



NORFOLK COMMUNITY
SAFETY PARTNERSHIP

Domestic Abuse Related
Death Review

Executive Summary for the Death of Angela in May 2023

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Independent Chair and Author



Preface

To ensure confidentiality, only the author and review panel's names have been disclosed; all other names are pseudonyms as accepted by the family.

The independent author and review panel send their deepest condolences to all those impacted by Angela's untimely passing and thank them for their involvement and support in this process.

The primary objective of a Domestic Homicide Review (DHR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each instance for these lessons to be thoroughly and effectively assimilated and what must be altered most to reduce the likelihood of such tragedies.

The author thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

The author expresses gratitude to the family for helping to ensure that the review appropriately portrayed Angela's life.

Angela was a devoted mother to her three grown children, who described her as a caring and nurturing parent. She played a significant role in their upbringing and well-being.

She was also a successful businesswoman, working as a bookkeeper in the family business and owning multiple companies. Her professionalism and dedication to her work contributed to her achievements.

Angela was known for her kindness, happiness, and fun-loving nature. Her family and friends remember her as a well-dressed, warm, and positive individual who brought joy to those around her.

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Section One: The Review Process

- 1.1.1 This summary outlines the process undertaken by the Norfolk Community Safety Partnership (NCP) domestic homicide review panel in reviewing the death of Angela, who was a resident in their area.
- 1.1.2 The family has selected the following pseudonyms:
- The victim: Angela
 - Mother: Michelle
 - Son: James
 - Daughter: Liz
 - Daughter: Nicole
 - Husband: Matthew
- 1.1.3 Angela was fifty-two at her death. She and Matthew had been together for thirty-two years and married for twenty-two. They had three children.
- 1.1.4 In August 2012, while residing abroad, Angela's brother died. Angela experienced an escalation in the occurrence of panic attacks and the emergence of 'tics' after her brother's death.
- 1.1.5 Furthermore, she revealed in 2015 that she had an intermittent, stressful relationship with her father. Matthew stated that her father was once relatively affluent but regrettably lost everything and turned to alcohol, factors that ultimately culminated in his death in March 2017.
- 1.1.6 Angela experienced stress, anxiety, depression, and intermittent, excessive alcohol consumption since 2003. In 2015 and 2018, Angela was referred to the mental health team by her GP. Additionally, she had self-referred to the community alcohol and substance service and the wellbeing service.
- 1.1.7 After her father's death, her developing tics, which were verbal and frequently involved swearing and shouting "no," became more severe. Consequently, her stress and anxiety levels intensified, and she would often jolt awake during the night, screaming.
- 1.1.8 Angela persisted in experiencing symptoms of anxiety, depression, and stress until her death. Following the removal of the Mirena Coil in 2022 and the cessation of her antidepressant prescription, these symptoms worsened.
- 1.1.9 Angela revealed to the drug and alcohol service (Change, Grow Live: CGL) her involvement in a collision with multiple vehicles and an overdose while driving fifteen

days before her death; she was engaged in a dispute with the property owner as she had damaged their fence with the property owner and Angela was arrested.

- 1.1.10 The day before Angela's death, Matthew discovered her hanging, and he cut her down. She then left the home to purchase alcohol, and he called for an ambulance. The ambulance's dispatch system advised him to contact the police instead, given that they were not provided with the caller's details or address. However, according to Matthew, their attendance declined, and they recommended that he contact the police. There were no calls to the police.
- 1.1.11 The ambulance service confirmed that no names or addresses were supplied in the call log from the day before Angela's death. The call was identified as having a poor connection. The call handler noted shouting and advised the caller to relocate to a better location. The caller stated that he wanted her "sectioned or just taken away."
- 1.1.12 The call handler explained that an ambulance could not be dispatched without a location, as they are sent only by location, and the caller would be required to contact the police. The caller was reportedly abusive and disconnected the line before the call handler could explain further.
- 1.1.13 The EEAST internal review of the call revealed that call handlers lacked explicit instructions regarding the processing of calls for patients with mental health requirements who do not remain at a single location. As a result, staff must obtain the necessary support and guidance and ensure that relevant information is recorded. EEAST has issued recommendations to enhance its response to mental health patients in such situations.
- 1.1.14 Angela purchased a bottle of tequila and one bottle of wine. After pouring the tequila into the sink, Matthew contacted Michelle, Angela's mum, to request that she stay with Angela for the evening. Matthew reported that Michelle had travelled to Angela's home, conversed with her while travelling there, and agreed to visit her the next day.
- 1.1.15 The next day, Michelle visited Angela and observed that the door was unlocked; despite calling for Angela, she received no response. She was aware of the incident that occurred the day before, during which Matthew discovered she had hanging. Michelle subsequently found Angela deceased.
- 1.1.16 The cause of death was:
 - 1(a) Hanging
 - 2 Combined Drug Use (Alcohol, Diazepam, Diphenhydramine)
- 1.1.17 The process began with the Community Safety Partnership meeting on 27 June 2023, when the decision to hold a domestic homicide review was agreed upon. All agencies

that potentially had contact with Angela and Matthew before the point of death were contacted and asked to confirm whether they had been involved with them.

1.1.18 Ten agencies contacted confirmed contact with Angela and/or Matthew and were asked to secure their files.

Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution- Chronology/IMR/Summary/Other
Breckland District Council	Chronology (not relevant to review)
Change Grow Live (CGL) Drug and Alcohol Service	Chronology and IMR
East of England Ambulance Service NHS Trust (EEAST)	Chronology and review of the call log for the day before Angela died
GP Practice	Chronology and IMR
Leeway Domestic Violence and Abuse Services	Chronology and Summary Report
Norfolk Constabulary	Chronology and IMR
Norfolk and Norwich University Hospital (NNUH) General Hospital	Chronology and Summary Report – Related to Matthew
Norfolk and Suffolk NHS Foundation Trust (NSFT) Mental Health Service	Chronology and Short Report
Norfolk and Waveney Mind (N&W Mind) Mental Health Charity	Chronology
Queen Elizabeth Hospital (QEH) General Hospital	Chronology and Short Report

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

Name	Role	Organisation
Amy Jolly	Head of Safeguarding Families	Norfolk and Suffolk NHS Foundation Trust
Amy Lucas	Sergeant	Norfolk Constabulary

Charlotte Richardson	Service Manager	Norfolk Integrated Domestic Abuse Service
Dave Burke	Detective Inspector	Norfolk Constabulary
Charlotte Richardson	Service Manager	Norfolk Integrated Domestic Abuse Service
Elaine Joyce	Sector Safeguarding Lead & Named Professional - Norfolk & Waveney Paramedic	East of England Ambulance Service
Gary Woodward	Safeguarding Adult Designate	Norfolk and Waveney Integrated Care Board
Hannah Nicolas	Safeguarding Lead for Adults and Children	Queen Elizabeth Hospital University Trust
Isabel Allison	Community Safety Officer	Office of the Police and Crime Commissioner of Norfolk
Jo Riley	Service Manager	Change, Grow, Live
John Mosedale	Complex Review Manager	Adult Social Care
Kate Brolly	Deputy Designated Professional Safeguarding Adults/ Clinical Mental Capacity Lead	Norfolk and Waveney Integrated Care Board
Kristal Oakley	Assistant Service Manager	NIDAS
Liam Bannon	Community Safety Manager	Office of the Police and Crime Commissioner of Norfolk
Nadia Jones	Public Health Principle	Public Health
Pippa Hinds	Detective Superintendent	Norfolk Constabulary
Suzannah Armstrong-Cobb	Communications Officer	Office of the Police and Crime Commissioner of Norfolk
Tina Chuma	Lead Professional for Safeguarding	Norfolk and Norwich University Hospital
Tracey Stevens	Community Safety Support Officer	Office of the Police and Crime Commissioner of Norfolk

3.1.2 The panel met a total of seven times.

Section Four: Author of the Overview Report

4.1.1 Parminder Sahota is an independent author with eleven years of experience in domestic abuse and safeguarding. Advocacy After Fatal Abuse provided the DHR Chair training in

2021. She has worked as a mental health nurse in the NHS for over twenty years and is a Director of Safeguarding, Prevention, and Domestic Abuse Lead for an NHS Trust.

4.1.2 Before this review, Parminder Sahota had no contact with Angela's family or friends and was independent of the participating agencies and the Norfolk Community Partnership.

Section Five: Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in May 2023 and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Angela.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.
- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Angela's voice is heard regarding her experiences and the impact of domestic abuse. Allowing her journey to be told and identifying the lessons that may be learnt.

5.1.2 The panel was informed that for more than thirty years, Angela and Matthew had been in contact with the police regarding incidents of domestic abuse and violence. The panel agreed to commence the review from April 2020 to May 2023 after a notable occurrence of physical domestic abuse in April 2020.

5.1.3 The panel agreed on fourteen terms of reference.

Section Six: Summary Chronology

April 2020

6.1.1 A 999 call was made following an incident of domestic assault. Police were present at the location. Angela had been subjected to an assault by Matthew, who repeatedly struck her in the head and face. EEAST advised a hospital visit due to the severity of the assault. However, Angela declined and said she would seek her daughter's advice and attend if necessary.

- 6.1.2 Reportedly, Matthew began drinking alcohol after a phone call to his mother caused him to become agitated. As Matthew continued to consume alcohol, he attacked Angela. The frequent and forceful strikes he delivered to Angela's face caused considerable oedema to her cheeks, forehead, and temples. Throughout the day, and while tormenting Angela, Matthew threatened her life on numerous occasions. Angela was concerned about her safety.
- 6.1.3 A referral was made to the Domestic Abuse Safeguarding Team (DAST). Angela requested to be contacted by DAST again in a few days and responded that she did not need further assistance.
- 6.1.4 A Multi-Agency Risk Assessment Conference¹ (MARAC) was held – no actions were specified.
- 6.1.5 Angela received guidance from the Independent Domestic Violence Advocate² (IDVA), who presented her with options for safe housing. According to Angela, Matthew was actively participating in Alcoholics Anonymous (AA) and had not consumed alcohol. The call was terminated as Matthew approached Angela. The DAST was provided with the information.

May 2020

- 6.1.6 Leeway contacted Angela via telephone, and she informed them that everything had been going well at home. Following the death of Matthew's mother, he had been alcohol-free for most of the previous days. Angela's children were present. Angela recognised that Matthew's conduct exhibited abusive qualities; however, she clarified that there is no apparent correlation between excessive alcohol consumption and abuse. The DAST was updated.

June 2020

- 6.1.7 Leeway made a call to Angela, but she did not answer. Angela sent a message informing them that she had part-time employment and was okay. She stated she would contact the Independent Domestic Violence Advocate (IDVA), but could not set a time due to her working hours.
- 6.1.8 A domestic abuse investigation by the police uncovered a verbal altercation between Angela and Matthew. Angela disclosed that Matthew had become verbally antagonistic towards her and their children while intoxicated after a family barbecue. No offences were reported, and Angela left to stay with her daughter. No further action was taken.

July 2021

¹ <https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf>

² <https://safelives.org.uk/what-is-an-idva>

6.1.9 A domestic abuse investigation. Matthew, who was significantly intoxicated, reported Angela as the source of his distress to the police and threatened to murder her if they did not intervene. When the police arrived, Matthew was aggressive; he reported that he and Angela had engaged in a verbal altercation and that she had since left. Angela informed the police over the phone that everything was in order and that the case resulted in no further action.

February 2022

6.1.10 Angela informed her GP she had stopped mirtazapine (antidepressant) as she felt tired on this.

March 2022

6.1.11 Angela reported feeling fine after her GP reviewed her hormone replacement therapy and contraceptive medication, in addition to discussing depression. She conveyed that despite experiencing symptoms such as night terrors, she was able to manage them and was keen to do so without resorting to antidepressant medication. She reported that her husband and friends had remarked on how much better she appeared.

May 2022

6.1.12 A call to 999 was made three times to report that Angela had taken an overdose of thirty diazepam tablets. The E EAST documentation indicated that a male could be overheard swearing as the caller disconnected. Matthew reported that Angela was responsible for three assaults on him. He denied sustaining any injuries and did not refer to the need for an ambulance. As the crew engaged in discussion, the sound of Angela screaming in the background was reported to dispatch. E EAST concluded that it was unsafe to approach. Nevertheless, Angela lost consciousness because of her deteriorating condition. Contact was made with the police, but they declined to intervene due to Angela's unconscious state. Upon the crew's arrival, Matthew, who appeared highly intoxicated, greeted them. Angela was documented as having a severe Glasgow Coma Scale (GCS) value of 3 (completely unresponsive). Angela was transported by ambulance to the QEH.

6.1.13 Angela was admitted to a ward in QEH. When asked why she had overdosed, she responded that she wished to "disappear." Angela was placed under Level 3 special observations³. She requested to return home that evening but was urged to remain overnight and see the MH team the next day. A CT scan was performed.

6.1.14 Angela was seen by the safeguarding team at QEH, who tried to complete a Domestic Abuse, Stalking, and 'Honour' Based Risk Assessment⁴ (DASH). Angela declared that she did not necessitate safeguarding and had no intention of participating in the DASH. The ward doctor assessed her and noted her mood had improved since the preceding day.

³ level 3. Within the eyesight of a staff member at all times, a staff member would always be in the bay.

⁴ https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

She disclosed experiencing suicidal thoughts upon awakening and never rising with a positive attitude. She stated that she had no current suicidal or self-harming intentions and that Matthew had not treated her violently in the past three years.

6.1.15 Angela was assessed by the Mental Health Liaison Team (MHLT); Angela exhibited caution in responding to specific enquiries. She disclosed that she impulsively overdosed following a family dispute that was intensified by alcohol. Angela discontinued the use of antidepressants in January 2022. She expressed her determination to live, citing her three children as protective factors, and she did not contemplate suicide. Angela was regarded as insightful and capable of weighing risks. The CT scan was normal, and the medical staff learned that she had purchased diazepam online. Angela felt her family did not understand her mental health. After Angela and Matthew discussed the risks and discharge, Matthew felt that Angela should be discharged. Angela declared that she had no intention of attempting an overdose in the future. Angela consequently accompanied Matthew home that evening.

6.1.16 Angela revealed to the MHLT that she had self-referred to a wellbeing program. She reported that her husband, who was initially supportive, became angry and frustrated with her because he failed to understand her mental health issues. She reported no history of alcohol abuse. Angela was referred for ongoing mood and risk assessment to the Crisis Resolution Home Treatment Team⁵ (CRHT). Together with the ward team, she agreed on a strategy for supporting her ongoing mental health issues. With her agreement, she decided to receive support from the wellbeing group sessions and CGL. Thus, CRHT was not implemented at the time of discharge.

June 2022

6.1.17 Angela was contacted via telephone by Norfolk and Waveney Mind; however, no response was received, so a letter of introduction was sent, requesting her to establish communication.

July 2022

6.1.18 CGL received a referral from the mental health service.

6.1.19 Angela attended the planned assessment with CGL. Angela disclosed that her drinking increased eleven years after the death of her brother. In response to a question regarding the risk posed by others, she stated that her husband was an "angry drinker." She disclosed that she had previously overdosed on alcohol and diazepam and that her mood fluctuated "in waves." She disclosed that the GP attended to her mental health concerns and that she had voluntarily sought assistance from the well-being service. She disclosed frequently consuming alcohol; she did not believe that she posed a risk to others.

⁵ <https://www.nsfh.nhs.uk/adults/service/crisis-resolution-and-home-treatment-team-central-norfolk-15/>

- 6.1.20 Angela agreed to receive telephone support from Mind after calling in response to the letter she received.
- 6.1.21 Police attended and found Angela and Matthew heavily intoxicated and engaged in a verbal altercation. Discussions about Angela's mental health were identified as the underlying cause of the dispute. Amidst the increasing conflict tensions, Angela accidentally struck Matthew in the face; no injuries were observed. While Angela was leaving, Matthew locked the door. Angela returned and shattered a pane of glass in the front door window.
- 6.1.22 Angela was seen in police custody by the Liaison and Diversion⁶ (L&D) The team is following up on concerns about her mental health. Angela declined an assessment but stated she had been referred to CGL, which was confirmed on the system. Angela was subsequently discharged to her GP for ongoing support with her mental health.
- 6.1.23 Angela disclosed during the GP's telephone review that she lived with her mother outside the county and had been arrested over the weekend following a dispute with her husband. She stated that a disagreement over the weekend prompted the police to be called. At that time, she felt Matthew held her responsible, and she was preparing to appear in court. Despite having maintained abstinence from alcohol for the preceding week, the return of her husband incited a resumption of drinking, leading to the intervention of the police. Angela agreed with her GP's recommendation that she and her husband try to control their alcohol consumption concurrently by temporarily separating.
- 6.1.24 Angela was referred to the Community Mental Health Team⁷ (CMHT) internally by the well-being team and presented with extreme anxiety, delusional thoughts, medication noncompliance, excessive alcohol consumption, and an inability to leave her house. CMHT accepted the referral and scheduled an appointment with Angela.

August 2022

- 6.1.25 CMHT Assessment. Disclosure of domestic abuse during their marriage. Matthew's behaviour was challenging, and he was also part of a team that studied sports-related head injuries. She reported experiencing hallucinations when she was tired and seeing people transform into animals. Alcohol misuse occurred regularly. She stated she was arrested once after a complaint from her husband. Physical and vocal tics were present during the assessment. She reported experiencing suicidal thoughts weekly but did not intend to act on them and sought psychological treatment through well-being sessions. Following these assessments, the plan was to request the GP to refer for a head scan and referral to neurology and CMHT if required. The GP was asked to follow up on pre-

⁶ <https://www.nsf.nhs.uk/service-details/service/liaison-and-diversion-service-ld-68/>

⁷ <https://www.nsf.nhs.uk/community-services/service/adult-community-mental-health-services-in-great-yarmouth-and-waveney-113/>

menopausal blood tests and treatment. Angela declined a referral to the Pandora Project⁸ for domestic abuse support.

September 2022

6.1.26 The GP noted a scan had been completed in 2017 and revealed no abnormalities.

6.1.27 Angela attended her scheduled consultation with CGL. Angela had decreased her alcohol consumption to one glass in the evening, supplemented by a few more on weekends. Angela indicated she did not believe she depended on alcohol. The agreed plan was for Angela to attend the Extended Brief Intervention⁹ (EBI) groups.

November 2022

6.1.28 CGL contacted Angela after the EBI group session. Angela elaborated on the reason she began drinking heavily: an incident that occurred in May 2022, for which she sought counselling. She was informed that CGL would attempt to have an Emerging Futures¹⁰ (EF) representative contacted her to assist with this.

6.1.29 EF supported Angela till her death in May 2023.

March 2023

6.1.30 A female called the police to report that she was involved in a domestic altercation that involved shouting. When the police arrived, they discovered two females, a mother and daughter, who reported being involved in an incident during which the mother received a minor cut to the finger. Matthew was arrested for common assault.

April 2023

6.1.31 Matthew was admitted to the hospital for physical health-related concerns.

May 2023

6.1.32 Angela was arrested by the police and transported to QEH while intoxicated, possibly having taken 14x5mg of diazepam. She was able to walk and disclosed that she had ingested diazepam in response to a verbal altercation with her husband about the cancellation of his surgery. Angela disclosed consuming a bottle of wine and, after that, commencing the use of diazepam to calm her; she reported no mental health concerns, low mood, or suicidal ideation. She had collided with a vehicle while driving down a narrow street; the police were dispatched.

6.1.33 The police sent a referral to adult social care concerning the above, including that Angela had taken an overdose.

⁸ <https://www.pandoraproject.org.uk/>

⁹ <https://www.nice.org.uk/guidance/ph24/chapter/4-Glossary#:~:text=See%20alcohol%20dependence,-.Extended%20brief%20intervention,positive%20reasons%20for%20making%20change.>

¹⁰ <https://www.emergingfutures.org.uk/projects/norfolk/>

6.1.34 Matthew was placed in a virtual ward at home; the hospital was tasked with maintaining contact with him every two hours while remotely monitoring his condition. Angela disclosed to CGL, in response to this information, that she was unable to cope and had intended to drive to gain access to a mental health hospital; she expressed apprehension and confusion regarding her wish to live.

6.1.35 A 999 call for uncategorised mental health issues. The caller stated he could not get her to stay still or give an address and was advised to call the police. The call was abandoned. Police were not called, and agencies did not see Angela, and subsequently, her mental health and risk were not assessed.

6.1.36 Two 999 calls were received for cardiac arrest; Michelle found Angela deceased.

Section Seven: Key Issues Arising from the Review/Lessons Learned

7.1.1 Response to Disclosures of Domestic Abuse

7.1.2 In April 2022, the Department of Health and Social Care published guidance to strengthen the response to domestic abuse further.

Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'

'Health professionals have a responsibility to address the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.'

7.1.3 The Norfolk Community Partnership and the Safeguarding Adult Board Partnership fund free introductory training sessions on trauma-informed practice for all partners, including those working with vulnerable adults. The objective is to gain insight into the participants, their teams, and service users and better understand their behavioural responses.

7.1.4 The Norwich City College YouTube Channel offers the following #SeeTheChains short films to strengthen the response:

- Controlling Behaviour: <https://www.youtube.com/watch?v=wOrAMTuPqWU>
- Emotional Blackmail: <https://www.youtube.com/watch?v=DvVfLWqSsyc>
- Jealousy: <https://www.youtube.com/watch?v=FD0R94WEVA4>
- Physical Violence: <https://www.youtube.com/watch?v=FD0R94WEVA4>

- 7.1.5 Furthermore, there is a diverse selection of posters that are intended to increase awareness of domestic abuse, with a particular focus on the friends and family of victims/survivors.
- 7.1.6 **Alcohol, Mental Health and Domestic Abuse**
- 7.1.7 The review underscores the critical link between mental health and domestic abuse, stressing the need for better identification, intervention, and multi-agency collaboration. Mental health issues increase both victimisation and perpetration risks.
- 7.1.8 Domestic abuse is often overlooked in mental health services, and domestic abuse services may lack the expertise to address mental health concerns.
- 7.1.9 GPs played a key role in Angela's care, but poor coordination and limited information sharing between services were problematic. Alcohol misuse is linked to domestic abuse and criminal activity, forming part of the risk trilogy: substance use, alcohol misuse, and domestic abuse, which increase the risk of serious harm.
- 7.1.10 Alcohol was cited as a common theme in a sample of 39 DHRs, with fifteen identifying the victim as experiencing alcohol problems and fifteen with both the victim and perpetrator.¹¹
- 7.1.11 The awareness of alcohol is commonplace in such tragedies. It requires services to ensure they have processes to identify victims/perpetrators who present with alcohol issues and work with multiple agencies to respond to this. The guide produced by AVA¹² may provide a baseline for good practice.
- 7.1.12 Angela's distress in custody, noted by her daughter Nicole, may have manifested as stress-induced tics, reflecting the impact of trauma on her mental health. Despite no self-harm concerns being reported, her psychological distress, especially after a collision, assault, and detention, may not have been fully recognised.
- 7.1.13 This situation highlights the need for mental health assessments in custody to identify and address subtle distress signs. The Liaison & Diversion service was unavailable during Angela's detention.
- 7.1.14 **Caregiving Responsibilities and Domestic Abuse**
- 7.1.15 Matthew's placement in a virtual ward made Angela feel responsible for his care. Angela stated that her life appeared to be pre-determined and that she would be the one to care for her grandkids. She also espoused the importance of family unity.

¹¹ <https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf>

¹² <https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf>

7.1.16 Suicide and Domestic Abuse

- 7.1.13 According to the Lancet¹³, one in every three women who attempted suicide in the previous year was a victim of intimate partner violence, compared to one in every twenty women in the general population. As a result, the findings advise routine enquiries regarding intimate partner violence in healthcare settings, along with protective measures for those who may be vulnerable. In addition, suicide attempts and self-harming behaviours are essential risk indicators for eventual suicide and are critical for suicide prevention.
- 7.1.14 A significant risk factor identified in the five-year national suicide prevention strategy is domestic abuse.¹⁴
- 7.1.15 A coroner's inquest in England determined that domestic abuse was the fundamental factor contributing to the suicide of a 34-year-old woman. This was the first instance in which a coroner in the United Kingdom had attributed suicide to domestic abuse.
- 7.1.16 The coroner advised that first responders recognise the correlation between domestic abuse and suicide more readily and that interagency coordination be enhanced to avert similar fatalities in the future.
- 7.1.17 Level 1 Zero Suicide Alliance and Level 2 Half-Day Suicide Prevention Course Training—No More Suicides¹⁵ is an available resource for all frontline practitioners.

Section Eight: Conclusion

- 8.1.1 Angela and Matthew had been together for more than thirty years. Angela, who was employed in the family business, disclosed that her coworkers were not aware of her mental health struggles. Michelle stated that Angela's three adult children succeeded in life, and Angela was proud of them.
- 8.1.2 Since the late 1990s, Angela and Matthew have had intermittent encounters with the police related to domestic abuse.
- 8.1.3 Angela discontinued taking mirtazapine in February 2022 due to feelings of lethargy and emotionlessness, and in March 2022, the Mirena Coil was removed from Angela.
- 8.1.4 Although it is not recommended to discontinue medicine without medical guidance, it is their right to do so as an adult with decision-making capacity. Angela had the capacity to

¹³ <https://www.thelancet.com/action/showPdf?pii=S2215-0366%2822%2900151-1>

¹⁴ <https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy>

¹⁵ <https://no-more.co.uk/training/>

make this decision. To mitigate potential adverse effects such as dizziness, anxiety, and nausea, it is advisable to reduce the dosage of mirtazapine gradually.

- 8.1.5 Removal of the Mirena Coil may result in mood swings as a potential adverse effect.
- 8.1.6 Angela took a significant overdose in May 2022, necessitating ITU intervention and subsequent hospitalisation. Angela had stated this was an attempt to end her life. Angela disclosed that both her mother and husband had mistreated her, and QEH made an unsuccessful attempt to conduct a DASH risk assessment. Angela was referred to CRHT and discharged with ongoing support from her GP, with whom Angela reported a positive rapport. Nonetheless, it was not made apparent in the letter to the GP that CRHT was not involved with Angela.
- 8.1.7 Angela became involved with CGL in July 2022. She was allocated a recovery worker and counselling with EF as she initiated the use of alcohol for sleep aids and mood regulation.
- 8.1.8 Angela disclosed domestic abuse during a CMHT mental health assessment in August 2022; she declined a referral to domestic abuse services. She was discharged from the CMHT and maintained ongoing CGL and GP support.
- 8.1.9 Angela was prescribed Citalopram and requested an increase in dosage in April 2023 in response to the stress she experienced after Matthew's heart attack.
- 8.1.10 Angela revealed to CGL that she felt obligated to care for Matthew after his discharge home and his placement on a "virtual ward." However, the virtual ward team had not spoken to Angela, as they were unaware that she was providing care to Matthew, that he was under round-the-clock monitoring, and that she was not required to provide him with care.
- 8.1.11 Angela had collided with multiple vehicles and engaged in a dispute with the owner of the fence she had driven into, prompting the police to be dispatched in May 2023. Angela was arrested as a result. She reported to Matthew that she had overdosed and drank alcohol; he informed the police, who transported her to QEH before returning her to police custody. The HCP at the police station reviewed Angela. However, she was not referred to the L&D as they were not on duty when Angela was in custody. Angela disclosed this to CGL as a suicide attempt; CGL did not disclose this to her GP, preventing an assessment of her mental health.
- 8.1.12 Angela attempted to end her life the day before her death; she communicated this to Matthew, who had left the family home to be with his family since he believed the strain at home was detrimental to his physical health. He found her with a scarf around her neck and cut her down when he arrived the same day. Although he called the

ambulance, they did not attend as Angela had left the home. They recommended that he contact the police, which he did not do.

8.1.13 After a verbal altercation, Matthew requested Michelle to remain with Angela. However, during her journey, Michelle spoke with Angela and agreed to visit in the morning.

8.1.15 Michelle discovered Angela's body during her visit the following day.

Section Nine: Recommendations from the Review

9.1.1 Individual Management Review Recommendations

9.1.2 Change Grow Live

1.1 The Norfolk CGL Service must provide risk management training to ensure staff are confident in identifying and managing risk.

9.1.3 East of England Ambulance Service

2.1 Provide guidance for call handlers regarding mental health patients who are on the move.

2.2 Highlight the dangers of inaccurate information.

9.1.3 Norfolk and Suffolk NHS Foundation Trust

3.1 Improve collaboration with CGL to develop combined treatment and care plans where possible.

3.2 The referral criteria within the CMHT Operational policy are to be updated.

3.3 Additional domestic abuse training should be made accessible to all practitioners throughout the Trust, with a particular focus on the identification of domestic abuse indicators without the need for disclosure.

9.1.4 Recommendation One: Response to Disclosures of Domestic Abuse

Domestic abuse is a critical issue that necessitates a multi-agency, trauma-informed, and consistent response. The purpose of this recommendation is to enhance the response to disclosures of domestic abuse, thereby ensuring that victims receive the necessary support, interventions, and protection.

Angela's GP Practice, NNUH, NSFT and QEH

- 1.a To review their domestic abuse policies and procedures and include references to the Pathfinder toolkit ¹⁶ as best practice for responding to domestic abuse and to inform the Norfolk Community Safety Partnership (NCSP) of progress.

CGL, Angela's GP Practice, NNUH, Norfolk Constabulary, NIDAS, NSFT and QEH

- 1.b NCSP to receive written confirmation from partners regarding their mechanisms and policies for documenting and responding to victims' and survivors' perspectives.
- 1.c To inform the NCSP of their domestic abuse training packages and how staff are supported to attend.
- 1.d To confirm the process for responding to disclosures and how staff are assisted in becoming aware of the pathway.
- 1.e To provide victims/survivors, their families, and friends with accessible information about local domestic abuse services.

9.1.5 Recommendation Two: Alcohol, Mental Health and Domestic Abuse

Alcohol and mental health are substantial intersecting factors that can both exacerbate and contribute to domestic abuse situations. The purpose of the recommendations is to improve outcomes for individuals affected by these interconnected issues, including reduced domestic abuse incidents, better mental health and alcohol misuse management, increased safety for victims, and more effective prevention and support services.

CCGL, Angela's GP Practice, NNUH, Norfolk Constabulary, NIDAS, NSFT and QEH

- 2.a To raise awareness of the correlation between alcohol, mental health, and domestic abuse among frontline practitioners.

9.1.6 Recommendation Three: Caregiving Responsibilities and Domestic Abuse

The recommendation aims to improve safeguarding for both carers and those they care for by identifying and addressing the risks of domestic abuse within caregiving contexts. The anticipated outcome includes enhanced carer support, increased awareness and training for professionals, strengthened legal protections, and better care outcomes for vulnerable individuals. Overall, it seeks to create safer environments for carers and those in their care while ensuring that abuse is recognised and addressed early.

CGL, Angela's GP Practice, NNUH, Norfolk Constabulary, NIDAS, NSFT and QEH

- 3.a To identify and promote training and guidance on adopting a trauma-informed approach to supporting domestic abuse victims. This shall encompass the

¹⁶

https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef35f557271034cdc0b261f/1593007968965/Pathfinder+Toolkit_Final.pdf

recognition of trauma associated with intimate partner violence, familial history, bereavement, psychological well-being, and substance misuse.

Angela's GP Practice, NNUH, NSFT and QEH

- 3.b Where carers are identified to provide access to appropriate support resources and assessments. Carers Matter Norfolk¹⁷ is offered in Norfolk.

NNUH and Norfolk Constabulary

- 3.c Discharge planning must ensure that appropriate documentation is provided for the individual being discharged/released and that provisions are made to ensure safe discharges/releases.

9.1.7 Recommendation Four: Suicide and Domestic Abuse

The recommendation aims to improve the identification, prevention, and support of individuals at risk of suicide due to domestic abuse. The anticipated outcomes include better awareness and early identification, enhanced risk assessments, integrated support services, reduced suicide rates, strengthened multi-agency collaboration, and empowered communities. This will ensure victims of domestic abuse receive comprehensive care, safeguarding, and effective interventions to address both their mental health and safety needs.

CGL, Angela's GP Practice, NNUH, NSFT and QEH

- 4.a To support an individual who has disclosed suicidal ideation by implementing a safety plan, with a particular emphasis on adhering to the guidelines established by NICE, as detailed below:
[Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE](#)
- 4.b Routine safeguarding enquiries to consider and explore trauma-informed approaches to suicidal ideation and self-harm, including enquiring about domestic abuse.

¹⁷ <https://carersmatternorfolk.org.uk/>