information on these organisations had been routinely and openly available in the GP surgery, but during covid were removed for hygiene reasons. These have now been replaced, and hard copy material is now visible and available.

Line of Enquiry (LOE5)– Policies, Procedures & training re domestic abuse

16.4.45 The practice benefits from a recently updated domestic abuse policy (May 22) with two sections, the first related to patients, the second related to staff. A process for dealing with disclosure, does include a helpful pathway including a section on enquiry, with a hyperlink to NICE guidelines and recognising domestic abuse. This section also notes that there is insufficient evidence to recommend screening or routine enquiry. Upon considering the discussion point at 16.3.34, it is agreed there is conflicting evidence. However, we know from Sarah's daughter and a statement from Sarah, that she did live with abuse, and yet she was never asked. In Sarah's case, it is suggested that the characteristics and presentations described within the chronology and analysis above (16.4.5, 16.4.6), merited a 'duty to ask', and that under these circumstances, the policy would benefit from review.

(LO12) Learning opportunity: Missed opportunities to ask about domestic abuse on the presentation of health indicators that may evidence domestic abuse.
Recommendation 2: Seek to 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.

16.4.46 The same policy provides guidance and sets expectations about training regarding safeguarding and domestic abuse. It may be suggested that as she was not asked about DA, there is a need to strengthen training and/or develop the focus for routine enquiry when patients display such symptoms. Linking this with policy amendments suggested above, this may provide an opportunity to refresh training requirements in terms of focus and frequency. It may be helpful to consider a framework for training, based upon a tiered system utilised in Wales, ranging from Group 1 - e-learning through to Group 2 – ask and act, group 3 – ask and act champions through to more strategic roles. [44]

(LO13) Learning opportunity: To strengthen the approach to training, to ensure staff are able to recognise and respond to domestic abuse.

[44] Source: National Training Framework on violence against women, domestic abuse and sexual violence | GOV.WALES (Accessed March 2022)

Recommendation 2: Seek to 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

16.4.47 The second chapter provides comprehensive guidance to staff and managers experiencing domestic abuse. This is recognised as good practice.

16.4.48 The IMR author also describes the role of 2 domestic abuse champions a practice nurse and safeguarding manager. The presence of DA champions is recognised as good practice.

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

Domestic Abuse

16.4.49 The existence of a domestic abuse section within the safeguarding policy helps to highlight the approach to domestic abuse.

16.4.50 Identification and response to indicators of abuse are documented above.

16.4.51 The panel explored whether the challenge of a patient seeing multiple GPs *(noted at 16.4.10)* and learned that some GP practices had previously had personal lists where a GP has a fixed set of patients within the wider practice population. The panel agree that there are advantages to this in providing continuity of care, but also note the reality is that may not be possible, with part time working, leave periods and other abstractions as well as the extensive work pressures frequently reported in the mainstream media. Furthermore, it may be argued that it is easier for patients to be given the opportunity to see any GP on the day they request an appointment, though a patient who wishes to see a particular GP may book in at the next available date with that GP. Whilst the panel agreed seeing the same GP would be best practice and considered the feasibility of making a recommendation in this regard, they were persuaded that this would not be achievable given current and foreseeable demands in primary healthcare. Therefore, this observation is suggested for wider learning on sharing this review.

(LO14) Learning opportunity:-Recognising there are benefits seeing the same GP to continuity of care.
Response: The learning opportunity/observation will be shared with clinicians as part of broader learning from this review dealt within recommendation 9 & 9a that describe how the learning from this review will be shared.

Self-Harm

16.4.52 The practice has demonstrated a patient focused approach, listening, and responding to Sarah in respect of her medication.

16.4.53 The practice may have shown improved professional curiosity, actively asking feedback from Sarah as to how referrals to counselling and mental health services had progressed. (See LO8 and LO10)

Line of Enquiry (LoE7) – Impact of Covid

16.4.54 There does not appear to have been any overt adverse impact of Covid on Sarah. However, the panel acknowledges the extraordinary pressures on the health service during the covid period. In an article by the Nursing Times published in January 2022, the chair of the general practitioners committee at the British Medical Association said “GP appointment figures for December were a staggering 20% higher than two years ago. And as well as vaccination rollout, we continued to care for patients with Covid, and deliver the day-to-day care our communities needed”.[45] There is also reporting on the effects of Covid on mental health,

[45] Source: Primary care nurses under pressure as GP appointment figures soar | Nursing Times (Accessed July 2022)

with the World Health Organisation reporting “A great number of people have reported psychological distress and symptoms of depression, anxiety, or post-traumatic stress. And there have been worrying signs of more widespread suicidal thoughts and behaviour”.[46]

Line of Enquiry (LoE8) – Consideration as to Sarah being an adult at risk

16.4.55 Safeguarding adults is defined as “Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances.”[47]

16.4.56 On considering the three conditions that would satisfy the needs for a local authority to undertake a safeguarding enquiry, the panel concur that there was nothing apparent to indicate she would have met the criteria set out below.

- **Condition 1:** The adult’s needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.
  - *In SARAH’s case mental capacity was clearly considered and there were no physical/mental impairment*
- **Condition 2:** As a result of the adult’s needs, the adult is unable to achieve two or more of the outcomes specified in the regulations.
  - *In SARAH’s case, there were no overt signs that any of the statutory ten outcomes for adults were a concern. (e.g., maintaining hygiene, managing nutrition, managing toilet needs, etc)*
- **Condition 3:** As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult’s wellbeing.
  - *Not applicable*

16.4.57 In Sarah’s case, she engaged with the GP throughout and has demonstrated capacity to make decisions. The panel agree, that whilst she had care needs, the three conditions above would not have been satisfied.

Line of Enquiry (LoE9) - Equalities

16.4.58 In 2020 around three-quarters of registered suicide deaths in 2020 were for men (3,925 deaths; 75.1%), which follows a consistent trend back to the mid-1990s.[48] This demonstrates the gendered nature of people taking their own lives.

16.4.59 Whilst the rate of suicide has fallen over the past forty years, a study conducted by a research team at the Menopause Experts Group has elucidated that suicide rates for women aged between 45 and 54 – the common age to be experiencing menopause or perimenopause – have risen by 6% in the last 20 years.[49]

16.4.60 In Sarah’s, she had displayed suicidal ideation and self- harming behaviour for many years, and whilst there is no evidence to suggest that the menopause was a factor, there is also no evidence to suggest it was not, and the panel therefore agree that it is a broader point of reflection in this case.

16.4.61 Upon discussion with local Public Health professionals, they reported they had observed increased numbers of women taking their own lives locally. There are difficulties in

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[46] Source The impact of COVID-19 on mental health cannot be made light of (who.int) (Accessed November 2022)

[47] Source: What is safeguarding? | SCIE (Accessed March 2022)

[48] Source: Suicides in England and Wales - Office for National Statistics (ons.gov.uk) (Accessed March 2020)

[49] Source: Menopausal women suicide rates are at their highest since 1996 (healtheuropa.eu)

recognising symptoms associated with menopause and hormone depletion. For those who already have exhibited an extended history of self-harm it could be even more challenging to identify an impact caused by or correlated with menopause. However, the research reviewed, and panel discussions suggest a practical way forward was in encouraging awareness through training a GP and nurse within the GP practice.

(LO15) Learning opportunity: To recognise the possibility of the menopause being a contributory factor that escalates the risk of self-harm/suicide.
Recommendation 5: To seek to raise awareness and the ability to recognise and respond to the risk of suicide associated with the menopause.

16.5 NHS111/IC24

16.5.1 The NHS 111 had six contacts with Sarah due to variety of ill health concerns. These varied from physical injuries including broken ribs following a fall, scalding her feet, through to breathing difficulties. These contacts resulted in advice and being signposted to either her GP or secondary healthcare.

Line of Enquiry (LoE1)– Communication and Co-operation between agencies

16.5.2 The panel learned that electronic messaging informed Sarah's GP of contact with NHS 111. This communication is one way, with a patient contacting NHS111 and passing this on to primary care or the ambulance service if the case is deemed to be sufficiently urgent. This does not provide the opportunity for greater inter-agency working, though contact can be made between agencies, it is not evident that this was required.

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

16.5.3 Of the six contacts, two related to medical matters that are not relevant to this review.

16.5.4 Of the other four calls, two related to injured ribs. The first call on the 2nd April 2017 and the second call on the 7th April regarded pain control for the injury. An examination of records states that the injury occurred after falling over and does not make it clear whether Sarah was asked how the injury occurred. Upon enquiry with the panel representative, it remains unclear whether she was asked. Whilst she was advised to attend the emergency department, it may be suggested that asking and recording how the injury had occurred may be useful in assessing the potential severity of injury, but through the lens of this review, whether it was resultant of an act of violence. After all, we know from elsewhere within this report, that Sarah's accounts for the injury vary from the one to the GP, where she apparently fell whilst decorating to, the account given to an occupational health professional of inflicting the injury on herself. One may therefore conclude that it may have been useful to ask how the injury occurred. Notwithstanding this, it was noted on both occasions that Sarah was not alone at the time, and therefore it is acknowledged it may not have been practical to make a routine enquiry that is subject of discourse elsewhere in the review. However, it may have been possible to ask a question, "were you alone when the injury occurred?"

16.5.5 That said, the policies for NHS 111 advise, "Carefully consider if it is safe to give advice on domestic abuse support & services at the current time – if the patient is with or is believed to be within earshot of the perpetrator, this could place them at greater risk of harm". In this case the records show that Sarah was not alone, though do not state who was present. The panel were informed that patients are routinely asked if they are alone, as a consideration of the circumstances if the patient's condition deteriorates.

16.5.6 The second two calls on the 18th and 20th July 2020 respectively relate to Sarah having spilled boiling water on to her feet. Sarah explained to the clinician/operator on the first call, that she had felt dizzy before the incident, and helpfully the consultation report linked to this incident states that 'the problem did not result from a suicide attempt or self-harm'. The second call related to seeking advice regarding having the injury re-dressed. On these

occasions, there is no record of her being asked whether she was alone or not, and as with the other incidents, no enquiry was made in relation to safety at home, or domestic abuse.

16.5.7 On considering the response to each contact, the panel learned that NHS111 work through an algorithm of questions when a patient calls. Known as "NHS Pathways telephone triage system". It is a clinical decision support system (CDSS) supporting the remote assessment of callers to urgent and emergency services.[50] The NHS Pathways system is broadly divided into three modules with the system taking a symptom-based approach, rather than a diagnostic one. In practice this means, the symptoms described will determine the questions that are posed.

16.5.8 The panel also learned that the module-based approach, is split into three phases of assessment, module 0, 1 & 2. Modules 0 & 1 are conducted by health advisors and module 2 is conducted by a clinician with enhanced training. Whilst on no occasion did Sarah speak to a clinician, the panel learned that assessment is for the purpose of clinical assessment, not diagnosis, cause or otherwise.

Line of Enquiry (LoE3) – Response to domestic abuse – self harm issues

16.5.9 Whilst neither domestic abuse or self-harm issues were identified, clinicians are taught in their safeguarding training to be alert for signs of domestic abuse or self-harm and when this is suspected clinicians do ask more questions of the patient and raise a Safeguarding Concern to the safeguarding team, which is then reviewed by a Senior Safeguarding Lead who decides on appropriate actions. It is noted that in Sarah's case a clinician had specifically noted 'the problem did not result from a suicide attempt or self-harm' that indicates an alertness to the possibility of self-harm. It may be argued that it would be positive if a clinician were able to make such a positive statement in relation to domestic abuse.

16.5.10 The panel learned that in all cases where mental health concerns are apparent, the service informs the patients GP.

Line of Enquiry (LoE4) – Access to specialist agencies

16.5.11 Where domestic abuse and/or matters of self-harm are identified, IC24 can signpost to both local and national agencies for support.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.5.12 The chair was also provided with a local IC24 domestic abuse policy for staff, that is clear, accessible and contains useful information. Such staff policies are recognised as good practice.

16.5.13 There is not currently any bespoke domestic abuse policy in respect of call handling, rather a generic safeguarding policy incorporating a section on domestic abuse that provides specific advice as to actions to be taken where domestic abuse is suspected.

16.5.14 The panel representative acknowledges that this review has shown an opportunity to improve the 'safeguarding response' and improve the service's ability to recognise and respond to domestic abuse. To that end, the panel learned that in addition to the level 3 safeguarding training that all clinicians receive, the safeguarding team are working with the learning and development team to source a stand-alone training programme in respect of domestic abuse for all IC24 staff. This is welcomed.

[50] Source: NHS Pathways - NHS Digital (Accessed May 2022)

16.5.15 The policy provides advice under a heading 'where there are concerns about domestic abuse' and continues 'colleagues will have to carefully consider if it's safe to give advice on domestic abuse and support & services at the current time'. Arguably this is passive and may benefit from asking colleagues to build upon the question of whether patients are alone, to make an enquiry about domestic abuse.

Learning Opportunity (LO16): To improve the agencies response, by thinking and being alert to the possibility of domestic abuse as being causal to symptoms described by patients.
Response: IC24 are working on a stand-alone training programme on domestic abuse for all staff.
+
Recommendation 2: Seek to 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.

Further lines of enquiry

16.5.16 There is no further relevant information or comment required in respect of the following lines of enquiry; Line of Enquiry (LoE6)– What helps or hinders accessing help and support, Line of Enquiry (LoE7) – Impact of Covid, (LoE8) – Consideration as to Sarah being an adult at risk, (LoE9) - Equalities

16.6 Norfolk and Norwich University Hospital (NNUH)

16.6.1. Sarah attended the hospital on multiple occasions, including emergency attendances, a number of elective inpatient admissions as well as a series of follow up appointments and clinics.

Line of Enquiry (LoE1)– Communication and Co-operation between agencies

16.6.2 Sarah had multiple contacts, including accident and emergency (A & E), general surgery, day procedures, specialists such as oral, gastroenterology, and gynecological specialists. Communication appears to be linear in nature, in other words referrals from primary care (GP) to see various specialists and then feedback being provided to the GP. In the case of her attendance at A & E, prompted communication with NSFT about specialist mental health support/assessment that was provided on the day, as required.

16.6.3 The IMR author has however highlighted, 'there was limited communication across departments and disciplines internally within the NNUH. Teams were working in professional disciplines / silos leading to a lack of professional curiosity on the potential cause for Sarah's multiple attendances at the hospital.' At the fourth panel it was confirmed that the trust is moving towards an electronic patient record system that is already live in some areas. Once roll-out complete, the risk of silo working will reduce, supporting the free flow of patient information.

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

16.6.4 There were multiple attendances at hospital, where it is contended staff may have used their professional curiosity to explore attendance at the hospital. These attendances include not only when she attended accident and emergency, but also other appointments. The missed opportunities to explore potential signs of domestic abuse, add weight to a report by Safelives that examined the domestic abuse response within health settings in London entitled "We only do bones here". This report found that "Survivors have experienced a lack of understanding, awareness and support from the health system, perpetuating the impact on their physical and mental health". [51] The examples highlighted by the IMR authors suggest local similar learning locally in Norfolk.

[51] Source: 'We Online Do Bones Here' - Why London needs a whole-health approach to domestic abuse_0.pdf (safelives.org.uk) (Accessed March 2022)

Accident and Emergency

- On 2nd April 2017, when Sarah attended regarding an injury to her ribs, there was no exploration as to the mechanics of the injury and how it was sustained. It is not clear as to why this was not explored, and whether there was a barrier to asking, such as whether a partner or other people were present.
- On 31st March 2020, Sarah attended with a right arm pain, following a fall one month previously. She explained that she had tripped over a cat, aggravating the injury. There was no evidence of exploring how the injury occurred or asking about her safety as she went through Xray and occupational therapy.
- On 12th April 2020, Sarah was admitted through A & E following an overdose. There is good evidence of having tested her capacity, and whilst referred to mental health and whilst keen to go home, there is no evidence of asking her what triggered her taking an overdose, save to say that she was feeling low in mood.
- On 18th July 2020, she attended hospital having scalded her feet. As before there does not appear to have been any exploration of the mechanics of the injury, or consideration as to links with previous attendances.

Other specialist departments

- In September 2017 when she attended a gynaecology appointment and reported irregular bleeding (PCB) It is documented that she was unable to tolerate any internal investigation / examination. The IMR author reports there was no indication that professional curiosity was used to explore other potential causes of bleeding such as rough / non-consensual sex, and why could she not tolerate the internal examination, nor why she had repeated UTI's. Abuse was not considered, and routine enquiry did not take place.
- In September 2018 when Sarah was admitted to the Gastroenterology Day Procedure Unit for a Colonoscopy / flexible Sigmoidoscopy, her admission paperwork records under the special requirements that she did not want her partner when discussing discharge, and that she wanted to keep this confidential from him. There is no indication in the health record that any additional exploration of the rationale behind this was made.
- In October 2019, when admitted to Gastroenterology Day Procedure Unit, her admission paperwork stated that she did not want her partner to be aware and to keep attendance confidential from him. The IMR author notes that no rationale was recorded.
- In September 2020, she attended a clinical appointment in the plastic surgery outpatient department when swelling to her jaw was identified and reported to have been obtained a year previously. The IMR authors have examined records and found that the mechanics of the injury were not explained, nor was any enquiry regarding domestic abuse made.

16.6.5 The subject of 'routine enquiry' was subject to discourse in the panel and attention was drawn to Quality Standard 116 of the National Institute for Health and Care Excellence, that sets out expectations that includes; "ensure that health and social care practitioners are trained to recognise the indicators of possible domestic violence and abuse".[52] Within the list of indicators cited, it notes the following that are pertinent in Sarah's case; - Suicidal tendencies or self-harming; - Unexplained gastrointestinal symptoms; - Genitourinary symptoms including frequent bladder or kidney infections; - Vaginal bleeding and Traumatic injury.

16.6.6 On considering why staff may not have shown enhanced professional curiosity to ask questions about potential abuse, or perhaps not identified the signs, the British Journal of Nursing posed the question as to what the barriers were and concluded, *"Several barriers to screening by health professionals were identified, including lack of training, education,*

[52] Source: Quality statement 1: Asking about dometic violence and abuse | Domestic violence and abuse | Quality standards | NICE (Accessed March 2022)

time, privacy, guidelines, policies and support from the employer, with the most prevalent of these being a lack of training and education".[53]

16.6.7 The IMR author made a series of individual policy and training recommendations regarding this learning opportunity.

(LO17) Learning opportunity: To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse, by ensuring policy and training requirements are in place. **Individual agency recommendations**: ➢ 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. ➢ A review of the Level 3 training packages to ensure more information is provided to teams on professional curiosity and how to ask the questions around DA will need to be undertaken by the Safeguarding team considering this DHR investigation. Whilst the trust has identified these recommendations, the overall recommendation below for other agencies, encapsulates these points. It is noted here for completeness only. ***Recommendation 2:*** *Seek to 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*

16.6.8 Whilst policy and training are vital, the trust also explored other means of ensuring that the pathway of a patients through the system provided opportunities to identify domestic abuse. This included the trust reviewing the systems and processes for recording patient information, that has resulted in IMR recommendations as to asking and recording trigger questions for all patients about feelings of safety. The panel welcome these recommendations and have been informed that a review is currently underway of admission/discharge paperwork.

(LO18) Learning Opportunity: Improve recognition and response to indicators of potential domestic abuse and apply enhanced professional curiosity and investigative mindset to explore those indicators. **Individual agency recommendations**: ➢ NNUH Paperwork for pre operation assessment, needs to be reviewed. Review pre operation assessment paperwork alongside surgical governance teams, to add in additional trigger questions to ask all patients about DA and Safeguarding concerns / do you feel safe are you concerned? Once complete to review at Safeguarding assurance, once agreed proceed through ratification process, upload revision to trust documents and disseminate to wider organisation via internal processes. ➢ Recording on symphony electronic system. Needs to be reviewed to add in additional trigger questions to ask all patients about DA and Safeguarding concerns / do you feel safe are you concerned? **+ Recommendation 2**

<u>Line of Enquiry (LoE3) – Response to domestic abuse & self-harm issues</u>

16.6.9 Given that domestic abuse was not identified, it is not possible to assess the response, but acknowledge the learning opportunities above. Further relevant comments are captured below under KLoE5.

16.6.10 Sarah presented to A & E on one occasion following a deliberate overdose in April 2020. An assessment of capacity was undertaken, as she was deemed to have temporary impairment owing to intoxication. She was referred to the Norfolk and Suffolk foundation trust who conducted a telephone assessment who made a recommendation to chase up a previous mental health referral.

16.6.11 The chronology, shows that staff continued to assess her capacity whilst at hospital and there is evidence of staff attempting to persuade her to remain at hospital, as she gained

[53] Source: What barriers prevent health professionals screening women for domestic abuse? A literature review | British Journal of Nursing (magonlinelibrary.com) (Accessed March 2022)

capacity. This shows that staff have actively considered the two-stage test regarding capacity.[54]

- Stage 1 – Is the person unable to make a particular decision (the functional test)?
- Stage 2 – Is the inability to make a decision caused by an impairment of, or disturbance in the functioning of, a person's mind or brain? This could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol (the diagnostic test).

16.6.12 Ultimately, Sarah decided to leave against medical advice and was provided with a Patient Advice and Liaison Service (PALS) leaflet. The panel agree that the trust has acted within the law, respecting an adult's decision to make an unwise decision.

16.6.13 Whilst Sarah provided an initial reason for the overdose relating to a call from her son, the IMR author notes that this was not subject to further follow up and enquiry, in other words enhanced professional curiosity. Further comments made under LoE5 below.

Line of Enquiry (LoE4) – Access to specialist agencies

16.6.14 Whilst domestic abuse was not asked about, or identified, the trust has ready access to Norfolk Integrated Domestic Abuse Service, MARAC, and all specialist services via appropriate referral.

16.6.15 The NNUH teams also have access to 108 trained Domestic Abuse Champions across their wards and departments. The panel learned that champions meet on a quarterly basis and receive update training and supervision during these sessions. The DA Champions role is to raise the profile and awareness of DA within their department areas and to support their teams with DASH[55] completion when the need for this is required. This is recognised as positive practice.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.6.16 The Trust has a policy for the Management of Reporting Incidents of Domestic that provides a useful pathway where abuse is suspected or disclosed. As acknowledged earlier that whilst there were signs of domestic abuse, these were not identified and nor does the policy require routine enquiry or follow the notion of having 'a duty to ask'. The IMR author has identified this learning opportunity, and individual agency recommendations have been made as noted above. The panel agree the benefits of moving from a passive stance to a more intrusive stance regarding domestic abuse.

(LO19) Learning Opportunity: To strengthen the local domestic abuse policy in order to encourage 'routine enquiry'. **Response:** Individual agency recommendation under 16.6.7 and 16.6.8 refers

16.6.17 The IMR author also highlighted an opportunity to consider the process for self-discharging, to ensure that domestic abuse, safeguarding matters, and mental health concerns are adequately considered by professionals, highlighting the missed opportunities to enquire about domestic abuse. It was also noted that when she attended hospital on the 20th April 2020 following an overdose, Sarah was not asked why she had taken an overdose. An individual agency recommendation has resulted.

(LO20) Learning Opportunity: Improve the discharge policy to ensure that safeguarding, domestic abuse, and mental health concerns are embedded into the pathway.

[54] Source: MCA: Assessing capacity | SCIE (Accessed March 2022)

[55] DASH: The Domestic Abuse, Stalking and Honour Based Violence (DASH) form is a standardized risk assessment implemented across most UK police forces. It is intended to facilitate an officer's structured professional judgment about the risk a victim faces of serious harm at the hand of their abuser. Dashing Hopes? the Predictive Accuracy of Domestic Abuse Risk Assessment by Police | The British Journal of Criminology | Oxford Academic (oup.com)

Individual agency recommendation: To review self-discharge flow charts and 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.
+ Recommendation 2

16.6.18 More broadly, the panel were informed that the trust had commenced work on a stand-alone domestic abuse policy to support professionals who disclose abuse. This is recognised as positive and will compliment and assist how staff deal with patients about abuse.

16.6.19 The panel learned that beyond the training of DA champions, all clinical staff undertake level 3 training including a whole day's face to face "Think family" safeguarding training which includes, an hour dedicated session on DA, with an additional session covering Female Genital Mutilation, Honour Based Abuse & Forced marriage. All other staff undertake level 2 safeguarding training which briefly covers DA. Notwithstanding this training, there were a number of overt signs of domestic abuse (described at 16.6.4), that were not recognised, indicating a more fundamental reminder and training about recognising signs of abuse. An individual agency recommendation has been made about reviewing information within training, professional curiosity and asking questions around domestic abuse.

(LO21) Learning Opportunity: To enhance the training regarding domestic abuse, ensuring staff are able to recognise and respond signs of abuse.
Individual agency recommendation: 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's required to facilitate an increase in staff knowledge and understanding.
+ Recommendation 2

16.6.20 The trust is also in the process of developing a standalone DA staff policy to support colleagues who disclose DA. This will be publicised across the hospital via their communications team once ratified and will help to raise awareness and understanding around DA.

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

16.6.21 The learning opportunities highlighted above in respect of recognising signs of abuse, responding to these signs through professional curiosity and not routinely asking to have all been acknowledged above.

16.6.22 The panel acknowledge the positive work in respect of DA champions and learned of local initiatives to advertise support for victims of abuse, that includes advertising material using QR codes that allow patients and staff to access advice and support when alone.

Line of Enquiry (LoE7) – Impact of Covid

16.6.23 The IMR author identified one instance when an outpatient appointment was rescheduled owing to Covid, other appointments being made/kept in keeping with the urgency of her health need.

16.6.24 Whilst, the panel identified learning opportunities around recognition and response to signs, the panel would like to acknowledge the severe pressure that the trust was under during Covid. During this period, Sarah attended A & E on three occasions and the IMR author noted that the trust was at OPEL 4 for sustained periods during this time. This refers to the most severe pressure within the 'Operational Pressures Escalation Framework that is defined as *"Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local*

escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL Four for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered". [56]

Line of Enquiry (LoE8) – Consideration as to Sarah being an adult at risk

16.6.25 Safeguarding adults is defined as "Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances."[57]

16.6.26 On considering the three conditions that would satisfy the needs for a local authority to undertake a safeguarding enquiry, the panel concur that there was nothing apparent to indicate she would have met the criteria set out at 16.4.55.

Line of Enquiry (LoE9) - Equalities

16.6.27 Neither the IMR author, nor panel's consideration that revealed learning opportunities in respect of equalities.

16.7 Norfolk and Suffolk Mental Health Trust

Line of Enquiry (LoE1) – Communication and Co-operation between agencies

16.7.1 Sarah first came to the attention of Mental Health Services as a routine referral in November 2018 (to be seen within 28 days) through the NSFT Single Point of Access (SPOA) by her General Practitioner (GP). The presentation was described as one of anxiety, depression, panic attacks suicidality and self-harm. Following 2 missed appointments she was referred back to her GP via letters that are sent electronically. Subsequent to these missed appointments, a new 'cancelled appointments policy' has been introduced that requires a more proactive approach. The effect is that no one can be discharged without being seen or referrers spoken to. The chair has been provided with a copy of this policy, providing clear unambiguous guidance, options to make contact as well as oversight and escalation.

16.7.2 The second occasion (first actual contact) Sarah came to attention of the community mental healthcare team via her attendance at the local accident and emergency department. Following assessment, she was referred back to the GP, showing effective communication with the primary care, though the result was that the GP referred her back to secondary care. This in effect resulted in Sarah going round a circle to arrive back with the trust for further assessment. The IMR author helpfully observes that the MHLT could have made the referral to CMHT rather than asking GP to do so. This would have reduced the steps in the service user accessing the appropriate service. This links with the observations by the GP and their agency recommendation. (See GP analysis 16.4.31). The IMR author had made an individual agency recommendation regarding this point "To improve the communication and referral pathways between NSFT services/ NSFT's MHLT and its Community mental health team (CMHT)". This is now in place, with direct referrals now taking place.

(LO22) Learning opportunity: To improve the communication and referral pathways between NSFT services/ NSFT's MHLT and its Community mental health team (CMHT)"

[56] Source: nhse-sc-opel-framework.pdf (england.nhs.uk) (Accessed March 2022)
[57] Source: What is safeguarding? | SCIE (Accessed March 2022)

Response: Changes have been implemented resulting in direct referrals from MHLT to CMHT

16.7.3 The third contact was via a pre- arranged call with Sarah for assessment that took place in April 2020, soon after the first wave of lockdown restrictions were put in place. Following assessment, she was referred directly back to her GP, with information shared electronically by letter. (See GP analysis 16.4.30 for related learning as to how this information is handled on receipt)

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

Domestic Abuse

16.7.4 On discussion with the panel representative, it was clarified that Sarah was asked about domestic abuse on both contacts with the NSFT, the first on the 12th April 2020 following an overdose and the second on 21st April. This provides evidence that NSFT routinely enquires about domestic abuse. This is recognised as positive practice. In response she disclosed historic abuse from her father and ex-husband, in the form of emotional and physical abuse. This included a report of being dragged by her hair, making her eat food off the floor and hitting her. She did not disclose any ongoing concerns regarding domestic abuse. She was signposted to a charity for survivors of domestic abuse.

Self-Harm

16.7.5 The referral by GP in 2018 was cited as "routine", however it contained information regarding risky behaviour that the IMR author on reflection considered may have necessitated the referral being given more urgency (reference to cutting a lump out of throat and cutting wrists). The author believes that more exploration of the information provided by the GP may have resulted in a regrading of the referral. This has been highlighted and discussed with the relevant Head of Clinical Practice for further discussion/ learning within the team and changes in policy would now ensure that the referral would have remained open pending contact with the patient or the referrer.

(LO23) Learning Opportunity: To improve how referrals are triaged, to identify high risk behaviour that informs prioritisation.
Response: Policy changes have been implemented that would have avoided closure of the case until the patient/referrer had been spoken to

16.7.6 On presenting at A & E, and assessment by the mental health liaison team (MHLT) in April 2020 a brief history was taken, and Sarah provided an explanation and the triggers for her overdose. She described her act as impulsive and it was concluded that taking alcohol was an influencing factor in the act, but there remained a risk of overdose when she drank alcohol.

16.7.7 The chair was provided with the local NSFT clinical risk assessment and management policy, that provides guidance that includes when to complete and content. This policy also directly links to a document entitled 'Assessing risk' by the Royal College of Psychiatrists. The policy states that 'all service users accepted for an assessment of their mental health needs should have an assessment for the current episode of care. In other words, the service at this point signposts only, unless admission is required. This is in accordance with guidance by the Royal College of Emergency Medicine that states "Mental Health triage is not recommended as a means to determine the risk of future self-harm or suicide".[58]

Line of Enquiry (LoE3) – Response to domestic abuse – self harm issues

Domestic Abuse

16.7.8 Whilst ongoing domestic abuse was not disclosed, the historic abuse noted above was disclosed. As a result, Sarah was signposted to 'The Survivors Trust' for support regarding historical domestic abuse.

[58] Source: Mental_Health_Toolkit_June21.pdf (rcem.ac.uk) (Accessed July 2022)

Self- Harm

16.7.9 Please see point 16.7.1 above regarding the initial referral.

16.7.10 On the second contact following her presentation at A & E and assessment by the MHLT, her capacity was assessed, and she was referred back to her GP, and provided with the numbers for Samaritans and the MIND crisis helpline. The panel agree that the actions were proportionate, and that Sarah could not have been compelled to remain.

16.7.11 Whilst these actions were proportionate, Sarah had stated that she was on a waiting list, and it does not appear that she was identified as someone previously referred and who had missed appointments. The IMR author helpfully observes that the MHLT could have made the referral to CMHT rather than asking GP to do so, thereby reducing the steps in the service user accessing the appropriate service. This has now been remedied as described at 16.7.2.

16.7.12 On the third contact a safety plan was discussed and the Consultant Psychiatrist has advised to refer Sarah back to GP with advice regarding changes in medication, and she was also signposted to support agencies of Sue Lambert Trust, Harbour Centre and The Survivors Trust and given contact numbers for Samaritans and MIND. The panel agree that these were practical suggestions for Sarah but agree with the IMR author's observation that the advice around the risk of increased alcohol consumption was either not documented or did not take place. The IMR author has made an individual agency recommendation regarding this point, as the expectation would be that a referral would be made to Norfolk's alcohol and drug behaviour service, 'Change Grow Live'.

(LO24) Learning opportunity: To ensure that risks associated with alcohol consumption and mitigation are acted upon and documented. **Response:** Raise issue of signposting to specialist substance misuse/ alcohol services.

16.7.13 Notwithstanding this practical advice, and Sarah having agreed with this plan, it does not seem that the historic emotional and physical abuse as a child was considered as an adverse childhood experience, that could inform alternative treatment such as CBT (available through Wellbeing service she had been signposted to) as discussed within the GP analysis. (16.2.2 & 16.2.3). After all, "many factors are implicated as leading to suicidal behaviour, Adverse Childhood Experiences (ACE) studies undertaken in the USA (Felitti et al., 1998) and the UK (Bellis et al., 2014; Kelly-Irving et al., 2013) show a strong association between childhood adversity, such as neglect or physical abuse, and suicide in adulthood".[59] Reflecting on a current public health initiative described at 16.4.29, it appears timely that the research into effective treatments to prevent suicide, incorporates the observations from this review that includes; "*undertaking a research paper on the effective treatments of depression to prevent suicide, including non-clinical interventions at the primary and pre-primary care level, that can create pathways into the suicide prevention action plan".* The panel agree this is broad learning observation, that fits into the local work streams being undertaken in Norfolk, that has been subject of discussion with public health and is formally shared as part of broader learning from this review.

(LO25) Learning opportunity: Recognising that adverse childhood experiences merit consideration when exploring treatment options for those expressing suicidal ideation. **Response:** The learning opportunity/observation will be shared with clinicians as part of broader learning from this review, and links with recommendations 9

16.7.14 Whilst Sarah was not deemed actively suicidal or a risk to others and did not have frequent contact with the trust, the net result was she was not with the trust for long enough to benefit from long-term care planning, as outlined under the GP analysis.

[59] Source: Adverse Childhood Experiences as Predictors of Self-harm and Suicide - Health Research Authority (hra.nhs.uk) (Accessed May 2022)

16.7.15 Recognising Sarah as a patient who had indisputably lived with suicidal ideation for many years and considering NICE clinical guidelines (CG133) in place at the time, it could have been concluded that she ought to have been overseen by mental health services. After all, the guidance says " Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment (see section 1.3) and the longer-term treatment and management of self-harm.[60] However, the panel recognised this was not clear cut, with patients such as Sarah having fluctuating needs, that at times of crisis require secondary healthcare intervention that in effect means a patient moves between primary and secondary healthcare. The panel agree this is a point of reflection that is best linked into the public healthcare initiative at 16.4.29. As referenced at 16.4.25, the panel would also note that in September 2022, NICE clinical guidelines (NH225)[61] were introduced, superseding previous guidance from 2011, providing additional information that may inform how the local partnerships improve the long-term management of those who self-harm. This new guidance will inform the recommendation below.

(LO26) Learning opportunity: Opportunity to improve the long-term management for those who have a history and continue to self-harm. **Recommendation 6**: 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 Public Health)*

Line of Enquiry (LoE4) – Access to specialist agencies

16.7.16 Sarah was signposted to a broad range of agencies as described above, with the exception regarding alcohol consumption. This omission has is subject of an individual agency action point described at 16.7.11.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.7.17 The chair was provided with several policies, that includes one related to patients and one related to staff. The patient policy is unambiguous, stating. "If safe to do so, all service users should be asked if they are experiencing any form of abuse, unless their partner or the suspected perpetrator is present". This is good practice.

16.7.18 Similarly, the staff policy is comprehensive, providing guidance in respect of victims and perpetrators. This is good practice.

16.7.19 The Trust has in place a Suicide Prevention Strategy that demonstrates a clear understanding of the local suicide picture with a local summary analysis of demand, that informed the local priorities. This includes a recognition that the majority of people who took their own lives had a diagnosis of depression (that we know Sarah had from the GP, with a diagnosis of depressive illness) and that 38% of people were discharged from NSFT services at the time of their death, with a recognition of work required to strengthen support available in the community. Each priority is underpinned, with a clear description of the priority and challenge, followed with a narrative as to how the priority is met. One priority is that of 'Clinical Pathways' subject of discourse at LoE6 below. The existence, comprehensive nature and accessibility of this strategy is cited as good practice.

16.7.20 Policy and strategy is supported by mandatory training, inclusive of updates on safeguarding and domestic abuse. The panel would note, their awareness of the recent findings of a Care Quality Commission inspection of the trust. Whilst focusing on inpatient services it was noted one area of improvement had included a note in respect of training

[60] Source: 1 Guidance | Self-harm in over 8s: long-term management | Guidance | NICE (Accessed April 2022)

[61] Source: Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE (accessed April 2023)

performance targets not being met.[62] In discussion it was noted that the findings did not relate to services that Sarah would have been in contact with.

Line of Enquiry (LoE6)– What helps or hinders accessing help and support.

16.7.21 The NSFT suicide prevention strategy has 'Clinical Pathways' as one of its priorities. We know that that matter of 'does not attend' has subsequently been addressed by the introduction of the 'cancelled appointments policy' in order to help ensure contact with patient or ensure the referrer is alerted to non-attendance. (See 16.7.1) We also know that the streamlining for referral from emergency departments is subject of an individual agency recommendation to remove a barrier to receiving specialist support more directly. (See 16.7.2.)

Line of Enquiry (LoE7) – Impact of Covid

16.7.22 During interactions with services in 2020, Sarah was not seen in person at any point. This was the default practice as stipulated by the NHS at this point in time during the management of the global pandemic – Covid-19, as part of infection control measures. Any appointment or need to meet with patients during this time would only have occurred where strictly necessary and on a risk assessed basis. There have been observations expressed that virtual or telephone assessments may reduce the amount of information available and inhibit assessment. However, it is not possible to determine whether her assessments were impaired and there is no evidence to suggest the assessment was compromised by being conducted in this manner.

Line of Enquiry (LoE8) – Consideration as to Sarah being an adult at risk

16.7.23 See GP analysis at 16.4.55.

Line of Enquiry (LoE9) - Equalities

16.7.24 The relationship between the menopause and mental health initially arose under discussion of the GP's contact with Sarah. The panel learned that this subject has been subject of some focus with NSFT, and the chair was provided with copies of locally produced summary reports outlining the challenge and links to locally accessible literature for service users on the subject. Whilst there is no indication to suggest that the menopause did or did not play a part in Sarah taking her own life, the relationship between the menopause and mental health, and a woman of her age does merit broader sharing with health professionals. The existence of a local menopause champion within NSFT is seen as a positive

Good Practice

16.7.25 The chair cites three policies and a local strategy for their clarity and direction.

- Did not attend.
- Domestic Violence and Abuse
- Supporting staff through domestic violence and abuse
- Suicide Prevention Strategy

16.8 Norfolk Constabulary

Line of Enquiry (LoE1)– Communication and Co-operation between agencies

16.8.1 Police had contact with Sarah on two occasions. (19.8.2020 & 22.05.2021) Both occasions related to domestic incidents and resulted in the completion of the domestic abuse, stalking, harassment, and honour-based violence assessment tool (DASH) risk identification checklist. On both occasions the risk was rated as medium, and this would not have

[62] Source: Norfolk and Suffolk NHS Foundation Trust - Care Quality Commission (cqc.org.uk) (Accessed May 2022)

attracted multi-agency consideration of her circumstances by being heard at a multi-agency risk assessment conference (MARAC)[63].

16.8.2 However, in both cases the risk associated with the two incidents were sent through to a multi-agency safeguarding hub (MASH) that brings together partner organisations including adults and children's services. This is recognised as positive.

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

16.8.4 The domestic abuse, stalking, harassment, and honour-based violence assessment tool (DASH) risk identification checklist assessment is a tool was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC). It enables risk to be categorised as standard, medium, and high. This was correctly used by police on the two occasions that they attended, and on both occasions the risk was assessed as medium that describes, "There are identifiable indicators of risk of serious harm. The perpetrator has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances e.g., relationship breakdown, failure to take medication, drug/alcohol misuse"[64]

16.8.5 Within the body of the DASH, are a series of 24 questions and if 14 or more are answered positively, this would attract a high-risk rating. One of those questions relates to feelings of depression or having suicidal thoughts. The IMR author has reviewed the DASH entries and it seems that on the first occasion Sarah had explained that she lived with depression and anxiety and had attempted suicide two months previously. However, on the second occasion, just prior to her taking her own life, she had said she had not.

16.8.6 An officer may also rate the risk as high on professional judgement, and it is noted that on the first incident (19.8.2020) the officer did identify there were previous incidents that had not been reported to police. These included damage to property, verbally and emotionally abusive behaviour, and a degree of control in that Samuel monitored how much money she spent.

16.8.7 In the first case, the completion of the risk assessment was subject to a secondary level of supervision which is seen as good practice. Indeed, on the first occasion a MASH officer spoke to Sarah shortly after the incident and ascertained that she was travelling to Nottingham. The risk rating remained rated as medium, though arguably as she has moved out of the area it could have been downgraded. On the second occasion, the risk rating was reduced to standard, as she was travelling to Cornwall.

16.8.8 During panel discussions, the panel learned of a number of initiatives designed to improve the investigation and risk management of domestic abuse, noted at 16.8.13 &14 below. Moreover, the panel were informed that Norfolk police will be moving to an alternative risk assessment model known as DARA (Domestic abuse risk assessment). Where the DASH employs yes/no questions, DARA asks victims how often behaviours occur on a scale from never to all the time. Whilst it is not possible to determine whether this would have materially affected risk assessments regarding Sarah, it is suggested this tool is more helpful in identifying controlling and coercive behaviour, that featured in the testimony of Sarah's daughter and statement to police in August 2020.

Line of Enquiry (LoE3) – Response to domestic abuse – self harm issues

16.8.9 The police investigative response to domestic abuse is usefully summarised by the College of Policing that describe a number of elements of best practice. These include lines of enquiry such as, securing a victim's statement, house to house enquiries, the use of body

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[63] MARAC: A Marac or multi-agency risk assessment conference is a regular meeting in which local frontline services share information and work out how best to help victims at high risk of serious harm or murder.

[64] Source: DASH risk assessment - Norfolk County Council (Accessed March 2022)

worn video evidence, use of photographic evidence of injuries and listening to the original 999 call. The police are also encouraged to take positive action, in other words arrest.

Incident 1 (19.8.2020)

16.8.10 Most of the minimum standards were considered, positive action was taken at the time and Samuel was arrested. House to house enquiries could not be completed at the time but were set as a task as part of an investigative plan.

16.8.11 The original 999 call to police was not listened to. This enables investigators to apply the principle of 'Res Gestae' to statements recorded at the time, that is a statement "*made by a person so emotionally overpowered by an event that the possibility of concoction or distortion can be disregarded*".[65] College of Policing Guidance says investigating officers should examine recordings to identify the following: caller's demeanour, background noise including comments from witnesses, suspects and victims and any first description of the incident as provided by the witness or victim.[66]

16.8.12 This case was subject to no further action, and so final enquiries were not completed. The IMR author raised several observations regarding this incident. The investigating officer (IO) did not update the victim personally and states in the enquiry log, that three attempts were made to contact her with no success, and subsequently speaks to her daughter. The IO did attend her address and notes that her clothes had been removed. This raises several questions.

a) To whom did Sarah indicate that she did not want to pursue a criminal allegation?
b) When attending the address, and finding her clothes gone, what efforts were made to ensure Sarah was safe and well?
c) The decision at this point was made without having considered evidence led prosecution.

16.8.13 In considering points a) The IMR author has reviewed the details of whom Sarah had indicated she did not want to pursue the allegation, and it seems that she had called into the multi-agency safeguarding hub, explaining that she was now in Nottinghamshire and was going even further away to Cornwall. Reflecting on points a) and c), the IMR author notes that the police have subsequently introduced a seven-point closure plan, that ensures that all proportionate lines of enquiry have been closed and a section on ongoing risk. This development is welcome. The author also observes that a further change has been made regarding police investigative policy that is "For all cases of Domestic Abuse, if a victim wishes to withdraw any allegation and a statement is required this should always be done in person".

16.8.14 The police IMR also highlighted an initiative "Op Investigate" a process exists to ensure that decisions made to Take No Further Action in respect of High-Risk Domestic Abuse Investigations are peer reviewed by a Detective Sergeant. This system of Peer Review applies to all Domestic Abuse Investigation's which have at some point been managed as being High Risk. This is welcomed, though it's limitations in respect of high-risk cases is noted.

16.8.15 In addition to this Domestic Abuse investigations are audited by the Op Investigate team in order to identify good practice where it exists, examine victim engagement and to identify opportunities where an evidence-led prosecution could be considered.

(LO27) Learning Opportunity: To seek assurance that minimum standards of investigation are adhered to, including closure of investigations. **Response:** Subsequent implementation of 'Seven Point Closure Plan' and 'Op Investigate.'

[65] Source: https://www.parksquarebarristers.co.uk/news/victimless-prosecutions/ (Accessed November 2019)

[66] Source: College of Policing. Major Investigation and Public Protection - Investigative Development. https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/domestic-abuse/investigative-development/?highlight=gestae?s=gestae (Accessed June 2019)

16.8.16 On considering point b), the IMR author notes that the officers should have made enquiries about her welfare, as the original investigation shows officer awareness that she had previously self-harmed. As noted above, there have been subsequent developments in relation to investigation standards and quality assurance.

Incident 2 (22.05.2021)

16.8.17 Most of the minimum standards were considered, positive action was taken at the time and Samuel was arrested. House to house enquiries were carried out and neighbours heard an argument but declined to give a statement. A pocketbook entry is signed by a third party who witnessed the incident, and this is signed by that witness. This is good practice, even though it is understood that person declined to provide a statement.

16.8.18 An initial statement was taken and recognised as containing minimal detail. It was however sufficient for Samuel to receive a simple police caution for the offence and Sarah agreed to this course of action.

16.8.19 Sarah took her own life in the days following this incident. It should be noted that in the officer's log, there was nothing to indicate a wider safeguarding concern, indeed, it was noted *"I shall be calling victim tomorrow to arrange collection of her keys."* This tends to show that the officer had no apparent concerns that she would take her own life.

16.8.20 The detail of the investigation indicates that both Sarah and Samuel were intoxicated at the time and Samuel indicated that Samuel had recently been unwell with a stay in hospital, inferring that his behaviour had become worse following his ill health. The panel recognise the potential adverse effects of ill health to have on an individual's state of mind, and whilst it is understood that Samuel had been in contact with healthcare agencies during the relevant period, the details of those contacts are not referred to as Samuel has not engaged with the review process. The panel also recognise alcohol consumption as an aggravating factor, though not a cause of domestic abuse.

Line of Enquiry (LoE4) – Access to specialist agencies

16.8.21 Whilst both incidents adhered to the majority of minimum expectations of investigation, in both cases, Sarah was not signposted to a support agency. However, in discussion with the IMR author as to how officers would know who to refer to, it was noted that the back of the DASH booklet, contain a list of local and national agencies suitable for providing abuse on domestic abuse. In addition, there are leaflets that officers are encouraged to refer to that includes a wider range of agencies linked to self-harm and suicide, such as: Samaritans, CALM, Papyrus, National Self-Harm Network. This is recognised a good practice.

(LO28) Learning Opportunity: Ensuring that survivors of domestic abuse are signposted to support services. **Response:** Whilst the DASH booklet contains a list of local and national agencies, Norfolk police have created a linked leaflet with more comprehensive range of support agencies to assist officers and signpost the public to.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.8.22 Training in relation to Domestic Abuse is delivered to all Norfolk Police Officers as part of their initial training. The training focuses on Harassment, Controlling and Coercive Behaviour and Stalking offences. Student officers are also trained to correctly complete the risk assessment process for Domestic Abuse Incidents. Those joining the constabulary also receive a full day's input on Female Genital Mutilation, Forced Marriage, and Honour Based Abuse.

16.8.23 Bespoke training in relation to Domestic Abuse is also delivered to departments within the organisation where staff perform a specific role such as within the Contact and Control

Room (CCR) where call takers are likely to be the first point of contact for many victims of Domestic Abuse.

16.8.24 As part of an ongoing commitment to improve investigative standards Op Investigate was launched jointly in both Norfolk and Suffolk Constabulary in 2019. Under the mantle of Op Investigate additional training in relation to Domestic Abuse Investigations and the Victim Code of Practice has been delivered to all sergeants across both forces in April 2021.

Key line of Enquiry (KloE9) - Equalities

16.8.25 Domestic abuse is recognised as being gender biased in that women are statistically more likely to report being a victim of abuse. The latest ONS report shows women as making up 73% of victims.[67]

16.8.26 It is clear from the investigations that action was taken based on the allegations, evidence presented and in the case of incident 2, a third party provided corroborating evidence.

Further lines of enquiry

16.8.27 There is no further specific, relevant information or comment required in respect of the following lines of enquiry; (LoE6)– What helps or hinders accessing help and support, Line of Enquiry (LoE7) – Impact of Covid, (LoE8) – Consideration as to Sarah being an adult at risk.

Good Practice

16.8.28 The panel learned from the police IMR of further innovation, with the local police introducing CARA (Cautions and Relationship Abuse), following an initiative funded by Norfolk Office for Police Crime Commissioner.[68] The scheme is offered; where appropriate, to domestic abuse perpetrators in order to reduce reoffending and ensure victim safety. The scheme is part of a Conditional Caution issued by Police which requires offenders to complete two workshops in which they are encouraged to reflect on their choices and find a positive way forward. The scheme uses education, group work and therapeutic techniques to bring about behavioural change.

16.8.29 Norfolk Integrated Domestic Abuse Service was launched in January 2022. The service based within the MASH is a partnership service designed to provide support for adults experiencing Domestic Abuse and for the children of any adults being supported by the service. The service brings together specialists from several organisations to ensure that support is available across the county.

16.9 Norfolk County Council Human Resources

16.9.1 Sarah was employed for 8 months, in a specialist outreach role, working alongside colleagues from the police, youth offending team, social workers and domestic abuse specialists. The IMR management review benefitted from its author interviewing Sarah's line manager and examination of supervision/appraisal records.

16.9.2 The IMR analysis shows that a work colleague was aware that Sarah had a difficult relationship with her partner, having moved to Norfolk to be with him. However, no further details have been provided / or were made available. It would also appear that she cited accommodation issues as a reason for initially resigning in October 2015, one month after she had started, though she did not eventually resign as the accommodation problem was resolved.

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[67] Source: Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk) (Accessed March 2022)

[68] Source: New scheme to break cycle of domestic abuse to be introduced in Norfolk | Norfolk PCC (norfolk-pcc.gov.uk)

Line of Enquiry (LoE1) – Communication and Co-operation between agencies

16.9.3. NCC had no cause to work with external agencies regarding Sarah, as they had not identified any safeguarding concerns, or concerns over domestic abuse, though her line manager recalls noticing bruising to her hand and a graze to her head. (See LoE2 below)

16.9.4 The council did work with occupational health specialists after she had left the council's employment to make an assessment for her application for deferred ill-health benefits. It seems an initial attempt to conduct this assessment did not progress as they did not have all the GP information. However, an HR advisor was able to progress this application, ensuring that Sarah's application was ultimately successful and ill-health pension benefits were awarded.

Line of Enquiry (LoE2) – Risk Assessment for domestic abuse and self-harm

Domestic Abuse

16.9.5 The IMR has highlighted several opportunities for further professional curiosity. These include;

- Her line manager recalling noticing bruising to her hand and a graze to her head.
- A colleague who had said that Sarah had recognised her partner as an "a&*!*hole" and 'quite controlling'.

16.9.6 In the first instance, Sarah had explained the injury (January 2016) as owing to her being accident prone. It is positive that this was followed up by the manager later in the year (May 2016), when he had noticed a graze to her head. She had replied that "there is nothing to be concerned about as I am no longer in that relationship". Whilst taking the answer on face value, it is understandable that this was not followed up. However, an alternative explanation may be that the manager was not equipped with the knowledge around domestic abuse, barriers to reporting and how to engage, risk assess and refer.

16.9.7 Furthermore, an observation was made that Sarah worked in a multi-agency hub surrounded by professionals including a domestic abuse specialist, again places the onus on the victim to report, perhaps not considering the barriers that victims are confronted with when reporting, as opposed to managers and colleagues being more proactive in their support.

16.9.8 It is well established that there are multiple barriers to disclosing abuse, such as those listed by Refuge on their website that includes; -denial; - shame; - financial dependence; - lack of self-confidence.[69] A review article entitled 'Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research' found that the second highest barrier was that 'victims feared being judged/ negatively evaluated by either the HCP or their environment, i.e., their family, friends, neighbours, acquaintances'.[70]

16.9.9 The barriers noted above relate to a victim's rationale for not reporting domestic abuse, and therefore it is possible that any, one or multiple of these factors may have been applicable. However, it is arguable that the physical signs injury, and verbal description of a partner as being controlling were either not recognized as signs of potential abuse, or there was a presumption that Sarah was a strong enough character and had access to on-site advice, that if she needed help, she would have asked. Conversely, as with healthcare professionals, one may argue that upon the presentation of symptoms, there is a 'duty to ask.'

[69] Source: Barriers to leaving - Refuge Charity - Domestic Violence Help (Accessed April 2022)

[70] Source: Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research - Heron - 2021 - Health & Social Care in the Community - Wiley Online Library

16.9.10 Helpfully the IMR author reports that there was a domestic abuse policy in existence at the time, but that the manager was not aware of it. In this regard it may be helpful to consider a recent government publication 'Workplace support for victims of domestic abuse: review report' that presented a number of findings on barriers including 'there is limited support available; or policies are not clearly signposted to, visible or up to date'.[71] Whilst it is reported that this policy has been updated and recirculated, it is suggested that there remains a need to ensure that managers and staff are equipped to recognise and respond to domestic abuse. This is further discussed under LoE5 below.

Line of Enquiry (LoE3) – Response to domestic abuse – self harm issues

16.9.11 In Sarah's case, neither DA nor self-harm was disclosed and therefore not responded to. However, the IMR author notes there is a 24/7 confidential counselling service available via a Norfolk Support Line. The manager was aware of this line but cannot recall whether he gave her these details.

Self-Harm

16.9.12 The referral to an OH consultant resulted in a report completed after she had left employment. This detailed a history of self-harm and that also said she had not disclosed this history to her employer as this may result in consideration as to her continuing with her career.

Line of Enquiry (LoE4) – Access to specialist agencies

16.9.13 The NCC domestic abuse policy contains the names of organisations, but not contact details.

Line of Enquiry (LoE5)– Policies, Procedures & training re domestic abuse

16.9.14 The chair was provided a copy of the local domestic abuse guidance that is broken down into a number of sections, including; definition of domestic abuse; responsibilities of employees and managers; support mechanisms.

16.9.15 On considering this policy, the chair reflected upon a local DHR (Maria)[72] completed in September 2019, that referenced a national 'Employers' Initiative on Domestic Abuse. The DHR made a recommendation to build upon the work in promoting the EIDA toolkit.

16.9.16 An examination of the EIDA toolkit suggests a model for employers, entitled the 4 R's, which are; *recognise, respond, refer, and record*. Given that a colleague and a manager had separately identified potential signs of abuse (injury and a description of behaviour as 'controlling'), it would seem there is an opportunity to provide additional information to staff via a refreshed policy, which empowers and encourages them to be more proactive.

16.9.17 In discussion between the chair and the panel representative, it was apparent that managers and the human resources department do not benefit from any enhanced training in relation to domestic abuse, and yet during panel discussions, it seems that the council are an organisation that were intended to receive more intensive support as part of a training offer via the 'Norfolk Integrated Domestic Abuse Service' (NIDAS) that is commissioned by Office of the Police & Crime Commissioner. Moreover, the council had been at the forefront of the 'Help Educate Awareness Respond' (HEAR) campaign launched in 2020, that includes a pledge, "We pledge to break the silence around domestic abuse and HEAR, help and provide support in the workplace".[73] The associated website provides a comprehensive link to information and policies.

[71] Source: Workplace support for victims of domestic abuse: review report (accessible webpage) - GOV.UK (www.gov.uk) (Accessed April 2022)
[72] Source: DHR-Maria-Overview-Report25-01-2021.pdf (norfolksafeguardingadultsboard.info) (Accessed May 2022)
[73] Source: HEAR campaign - Norfolk County Council (Accessed June 2022)

16.9.18 The chair was provided with a copy of the local domestic abuse policy and notes it would benefit from bringing the definition of domestic abuse up to date and include a description of controlling and coercive behaviour.

16.9.19 The panel therefore agree that linked with observations at 16.9.11, there is an opportunity to refresh and reinvigorate its approach to domestic abuse, ensuring that staff and managers are able to 'recognise, respond, refer and record' when domestic abuse is suspected or apparent.

16.9.20 Whilst a learning opportunity is summarised below, the chair suggests the council would benefit from mandating domestic abuse training. In support of this argument, the following are noted: - According to the Crime Survey of England and Wales year ending March 2018, only 18% of women who had experienced partner abuse in the last 12 months reported the abuse to the police.[74] - An estimated 4.6m women (28% of the adult population) have experienced domestic abuse at some point since the age of 16. [75] The chair notes that if one accepts the estimated prevalence data, a considerable proportion of the council's 3,000 employees will have experienced abuse.

(LO29) Learning Opportunity: To ensure that all staff are able to 'recognise, respond, refer and record' all facets of domestic abuse. **Recommendation 7:** Improve the ability of staff to identify signs of domestic abuse and respond with appropriate professional interest, by bringing the local domestic abuse policy up to date and seeking to mandate that all staff receive domestic abuse training

Line of Enquiry (LoE9) - Equalities

16.9.22 The IMR author reports that a colleague of Sarah who had said that she recognised her partner as being quite controlling, also described her as being 'a strong northern woman'. And yet we know that not only was Sarah a victim of domestic abuse, she also self-harmed. She also said that she did not disclose her self-harming, as this could jeopardise her career.

16.23 It may be that Sarah portrayed an image of being strong but concealed the true nature of her vulnerability. Considering, 'a gender stereotype is a generalized view or preconception about attributes or characteristics, or the roles that are or ought to be possessed by, or performed by, women and men'[76], it seems this perception risked intersecting with other stereotypes and her mental health risking a disproportionate negative impact on Sarah.

(LO30) Learning Opportunity: Stereotyping risks applying characteristics to an individual, that masks the true vulnerability of Sarah a person living in an abusive relationship. **Recommendation 8**: Seek to reduce the risks of stereotyping that risks the true vulnerability of those living with domestic abuse having confidence to disclose.

Further lines of enquiry

16.5.10 There is no further specific, relevant information or comment required in respect of the following lines of enquiry; (LoE6)– What helps or hinders accessing help and support, Line of Enquiry (LoE7) – Impact of Covid, (LoE8) – Consideration as to Sarah being an adult at risk.

[74] Source: How common is domestic abuse? - Women's Aid (womensaid.org.uk) (Accessed June 2022)
[75] Source: How widespread is domestic abuse and what is the impact? | Safelives (Accessed June 2022)
[76] Source: OHCHR | Gender stereotyping (Accessed April 2022)

17. CONCLUSIONS AND LESSONS LEARNED

17.1 Conclusions

17.1.1 The chair and panel are mindful of 'Hindsight Bias', highlighting what might have been done differently and avoiding the 'counsel of perfection'. This review panel has attempted to view as broadly as possible what happened, to understand the circumstances of Sarah's life to help explain her death. The panel has also reflected on local service developments and initiatives, as well as wider academic studies and a local suicide audit of 801 suicides published in 2019. Finally, the panel is grateful to her daughter Margaret whose insight shone a light on Sarah's relationship with Samuel.

17.1.2 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.

17.1.3 One of two children, Sarah had a difficult childhood, that her daughter understood to have been a strict upbringing, but that Sarah had described to professionals as being physically and emotionally abusive (16.7.4).

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

17.1.5 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 and corroborated by the account of her daughter and friend, the relationship was controlling and coercive, typified by, financial abuse such as exploiting Sarah in respect of her pension 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.

17.1.6 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.

17.1.7 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.

17.1.8 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.

17.1.9 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.[77]

17.2 Lessons Learned

17.2.1 This review has benefitted from detailed chronologies, candid IMRs and open conversations with panel representatives and other professionals. The contribution of Sarah's daughter has proven invaluable in providing insight and clarifying the panel's understanding of Sarah's lived experience. Collectively this has added weight to the identification of a number of 'Learning opportunities' that are contained within the overall analysis for each agency. The review of this case has shone a light on circumstances, enabling thematic learning described below that resulted in this panel's review recommendations that have built upon individual agency recommendations where necessary.

Recognition and Response: Professional Curiosity & Routine Enquiry
(LO2, LO3, LO4, LO9, LO12, L013, LO17, LO18, LO29)

17.2.2 Sarah had significant contact with 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.

17.2.3 Moreover, Sarah had spoken about issues with her partner (16.3.3) and 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.

17.2.4 These learning opportunities identify several lessons to be learned. The first is ensuring that professionals are equipped with the knowledge to recognise indicators of potential abuse. The second is, presuming they have the knowledge, the next step is to ensure professionals respond with an open mindset and professional interest to find out more and finally to consider the extent to which routine enquiry should be described within policy expectations.

Domestic Abuse: Policy (LO1, LO12, LO16, LO18, LO20, LO29)

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

17.2.6 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."

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

17.2.7 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.

17.2.8 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.

17.2.9 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 (LO5, LO6, LO23, LO24)

17.2.10 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.

17.2.11 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 ending, 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 (LO8, LO10)

17.2.12 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.

17.2.13 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 (LO14, LO26)

17.2.14 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. (16.7.15). This suggests a learning opportunity in respect of the long-term care planning for patients such as Sarah.

17.2.15 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' (LO3, LO24, LO11, LO15,)

Adverse Childhood Experience

17.2.16 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

17.2.17 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

17.2.18 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 (LO10, LO22)

17.2.19 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

17.2.20 It is apparent that Covid has had a significant impact on health services, with demands on GPs haven risen (16.4.53), and the Norfolk and Norwich hospital having been working under immense stress at times during the relevant period, though on only one occasion was an appointment with Sarah effected. The pandemic also effected 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.

17.2.21 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 (LO15, LO30)

17.2.22 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 take their own lives, though recent research has shown increases in women taking their own lives, within an age group associated with the menopause. (See 17.2.18)

17.2.23 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.

Hidden nature of abuse

17.2.24 As a final reflection, the panel acknowledges the hidden nature of the abuse experienced by Sarah over time, experiencing physical abuse, but hidden and ongoing controlling behaviour and financial abuse in respect of her own pension. It is important that in sharing the learning from the review, the 'hidden nature' of abuse is reinforced with professionals and requires ongoing awareness raising across our communities.

17.3 Good Practice Identified and Significant Developments

17.3.1 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
- 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

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.

18. RECOMMENDATIONS

18.1 Local Recommendations

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

18.1.1 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.

18.1.2 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.

18.1.3 NSFT

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

18.2 Panel Recommendations

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, introduce 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

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE: CASE OF SARAH

This Domestic Homicide Review is being completed to consider agency involvement with **Sarah** and Samuel following the death of Sarah in May 2021. The Domestic Homicide Review is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

Purpose of DHR

1. To review the involvement of each individual agency, statutory and non-statutory, with **Sarah** and **Samuel** during the relevant period of time **21.06.2016 to 23.05.2021**.
2. To summarise agency involvement prior to **21.06.2016**.
3. To 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. To 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. To apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
6. To prevent domestic violence and homicide, deaths related to domestic abuse (suicide), 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.
7. To contribute to a better understanding of the nature of domestic violence and abuse.
8. Identify good practice.

Key Lines of Inquiry

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:
   The Care Act 2014 states; "*Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances.*"
I. **Equalities**: The Review Panel will consider all protected characteristics as noted at paragraph 13.

Role of the DHR Panel, Independent Chair and the CSP

9. The Independent Chair of the DHR will:
   a) Chair the Domestic Homicide Review Panel.
   b) Co-ordinate the review process.
   c) Quality assures the approach and challenge agencies where necessary.
   d) Produce the Overview Report, Executive Summary and collate action plan by critically analysing each agency involvement in the context of the established terms of reference.

10. The Review Panel:
    a) Agree robust terms of reference incorporating those terms of reference that wish to be included by family and friends of the victim.
    b) Ensure appropriate representation of your agency at the panel: panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
    c) Prepare Individual Management Reviews (IMRs) and chronologies through delegation to an appropriate person in the agency.
    d) Discuss key findings from the IMRs and invite the author of the IMR (if different) to the IMR meeting.
    e) Agree and promptly act on recommendations in the IMR Action Plan.
    f) Ensure that the information contributed by your organisation is fully and fairly represented in the Overview Report.
    g) Ensure that the Overview Report is of a sufficiently high standard for it to be submitted to the Home Office, for example:
        - The purpose of the review has been met as set out in the ToR.
        - The report provides an accurate description of the circumstances surrounding the case; and
        - The analysis builds on the work of the IMRs, and the findings can be substantiated.
    h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
    i) On completion present the full report to the Community Safety Partnership.
    j) Implement your agency's actions from the Overview Report Action Plan.

Norfolk Community Safety Partnership working with the DHR Chair:
    a) Submit the Executive Summary, Overview Report and Action Plan to the Home Office Quality Assurance Panel.
    b) Working with the Chair of the DHR forward Home Office feedback to the family, Review Panel and NCSP.
    c) Agree publication date and method of the Executive Summary and Overview Report.
    d) Notify the family, Review Panel and NCSP of publication date.

Definitions: Domestic Violence and Coercive Control

11. The Overview Report will make reference to the term's domestic violence and coercive control. The Review Panel understands and agrees to the use of the cross-government definition (amended March 2013) as a framework for understanding the domestic violence experienced by the victim in this DHR. The cross-government definition states that domestic violence and abuse is:

    "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; and emotional.
    Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
    Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."
    This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

12. The overview report will make reference to the term domestic abuse and the statutory definition as per the Domestic Abuse Act.
    (1) This section defines "**domestic abuse**" for the purposes of this Act.

    (2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

    (a) **A and B** are each **aged 16 or over** and are **personally connected** to each other, and

(b) the behaviour is abusive.

(3) Behaviour is **"abusive"** if it consists of any of the following—

(a) physical or sexual abuse;

(b) violent or threatening behaviour;

(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));

(e) psychological, emotional, or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

(4) "**Economic abuse**" means any behaviour that has a substantial adverse effect on B's ability to—

(a) acquire, use, or maintain money or other property, or

(b) obtain goods or services.

(5) For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Equality and Diversity

13. The Review Panel will consider all protected characteristics (as defined by the Equality Act 2010) of both **Sarah** and **Samuel** (age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation) and will also identify any additional vulnerabilities to consider.

Parallel Reviews

14. Coronial proceedings continue in parallel. The inquest is scheduled for the 15th December 2021 and the coroner's officer has been appraised of this review

Membership

15. It is critical to the effectiveness of the meeting and the DHR that the correct management representatives attend the panel meetings. Panel members must be independent of any line management of staff involved in the case and must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.

16. The following agencies are to be on the Review Panel:

DHR Chair Role and the Panel

17. **Mark Wolski** has been commissioned by NCSP to independently chair this DHR. His contact details will be provided to the panel and you can contact them for advice and support during this review.

Collating information to support the review

18. Each agency to search all their records outside the identified time periods to ensure no relevant information was omitted and secure all relevant records.

19. Chronologies and Individual Management Review (IMRs) will be completed by the following organisations known to have had contact with **Sarah** and **Samuel** during the relevant time period:

Chronologies and IMRs

20. Each IMR will:
    - Set out the facts of their involvement with **Sarah** and **Samuel**
    - Critically analyse the service they provided in line with the specific terms of reference;
    - Identify any recommendations for practice or policy in relation to their agency;
    - Consider issues of agency activity in other areas and review the impact in this specific case.

Development of an action plan

21. Individual agencies to take responsibility for establishing clear action plans for the implementation of any recommendations in their IMRs with clear owners and completion dates of those actions. The Overview Report will make clear that agencies should report to NCSP on their action plans within 3 months of the Review being completed.

Liaison with the victim's family and [alleged] perpetrator and other informal networks

22. The review will sensitively attempt to involve the family of Sarah in the review once it is appropriate to do so in the context of on-going criminal proceedings. The chair will lead on family engagement.

23. Sarah's partner **Samuel** will be invited to participate in the review.

24. Family liaison will be coordinated in such a way as to aim to reduce the emotional hurt caused to the family by being contacted by a number of agencies and having to repeat information.

25. The Review Panel discussed involvement of other informal networks of the Sarah and Samuel and will consider such involvement as the review progresses.

Media handling

26. Any enquiries from the media and family should be forwarded to NCSP who will liaise with the chair and associated agencies communications leads. Panel members are asked not to comment if requested. The NCSP and its Chair will make no comment apart from stating that a review is underway and will report in due course.

27. The NCSP are responsible for the final publication of the report and for all feedback to staff, family members and the media.

Confidentiality

28. All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the responsible agency's representative. That is, no material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

29. All agency representatives are personally responsible for the safe keeping of all documentation that they possess in relation to this DHR and for the secure retention and disposal of that information in a confidential manner.

30. It is recommended that all members of the Review Panel set up a secure email system, e.g. registering for criminal justice secure mail, nhs.net, gsi.gov.uk, pnn or GCSX. Documents will be password protected.

31. If an agency representative does not have a secure email address, then their non-secure address can be used but all confidential information must be sent in a password protected attachment. The password used must be sent in a separate email.

32. If you are sending password protected document to a non-secure email address it must be a recognisable work email address for the professional receiving information. Information from DHR should not be sent to a gmail / hotmail or other personal email account unless in rare cases when it has been verified as the work address for an individual or charity.

33. No confidential content should be in the body of an email to a non-secure email account. That includes names, DOBs and address of any subjects discussed at DHR.

Disclosure

34. Disclosure of facts or sensitive information will be managed and appropriately so that problems do not arise. The review process will seek to complete its work in a timely fashion in order to safeguard others.

35. The sharing of information by agencies in relation to their contact with the victim and/or the alleged perpetrator is guided by the following:
    a) The Data Protection Act 1998 governs the protection of personal data of living persons and places obligations on public authorities to follow 'data protection principles'
    b) The 2016 Home Office Multi-Agency Guidance for the Conduct of DHRs (Guidance) Section 10 outlines data protection issues in relation to DHRs (Par 98).
    c) Data Protection Act and Living Persons: The Guidance notes that in the case of a living person, for example the perpetrator, the obligations do apply. However, it further advises in Par 99 that the Department of Health encourages clinicians and health professionals to cooperate with domestic homicide reviews and disclose all relevant information about the victim and where appropriate, the individual who caused their death unless exceptional circumstances apply.
    d) Where record holders consider there are reasons why full disclosure of information about a person of interest to a review is not appropriate (e.g. due to confidentiality obligations or other human rights considerations), the following steps should be taken:
        - The review team should be informed about the existence of information relevant to an inquiry in all cases; and
        - The reason for concern about disclosure should be discussed with the review team and attempts made to reach agreement on the confidential handling of records or
        - partial redaction of record content.

    e) Human Rights Act: information shared for the purpose of preventing crime (domestic abuse and domestic homicide), improving public safety, and protecting the rights or freedoms of others (domestic abuse victims).
    f) Common Law Duty of Confidentiality outlines that where information is held in confidence, the consent of the individual should normally be sought prior to any information being disclosed, with the exception of the following relevant situations – where they can be demonstrated:
        i) It is needed to prevent serious crime.
        ii) there is a public interest (e.g., prevention of crime, protection of vulnerable persons)

APPENDIX B – CONTACT WITH FAMILY

Date and time of contact (or attempt)	Name and relationship to victim of individual contacted	Mode of contact (Phone, email, text etc.)	Outcome of contact
16.10.2021	Mum	Letter	Introduction
	Son	Letter	Introduction
	Daughter	Letter	Introduction
17.10.2021	FLO	Email	Request emails and phone numbers
28.10.2021	Daughter	Email	Introduction
28.10.2021	Daughter	Phone call	Agreed to speak
	Son	Phone call	He will text
	Mum	Phone call	Initial contact. Does not want to engage
02.11.2021	Son	Phone call	Message left
	Daughter	Phone call	No voicemail facility
05.11.2021	Son	Phone call	Message left
	Daughter	Phone call	No voicemail facility
06.11.2021	Daughter	Phone call	No voicemail facility
26.11.2021	Son	Text	Update and offer
	Daughter	Text	Update and offer
02.12.2021	Daughter	Text	From daughter. Exchanged texts. Contact ceased
15.12.2021	Daughter	Texts	Texts x 3
15.12.2021	Daughter	Text	Texts x 2, arranged a discussion
18.12.2021	Daughter	Text	Daughter unwell
05.01.2022	Daughter	Text and email	Update and offer
05.01.2022	Son	Text	Update and offer
09.03.2022	Mum	Letter	Update
09.03.2022	Son	Letter	Update
09.03.2022	Daughter	Letter	Update
27.04.2022	Daughter	Email	Agrees to meet
02.05.2022	Daughter	Phone call	No reply
03.05.2022	Daughter	Email	Feeling nervous. Asks to defer and questions. Sent.
03.05.2022	Son	text	Update and offer
25.06.2022	Daughter	Email	Update and offer
27.06.2022	Daughter	Phone call	Information shared. Notes taken and she will seek permission to share a friend's details
28.06.2022	Daughter	Email	Friends' details shared by daughter
11.07.2022	Friend	Phone call	Message left
25.07.2022	Friend	Email	Friend contacts chair, and agrees for telephone call
26.07.2022	Friend	Phone call	Chair speaks to friend
23.08.2022	Friend	Email	Request for follow up discussion
23.08.2022	Daughter	Letter	Update re panel 1st Sept
23.08.2022	Son	Letter	Update re panel 1st Sept and offer to contribute
26.08.2022	Friend	Phone call	Chair speaks to friend
02.09.2022	Daughter & Son	Letter	Update and offer to meet
15.10.2022	Daughter	Emails	Update and offer for meeting
27.05.2023	Daughter	Email	Update and offer to meet (she had moved)
27.05.2023	Son	Letter	Update and offer to meet
21.06.2023	Daughter	Email	Reply from daughter
21.06.2023	Daughter	Email	Update and offer to meet

APPENDIX C – DHR ACTION PLAN

Recommendation	Scope	Action to take	Lead Agency	Key Milestones achieved	Target Dates	Date of completion and outcome
R1: Sherwood NHS Trust to Review and refresh the Domestic Abuse Policy in accordance with legislative and best practice developments.	Local	Update policy in keeping with any legislative or best practice developments. *(Domestic Abuse Act and encouraging enquiry upon indicators of potential abuse)* Publish policy with relevant launch information highlighting key amendments. Review impact of change through number of DASH referrals	Sherwood NHS Trust	Policy update completed. Policy published. Impact measured	May 2023 July 2023 December 2023	December 2023 Increased referrals/signposting of DA survivors
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*	Local	Develop and deliver safeguarding training which incorporates domestic abuse case scenarios which prompt use of professional curiosity, consideration of routine enquiry regarding domestic abuse and appropriate signposting to domestic abuse services. Offer training to all clinical general practice staff. Monitor outcomes through participant written feedback	GP/ICB	Training devised. Training delivered. Outputs/outcomes monitored	July 2023 September 2023 December 2023	March 2024 Increased referrals/signposting of DA survivors
R2(a): 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.	Local	Review of Domestic Abuse Policy to ask Clinicians and Health Advisors to give consideration to having a wider awareness about patient safety in addition to considering their vulnerabilities in terms of their ill- health. Revise domestic abuse Policy implemented. Deliver Training to staff. Monitor outcomes/outputs	NHS111/IC24	Policy changed. Policy implemented. Training devised delivered - ongoing. Monitor outcomes/outputs	July 2023 September 2023 December 2023 March 2024	March 2024 Increased referrals/signposting of DA survivors
R3: The ICS' Suicide Prevention Partnership, led by Public Health, works together to support primary		Consideration of Primary care pathways is a strategic commitment in the 2023 Norfolk Suicide Prevention Strategy.	Norfolk County Council Public Health	The Suicide Prevention strategy and action plan is	Milestone – June 2024	Strategy 2023-2028 Primary cares are able to improve recognition

care to improve recognising and managing risk including safety planning for suicidal patients.		The suicide prevention partnership agrees the activity needed to support strategic commitment.		published with the strategic commitment included. The suicide prevention partnership agrees activity to be included in the partnership action plan.		and management of risk, including safety planning for suicidal patients
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.	Local	Findings of DHR and suicide audit shared with GP/ICB Practice management meeting to consider any internal policy requirements that need amending. Policy amended. Instruction given to all practice staff.	GP/ICB	DHR and suicide audit shared. Practice management meeting consider policy changes needed Yes/No Policy changes made. Instruction sent to staff	Complete June 2023 August 2023 October 2023	October 2023 Improved identification of alcohol misuse and signposting for support
R5: To seek to raise awareness and the ability to recognise and respond to the risk of suicide associated with the menopause.	Local	Findings of DHR presented at Safeguarding practice meeting	GP/ICB	Findings presented	July 2023	July 2023 Raised awareness of menopause
R6: Work in Partnership to ensure that people who self-harm are in receipt of appropriate care and support.		As part of the suicide prevention partnership, devise clear actions for partner agencies to prioritise prevention and safeguard the wellbeing of people who self-harm	Norfolk and Waveney ICS Suicide Prevention Partnership led by Norfolk County Council Public Health	Agree an action plan as part of the Suicide Prevention Strategy, and Develop a toolkit for self-harm. Where resources allow, increase training for staff on recognising and	Action plan Septembe r 2023 Toolkit October 2023	October 2023 Toolkit for professional dealing with self-harm

				responding to self-harm.		
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).*	Local	Findings to be presented to the council policy team. Learning and development team to review the mandatory training. Policy to be revised and implemented. Training content and delivery (including e-learning) reviewed. Implement new training. Monitor outcomes/outputs	Norfolk County Council	Findings presented. L & D review training New policy Revised training implemented. HEAR relaunched. Outcomes/outputs monitored	May 2023 June 2023 August 2023 October 2023 December 2023	December 2023 Increased referrals/signposting of DA survivors
R8: Seek to reduce the risks of stereotyping that risks the true vulnerability of those living with domestic abuse having confidence to disclose.	Local	Findings of this DHR are shared with the council Equalities, Diversity, and Inclusion (EDI) group and utilised to develop awareness of stereotyping. Learning shared broadly across the council via newsletter / intranet.	Norfolk County Council	DHR shared with EDI group. Learning shared across council	May 2023 October 2023	October 2023 Raised awareness of staff around stereotyping
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.	Local	The NCSP team will develop a communications plan to detail how the findings of the report will be shared professionals and the public, prior to publication. The NCSP team will publish the report, enacting its comms plan	OPCCN/NCSP	Communication plan created. Communication plan enacted. Report published	September 2023 October 2023 January 2024	Partnership is provided with information on learning opportunities presented by this review
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.*	Local	Findings of DHR and suicide audit shared with GP/ICB Findings of DHR presented at Safeguarding practice meeting.	GP/ICB	Findings presented	June 2023 July 2023	GP and wider practices are provided with information on learning opportunities presented by this review

-opportunities to close the feedback loop with patients by asking how referrals had progressed. *-recognising the potential benefits of seeing the same GP*						

Appendix D

Learning Opportunity	R.'tion Y/N	Agency R.'tion	Agency
(LO1) Learning Opportunity: To bring the domestic abuse policy up to date and strengthen the approach to routine enquiry that affords survivors the chance to disclose domestic abuse	R1	N	Sherwood
(LO2) Learning Opportunity: To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse.	R2	N	GP
(LO3) Learning Opportunity: Recognition that adverse childhood experiences can/may have an effect on long-term health and well-being.	R9/R9a	N	GP
(LO4) Learning Opportunity: Recognition that self-harm and suicidal ideation are potential indicators of patients experiencing domestic abuse.	R2	N	GP
(LO5) Learning Opportunity: To ensure consistent use of terminology regarding risk assessment and mental health reviews	R9/R9a	N	GP
(LO6) Learning Opportunity: An opportunity to strengthen and/or standardise the approach to suicide risk management and safety planning.	R3	N	ICS / P. Health
(LO7) Learning opportunity: Raising awareness of co-morbidities and medication that may impact on use of medications used for smoking cessation	N	Y	GP
(LO8) Learning opportunity: For the practice to close the feedback loop with patients and ask how referrals had progressed	R9/R9a	N	GP
(LO9) Learning opportunity: Through improved professional curiosity understand why people's anxiety/depression fluctuated.	R2	N	GP
(LO10) Learning opportunity: To improve/streamline the communication and referral pathways between primary and secondary healthcare. *(resolved)*	N	N	GP/NSFT
(LO11) Learning opportunity: Recognition of alcohol misuse as a factor requiring exploration for those experiencing suicidal ideation.	R4	N	GP
(LO12) Learning opportunity: Missed opportunities to ask about domestic abuse on the presentation of health indicators that may evidence domestic abuse.	R2	N	GP
(LO13) Learning opportunity: To strengthen the approach to training, to ensure staff are able to recognise and respond to domestic abuse.	R2	N	GP
(LO14) Learning opportunity: Recognising there are benefits seeing the same GP to continuity of care	R9/R9a	N	GP
(LO15) Learning opportunity: To recognise the possibility of the menopause being a contributory factor that escalates the risk of self-harm/suicide.	R5	N	GP
(LO16) Learning Opportunity: To improve the agencies response, by thinking and being alert to the possibility of domestic abuse as being causal to symptoms described by patients.	R2	N +other	NHS111/ IC24
(LO17) Learning opportunity: To improve the recognition and response to signs of domestic abuse, demonstrating improved professional curiosity and asking about domestic abuse, by ensuring policy and training requirements are in place.	R2	Y	NNUH
(LO18) Learning Opportunity: Improve recognition and response to indicators of potential domestic abuse and apply enhanced professional curiosity and investigative mindset to explore those indicators.	R2	Y	NNUH
(LO19) Learning Opportunity: To strengthen the local domestic abuse policy in order to encourage 'routine enquiry'.	N	Y	NNUH
(LO20) Learning Opportunity: Improve the discharge policy to ensure that safeguarding, domestic abuse, and mental health concerns are embedded into the pathway.	R2	Y	NNUH
(LO21) Learning Opportunity: To enhance the training regarding domestic abuse, ensuring staff are able to recognise and respond signs of abuse	R2	Y	NNUH
(LO22) Learning opportunity: To improve the communication and referral pathways between NSFT services/ NSFT's MHLT and its Community mental health team (CMHT) ***(resolved)***	N	N	NSFT
(LO23) Learning Opportunity: To improve how referrals are triaged, to identify high risk behaviour that informs prioritisation ***(resolved)***	N	N	NSFT
(LO24) Learning opportunity: To ensure that risks associated with alcohol consumption and mitigation are acted upon and documented.	N	Y	NSFT
(LO25) Learning opportunity: Recognising that adverse childhood experiences merit consideration when exploring treatment options for those expressing suicidal ideation	R9/R9a	N	NSFT
(LO26) Learning opportunity: Opportunity to improve the long-term management for those who have a history and continue to self-harm	R6	N	ICS / P.Health
(LO27) Learning Opportunity: To seek assurance that minimum standards of investigation are adhered to, including closure of investigations. ***(resolved)***	N	N	Norfolk constabulary
(LO28) Learning Opportunity: Ensuring that survivors of domestic abuse are signposted to support services. ***(resolved)***	N	N	Norfolk constabulary
(LO29) Learning Opportunity: To ensure that all staff are able to 'recognise, respond, refer and record' all facets of domestic abuse.	R7	N	NCC
(LO30) Learning Opportunity: Stereotyping risks applying characteristics to an individual, that masks the true vulnerability of Sarah a person living in an abusive relationship.	R8	N	NCC

APPENDIX E: 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
NNUHT	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 F: ONE PAGE SUMMARY

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.

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.
Police: good secondary supervision, leaflets for responders on support agencies
Other: DA champion network across Norfolk

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*

ANNEX G: HOME OFFICE FEEDBACK LETTER

ANNEX G: HOME OFFICE FEEDBACK

Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848

www.homeoffice.gov.uk

Liam Bannon (he/him)
Community Safety Officer
Community Safety and Violence Reduction Coordination
Team Office of the Police and Crime Commissioner for
Norfolk Norfolk County Council
County Hall
Martineau Lane
Norwich, Norfolk
NR1 2DH

15th February 2024

Dear Liam,

Thank you for submitting the Domestic Homicide Review (DHR) report (Sarah) for Norfolk Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Panel. The report was considered at the QA Panel meeting on 21st December 2023. I apologise for the delay in responding to you.

The QA Panel concluded that family and friends helped amplify Sarah's voice within the report. There was positive engagement with Sarah's daughter Margaret and her friend who provided an insight to Sarah as a person.

The report includes two recommendations around self-harm and suicide, these are often lacking in DHRs relating to domestic abuse suicide. It was also good to see reference to workplace policies on domestic abuse and the need to support staff. More generally, the Panel highlighted the clear conclusion, chronology, lessons learned and recommendations of the report.

The QA Panel felt that there are some aspects of the report which may benefit from

further revision, but the Home Office is content that on completion of these changes, the DHR may be published.

Areas for final development:

- There is evidence from family of financial/economic abuse, this is acknowledged by the panel, yet there is no analysis of this. The report would benefit from analysis of financial and economic abuse.

- The Chair is referred to as a "Home Office approved chair for Offensive Weapons Reviews" in the executive summary which is misleading. The terms

  of reference could also include something more specific about domestic abuse and suicide.

- In the executive summary the name is missing at 5.4 "covering an event where……took an overdose." Also 6.12 could be rewritten to be clearer.

- There is a lack of relevance including the male suicide figures in the overview report at 11.3.

- There is a word missing in paragraph 14.5 and 14.2.7 should read anti- depressant.

- The report states there is no evidence that Sarah's suicide was linked to the menopause or if she had any issues related to this. However, the reference at
  16.4.61 links to increased suicide amongst women at this time.

- There were missed opportunities to undertake domestic abuse, stalking and 'honour'-based violence (DASH) risk assessments, importantly a failure to refer to multi agency risk assessment conference (MARAC).

- There were no care and support needs identified within the review however, Sarah was treated for mental health illnesses and may have benefited from onward referral for a care assessment.

- There were concerns around missed appointments and engagement with services.

- Public Health were not represented on the CSP panel (although they are identified on panel membership). It would have been helpful for their suicide prevention lens and expertise to contribute to panel meetings.

- There is reference to a termination at 17 which lead to the victim attempting suicide, not sure if this was relevant at the time of her death. The inclusion of the suicide note in the report should be reviewed.

- There is some repetition within the report which could be addressed.

- The Terms of Reference include the actual date of death.
- The month and year of death are missing from the front page.
- The CSP and panel might consider removing the exact date of the inquest at page 66 and at 10.1 and 13.4 to better support anonymity, instead stating just the month and year.
- Section 1.4 refers to 'homicide' this should be changed to 'suicide' to reflect the circumstances of the victim's death.
- The report requires a thorough proofread for typos and grammar issues.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel

ANNEX H: DHR CHAIR AND PANEL RESPONSE TO HOME OFFICE LETTER

No.	Description	Response from chair	RAG status
1	There is evidence from family of financial/economic abuse, this is acknowledged by the panel, yet there is no analysis of this. The report would benefit from analysis of financial and economic abuse.	16.2.6 amended to highlight financial abuse 17.1.5 altered slightly to reinforce the controlling , coercive nature and financial abuse that took place over time The chair has also added an end paragraph 17.2.24 to the conclusion. One page summary has also been amended to reflect the learning opportunity.	**18.02.2024**
2	The Chair is referred to as a "Home Office approved chair for Offensive Weapons Reviews" in the executive summary which is misleading. The terms of reference could also include something more specific about domestic abuse and suicide.	Executive Summary amended . The terms of reference have been agreed by the panel and were the ToR that guided the process. That said, the full terms of reference have been amended to include at Appendix A under Purpose of DHR • To prevent domestic violence and homicide, ***deaths related to domestic abuse (suicide***), 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.	**17.02.2024**
3	In the executive summary the name is missing at 5.4 "covering an event where……took an overdose." Also 6.12 could be rewritten to be clearer.	Para 5.4 line 2, change made Alternative paragraph for 6.12 provided	**17.02.2024**
4	There is a lack of relevance including the male suicide figures in the overview report at 11.3.	The panel sought to understand the phenomenon of suicide and in so doing identified a number of facts that provide context for the review. The paragraph has been retained	**17.02.2024**

5	There is a word missing in paragraph 14.5 and 14.2.7 should read anti depressant.	There is no paragraph 14.5. Have inserted word 'was' in 14.2.7. Word amended – thank you	**17.02.2024**
6	The report states there is no evidence that Sarah's suicide was linked to the menopause or if she had any issues related to this. However, the reference at 16.4.61 links to increased suicide amongst women at this time.	16.4.60 states there is no evidence to suggest that menopause was a factor and whilst local professionals have seen an increase in numbers of women taking their own lives, the panel concluded that there could be the 'possibility' of a link. Hence a recommendation to <u>be alert to this possibility</u> of this link. This was a nuanced discussion that the panel concluded merited inclusion and sharing. It further demonstrates the broad reflections and professional curiosity of the whole panel.	**17.02.2024**
7	There were missed opportunities to undertake domestic abuse, stalking and 'honour'-based violence (DASH) risk assessments, importantly a failure to refer to multi agency risk assessment conference (MARAC).	DASH was completed by police when they were called and on consideration the panel did not conclude referrals should have been made to MARAC. One cannot assume a DASH completed will result in a MARAC and to conclude there was a failure to refer relies too much on the counsel of perfection that is hindsight bias. Moreover, there was an occasion where risk was downgraded (see 16.8.7). In addition, the local police are moving to a DARA risk assessment model (16.8.8) The primary learning across the board relates to recognition and response to Domestic Abuse and whilst had abuse been recognised this may have greater consideration as to response (and risk assessment), the panel agreed it is not proportionate to consider this at this juncture.	**17.02.2024**
8	There were no care and support needs identified within the review however, Sarah was	Paragraph 16.4.56 deals with this specifically.	**17.02.2024**

	treated for mental health illnesses and may have benefited from onward referral for a care assessment.	On considering the three conditions that would satisfy the needs for a local authority to undertake a safeguarding enquiry, the panel concur that there was nothing apparent to indicate she would have met the criteria set out below	
9	There were concerns around missed appointments and engagement with services.	This has been specifically addressed at 16.7.1 to 16.7.2 (LO22)	**17.02.2024**
10	Public Health were not represented on the CSP panel (although they are identified on panel membership). It would have been helpful for their suicide prevention lens and expertise to contribute to panel meetings.	Public Health were on panel (Sue Marshall) The chair had numerous meetings with, and exchanges of information with public health. This is also evidenced in respect of recommendations. However, the panel agrees that Public Health should be considered as key stakeholders in dealing domestic abuse related death reviews.	**17.2.2024**
11	There is reference to a termination at 17 which lead to the victim attempting suicide, not sure if this was relevant at the time of her death. The inclusion of the suicide note in the report should be reviewed.	15.2.2 & 16.4.4 redacted – whilst matters of fact, do not add to report. Agreed and thank you. Note removed and very short precis added to 13.3	**17.2.2024**
12	There is some repetition within the report which could be addressed.	It is acknowledged there is an element of repetition, but the chair/author's style is to demonstrate the 'working out'. As an example, numbering off learning opportunities as they arise and drawing them together to shape lessons learned. With this in mind, as well as an executive summary, a one page summary is provided to assist the reader and professionals.	**17.2.2024**
13	The Terms of Reference include the actual date of death.	Changed – thank you	**17.02.2024**
14	The month and year of death are missing from the front page.	Revised – thank you	**17.02.2024**
15	The CSP and panel might consider removing the exact date of the inquest at page 66 and at	Revised – thank you	**17.02.2024**

	10.1 and 13.4 to better support anonymity, instead stating just the month and year.		
16	Section 1.4 refers to 'homicide' this should be changed to 'suicide' to reflect the circumstances of the victim's death.	Revised – thank you	**17.02.2024**
17	The report requires a thorough proofread for typos and grammar issues.	Completed	**17.02.2024**