NORFOLK COMMUNITY SAFETY PARTNERSHIP

Domestic Abuse Related Death Review

Overview Report into the death of Angela in May 2023

Parminder Sahota
Independent Chair and Author

Contents

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. The author expresses gratitude to the family that assisted with the review to ensure it appropriately portrayed Angela's life.

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.

1.1 Introduction

1.1.1 The report was written following Angela's tragic death in May 2023. Norfolk Constabulary referred Angela, who was fifty-two and a resident of Norfolk, to the Norfolk Community Safety Partnership (NCSP) in May 2023.

1.1.2 The case was discussed at a partnership meeting on 27 June 2023. The partnership panel unanimously found that the DHR criteria had been satisfied.

1.1.3 Adopted in 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004 added DHRs. A DHR refers to an investigation into the circumstances surrounding the death of a sixteen-year-old or older individual that has or appears to have been caused by violence, abuse, or neglect.

1.1.4 The review was conducted following the Home Office's Multi-Agency Statutory Guidance for Domestic Homicide Reviews (updated in December 2016). [1]

1.1.5 Section 2 of the statutory guidance highlights circumstances which indicate a Domestic Homicide Review:

'Where a victim took their own life (suicide), and the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.'

1.1.6 This review examines the agency's responses and support for Angela.

1.1.7 The DHR panel was informed that for more than thirty years, Angela and her husband, Matthew, had contact with the police regarding incidents of domestic abuse and violence. The panel reached a consensus to commence the timeline after a notable occurrence of physical domestic abuse in April 2020 to May 2023, and to provide a summary of the preceding events.

1.1.8 This review does not replace a criminal or coroner's court or resemble a disciplinary proceeding.

1.1.9 Angela was discovered deceased at her home address by her mother, Michelle.

1.1.10 The cause of death was:

1(a) Hanging
2 Combined Drug Use (Alcohol, Diazepam, Diphenhydramine)

[1] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

1.2 Case Summary

1.2.1 Angela's husband, Matthew, was accused of assaulting Angela in April 2020 when the police were called to their home. Matthew was arrested. Angela was referred to the domestic abuse service.

1.2.2 Angela discontinued her antidepressant medication in February 2022 due to fatigue and overall well-being. Despite persistent night terrors, she maintained that she could manage without the use of the antidepressant. Simultaneously, her Mirena Coil[2] was removed as it had expired.

1.2.3 In May 2022, Angela was admitted to the Intensive Treatment Unit (ITU) following a significant overdose of medications with alcohol; she reported a family disagreement and expressed a wish to "disappear." Angela agreed to self-refer to alcohol services and the well-being service.

1.2.4 Angela disclosed suicidal ideation in June 2022 with no intent or plans. She disclosed symptoms of anxiety and depression to her GP. She had begun using alcohol and Diazepam simultaneously to cope with her symptoms.

1.2.5 She informed her GP in July 2022 that she had discontinued the use of her antidepressant and was having difficulty regulating her alcohol consumption; she had been resorting to alcohol as a sleep aid. She was engaging with Change Grow Live (CGL, alcohol service) to address her alcohol usage.

1.2.6 She was arrested in July 2022 after a dispute with Matthew. She had briefly stayed with her mother, Michelle, who lived out of county.

1.2.7 She was prescribed Citalopram (antidepressant) by her GP.

1.2.8 In December 2022, she was experiencing a fluctuating mood and was working with CGL and using the antidepressant as needed. She felt she was managing at this point.

1.2.9 Angela had a disagreement with Michelle and Matthew in April 2023, during which she had heightened anxiety.

1.2.10 Her son remained with her due to the increase of her 'tics'. She requested a higher dosage of Citalopram to alleviate the stress she was experiencing because of Matthew's acute cardiac event. He was scheduled to undergo surgery.

1.2.11 The last domestic abuse incident documented by the police occurred three weeks before Angela died. This was recorded as a verbal argument with Matthew, during which Angela left the home after taking diazepam and was involved in a road traffic collision (RTC).

[2] https://www.nhs.uk/conditions/contraception/ius-intrauterine-system/

1.2.12 Angela disclosed to CGL fifteen days before her death that she had overdosed and driven, resulting in the RTC. She was also involved in a confrontation with the property owner, during which her car damaged their fence. She was arrested following police attendance.

1.2.13 Nicole, Angela's daughter, expressed that the arrest and Angela's fear of imprisonment were so distressing that she frequently broached the subject and expressed her inability to manage the situation if she were imprisoned.

1.2.14 Matthew travelled to visit family the day before Angela's death in May 2023. Angela called him on the way to his family to inform him that she was contemplating suicide by hanging.

1.2.15 When Matthew returned and discovered her hanging, he cut her down. He pursued her as she exited the home to go to the shop and summoned the ambulance; however, the ambulance advised that he should contact the police, as they were not provided with Angela's address. Matthew stated, however, that they declined to attend and recommended that he contact the police. Police were not called.

1.2.16 Angela acquired a bottle each of wine and tequila from the shop. Matthew left the home after pouring the tequila into the sink and contacted Michelle to invite her to spend the night. According to Matthew, Michelle travelled to Angela's house and conversed with her during her journey. Following the conversation, Michelle agreed to visit the following day.

1.2.17 Michelle visited Angela the following day and discovered the door was unlocked; she received no response after entering the address and calling Angela. Michelle subsequently found Angela deceased.

1.3 Background Information about Angela

1.3.1 Angela was a mother of three grown children. Her children reported she was a good mother and took care of them. She met Matthew thirty-two years ago, and they were married for twenty-two years. The police reported thirty years of domestic abuse between the couple.

1.3.2 Angela worked as a bookkeeper in the family business with her husband. She was a successful businesswoman who owned multiple companies and was consistently well-dressed. Nicole, Angela's daughter, stated that her mother was known by her family and friends as a kind, happy, and fun individual.

1.3.3 Angela's brother died while living abroad in August 2012. He had a motorbike accident while living abroad, returned to the UK, and was scheduled to have surgery. He returned abroad to await his surgery. He called his mother to report he felt unwell; she encouraged him to seek medical assistance; he declared that he would seek medical attention at the hospital if his health failed to improve. He died the following day from sepsis.

1.3.4 Following her brother's death, Angela reported an increase in the frequency of panic attacks and the development of tics.

1.3.5 Additionally, the family reported she had an intermittent stressful relationship with her father in 2015. According to Matthew, he was once relatively affluent but tragically lost it all and turned to alcohol, which ultimately contributed to his death in March 2017.

1.3.6 Since 2003, Angela experienced stress, anxiety, depression, and intermittent, excessive alcohol usage. Her GP had referred Angela to the mental health team in 2015 and 2018, and Angela had self-referred to the wellbeing service and the community alcohol and drug service.

1.3.7 Her developing tics, which were verbal and frequently consisted of swearing and shouting "no," increased following the death of her father. As a result, her anxiety and stress levels escalated, and she would frequently awaken at night screaming.

1.3.8 Angela continued enduring symptoms of depression, anxiety, and stress until she died. These symptoms were exacerbated after the discontinuation of her antidepressant prescription; a different antidepressant was prescribed in July 2022.

1.3.9 Angela maintained professional conduct in her interactions with friends and family, and her symptoms did not interfere with her capacity to continue administering the business.

1.4 Timescales

1.4.1 Following the Statutory Guidance, NCSP commissioned this DHR in response to a decision to proceed with a review on 27 June 2023.

1.4.2 The Statutory Guidance specifies the requirements of the review chairs and authors in sections 36 through 39. In this review, the responsibilities of the chair and author were merged.

1.4.3 The independent author was commissioned on 7 September 2023. NCSP approved the finalised report on 15th April 2025.

1.4.4 The first panel meeting was held on 24 October 2023. The agency's detailed chronologies were reviewed, and seven reports were required. At the second meeting, the reports were discussed so the panel could pose questions and seek clarification as necessary.

1.4.6 Further meetings were held to discuss and agree on the recommendations.

1.4.7 The panel was requested to approve the final report in July 2024 before sharing it with the family. However, Norfolk and Suffolk NHS Foundation Trust did not approve

the final report. The Independent Author and NCSP Community Safety Manager escalated this issue to the Trust's Chief Executive Officer. The Trust approved the report on 14 October 2024.

1.4.8 The Trust panel member was actively involved in the review.

1.4.9 Consequently, on 14 October 2024, the chair shared the report with the family.

1.5 Confidentiality

1.5.1 The review is confidential until the Home Office Quality Assurance Panel approves the release of the overview report. Only contributing officers/professionals and line managers have access to confidential information.

1.5.2 The following terms have been anonymised throughout this report to preserve the victim and her family's identities.

- The victim: Angela
- Angela's Mother: Michelle
- Son: James
- Daughter: Liz
- Daughter: Nicole
- Husband: Matthew

1.6 Terms of Reference

1.6.1 This review intends to identify the lessons learned from Angela's tragic death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.

1.6.2 Section 3.2 contains the complete terms of reference. Michelle was emailed the terms of reference, and no disagreements or additions were made.

1.6.3 The Domestic Abuse Act (2021) specifies the following legal definition of domestic violence:

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

"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).

Two people are "personally connected" to each other if any of the following applies:

(a) they are, or have been, married to each other;
(b) they are, or have been, civil partners of each other;
(c) they have agreed to marry one another (whether or not the agreement has been terminated);
(d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
(e) they are, or have been, in an intimate personal relationship with each other;
(f) they each have, or there has been a time when they each have had, a parental relationship concerning the same child;
(g) they are relatives.

1.7 Methodology

1.7.1 The Home Office guidelines outline the procedure for performing a DHR.

1.7.2 Angela had lived in Norfolk before her death; hence, agencies from Norfolk comprised the review panel.

1.7.3 At the first review panel meeting, panellists shared their agency engagements with Angela.

1.7.4 The review's approach was to request that agencies submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or summary report. Seven reports were requested.

1.7.5 The chronologies, reports and family contact influenced the recommendations in this review.

1.7.6 The panel met a total of seven times.

1.8 Involvement of Family and Friends

1.8.1 The review author and panel acknowledged the vital role Angela's family could have in the review. The family was invited to meet with the panel, but they declined.

1.8.2 The author contacted Michelle, Angela's mother, and outlined the review's objectives. She was also provided with the Home Office leaflet concerning DHRs and

information on an advocacy service: Advocacy After Fatal Domestic Abuse (AAFDA). She was asked to share with other family members as appropriate.

1.8.3 **On 4 October 2023, the author contacted Michelle**.

1.8.4 Angela and Matthew had three adult children throughout their thirty-year marriage. Michelle described the marriage as volatile and said she frequently intervened in their disagreements. Michelle did not feel that Angela feared Matthew, but believed Angela was angry with him. Michelle spoke of when Angela left the family home and stayed with her for eight to nine days. Angela spent much of this time communicating with Matthew via telephone.

1.8.5 Michelle was aware that Angela had received counselling from an alcohol services counsellor, most likely Cognitive Behaviour Therapy (CBT).

1.8.6 Michelle reported that Angela began drinking and experiencing anxiety approximately four and a half years ago. She had tics and constantly said "no." Michelle queried Angela if she was in menopause, to which Angela said she was not experiencing menopause and did not wish to take medication. Michelle had mentioned the Priory and private treatment.

1.8.7 Michelle was aware that Angela had purchased Diazepam online.

1.8.8 Angela and Michelle were close; they spent their holidays and Christmas together.

1.8.9 **On 26 January 2024, the author contacted James, Angela's son.**

1.8.10 Following the author's explanation of the contact's intent, James consented to a call the following weekend. He also agreed to speak to his sisters and father and ask if they would like to participate in the review.

1.8.11 The author forwarded an email to James in which she elaborated on why contact had been made and attached the Home Office DHR and AAFDA information, stating that he might forward it to others if he deemed it appropriate.

1.8.12 **On 9 February 2024, the author contacted James,** who was unavailable and agreed to make contact when he could.

1.8.13 **On 9 February 2024, the author, called Liz, is Angela's daughter. There was no response, so** a text message was sent asking her to make contact.

1.8.14 **On 9 February 2024, the author called Nicole, Angela's daughter;** no connection was made.

1.8.15 **On 9 February 2024, the author spoke with Matthew, Angela's husband.**

1.8.16 In 2020, Matthew disclosed that Angela had attempted to run him over and stab him. He did not pursue this with the police. He further reported that Angela pushed him into the kitchen of their home, causing him to fall. Angela sustained a black eye after breaking a stool and striking her face against the counter after falling. Angela phoned the police; Matthew explained that she did so to prevent the situation from escalating further. According to him, the police discovered him holding the stool spindle and suspected he was responsible for Angela's injury, and he was arrested.

1.8.17 He stated that as a professional boxer, he could have likely fractured Angela's nose, and she would have had missing teeth had he struck her.

1.8.18 Matthew disclosed that Angela was prescribed medication to treat her panic attacks. Following her report of feeling emotionless, she discontinued the prescribed medication. Simultaneously, the Mirena coil was removed as it was out of date. The following month, in March 2022, she was hospitalised for one week due to a Diazepam overdose (the panel learned this was a two-day admission in May 2022). She recommenced antidepressant medication in July 2022.

1.8.19 Angela informed Matthew around Christmas 2022 that she wished to "sort herself out" because she was afflicted with morning panic episodes. Matthew declared that he spent three months off work to be with Angela.

1.8.20 She sought counselling from MIND and disclosed that the sessions had become "too heavy." She was unable to obtain diazepam from her GP due to the overdose, and she resorted to alcohol as a sleep aid. Her counsellor subsequently informed her that they were unable to support her due to the alcohol. (Information from MIND does not corroborate this.)

1.8.21 A week before Angela died, he felt unable to speak with her, and as he had had a heart attack, he felt the stress was not good for his heart, so he travelled out of the county to stay with family. He returned the same day as Angela had reported having taken an overdose; he tried to establish contact with her, and as he could not, he called the police. With his permission, the police placed a tracker on her phone and were able to locate her.

1.8.22 Matthew reported that Angela was on her way to the hospital after overdosing on diazepam; in doing so, she collided with the cars en route.

1.8.23 Matthew expressed his dissatisfaction with the police. He stated that he was on the phone with Angela while the police were present, and they heard Angela being involved in an altercation in which she was being assaulted.

1.8.24 The police arrested Angela; she was breathalysed and found to be under the limit. She was taken to the hospital and discharged. Matthew believed that she ought to have received a mental health assessment.

1.8.25 He stated that Angela was taken to the same hospital she had been admitted to in May 2022 following an overdose, and they should have checked their records to learn she had previously taken a significant overdose to end her life. However, he stated that she was charged and placed in custody.

1.8.26 He reported that the police custody suite was detrimental to her mental well-being, which necessitated her to be let out of the cell intermittently (the police held no record that this had occurred). She was released from custody and took a cab home at 2am.

1.8.27 Matthew stated that the day before Angela's death, while he was staying with their daughter, Angela called him to inform him that she had attempted suicide by hanging herself. Upon his return home, he cut her down. After failing to take his car keys, she proceeded on foot to the shops to purchase alcohol.

1.8.28 He contacted an ambulance out of fear and was instructed to contact the police. Matthew reported that Angela had purchased tequila and wine. He regrets pouring the tequila down the sink since he believes she could have consumed it and gone to sleep instead of ending her life.

1.8.29 Matthew confirmed Nicole's telephone number and said he would request that she contact the author.

1.8.30 **Nicole contacted the author on 21 February 2024. Information about AAFDA was discussed with Nicole.**

1.8.31 Nicole felt that in the months before her mum's death, she had unsuccessfully sought help for her mental health.

1.8.32 Nicole was aware that mum was seeing an alcohol counsellor. However, she felt this did not address the underlying problem, given that her mum had endured a decade of poor mental health and believed that her mum had an undiagnosed mental illness.

1.8.33 Nicole perceived that her mum’s response to the death of her brother precipitated her depression, deteriorating mental health, and the emergence of her tics, for which she had begun taking diazepam to manage in January 2023.

1.8.34 Nicole and her family tried to support mum, constantly reassuring her of their love and support. Nicole stated, however, that her mum did not believe them and thought the family were against her.

1.8.35 According to Nicole, "The family struggled because they did not know how to support mum."

1.8.36 She disclosed that her dad would lie in bed with her mum when she struggled to get up. He had taken time off work to provide her with the necessary support and would

bring her to her appointments. Dad had endeavoured to support her during this period; despite his poor physical health, he was anxious to ensure her good health.

1.8.37 Nicole believed that her mum's reality had shifted, and mum had concluded that everyone was against her. As a result, when her dad communicated with her nan, her mum saw this as a conspiracy.

1.8.38 When her dad and the family attempted to obtain counselling, they were informed that her mum was initially deemed not ill enough or that she was too ill. The family also considered private therapy, and mum sought help from MIND.

1.8.39 Nicole identified the subsequent elements and questions of services as possible contributors to her mum's declining mental well-being.

- Mum was not receiving the right support for her mental health. However, Nicole acknowledged that the GP provided support. The counselling did not result in a positive outcome for Mum as it was coming to an end, and mum was concerned about her future coping.
- Mum used alcohol and internet purchases of diazepam to regulate her mental health.
- Mum was the only individual detained and charged after the RTC, despite having been assaulted by members of the public. Mum reported feeling suicidal, but the police did not contact mental health to conduct an assessment.
- The police transported mum to the general hospital; however, neither the hospital nor the police considered mental health care. This hospital was the same one where mum had been admitted to the intensive care unit after a substantial overdose.
- After being released from police custody in the early hours, she returned by cab. Thoughts consumed mum that she would end up in prison, and she was concerned about her inability to cope, given that she struggled while in the police cell.
- The day before mum died, dad requested an ambulance since she had attempted to end her life the day before. Mum had fled the family home without shoes on, and the ambulance informed dad that they were unable to attend since she was not at home.
- Nicole contacted CGL following mum's death since she became aware that mum had an appointment. A message was left with CGL to contact Nicole. No one called her.

1. **How are mental health services accessed?**

The panel confirmed the following:

- Self-referral to talking therapies
- GP referrals
- A&E referrals
- Contacting 111 and selecting the mental health option

- Family members and the public can access the Norfolk and Suffolk NHS Foundation Trust (NSFT) Website: suicide prevention page[3].
- Liaison and Diversion service whilst in Police Custody, who can signpost to mental health services.

2. **What measures are implemented to facilitate the termination of therapy?**
   Emerging Futures[4] (EF - CGL's counselling service) has a withdrawal plan. Nevertheless, CGL confirmed Angela was not discharged from their service and continued to have a named key worker.

3. **What measures may be taken to prevent the online purchase of prescription medications?**
   The panel agreed that this is a problematic area. Nicole stated the source was in the United Kingdom, and the police force panellist agreed to receive the information to investigate.

4. **Why were the others not arrested by the police? The police overheard the assault while they were with dad, who was on the phone with mum at the time. Mum sustained bruises as a result.**
   The police panellist agreed to discuss this with Nicole.

5. **Was the hospital aware of mum's previous suicide attempt, and why did the police not request a mental health assessment when mum disclosed she was suicidal?**
   Following the May 2023 RTC, Angela informed the hospital that she was angry with Matthew. The hospital discussed her mental health, and she did not disclose experiencing suicidal thoughts or symptoms of depression.

6. **Why would a troubled individual, requiring frequent release from the police cell and having reported to be suicidal, be sent home by cab in the early hours of the morning?**
   The police cannot detain individuals after deciding to release them. Upon release, individuals are typically escorted from the station by the police or a taxi. Each released individual will receive a risk assessment, which Angela completed. She declared herself in good health and requested a taxi.

   Angela was released on bail pending additional investigations without formal charges. During her interview, she had a legal advisor who would have explained the conditions and said that no formal charges had been made.

   According to the police, Angela presented as calm, and they had no logs to state that she needed to be let out of the cell frequently or that she was distressed.

7. **Why did the ambulance not contact the police or pursue this further?**
   The ambulance panellist reviewed the recording. The person's name or location was not given, and the caller stated he would call the police. It was a brief call.

[3] https://www.nsft.nhs.uk/suicide-prevention/
[4] https://www.emergingfutures.org.uk/projects/norfolk/

8. **What is CGL's policy about absences, and why did they not return Nicole's call?** After reviewing the notes, they found no record of this. Appointments that are "Missed" result in an automated text message requesting the individual reschedule the appointment. In addition, this would be the subject of discussion at the CGL meeting. CGL is certain Angela would have received a text message informing her of the missed appointment.

1.8.40 Mum informed Nicole that to continue undergoing counselling, she was told by the counsellor that she had to leave her dad, which caused her distress because she did not wish to do so. Emerging Futures confirmed this would not be a mandatory component of ongoing counselling. Nicole stated that mum was happy with her dad, loved him, and had no intention of parting ways with him.

1.8.41 **The author spoke with Liz on 13 March 2024.**

1.8.42 Liz identified with the concerns raised by Nicole and Matthew, which aligned with her own. She believed that the death of her mum was due to the lack of support she received, precisely the absence of a mental health assessment at the police station and the failure to dispatch an ambulance when her dad called the day before her mum died. She did not believe domestic abuse was a factor.

1.8.43 The family was kept informed of the progress of the review. They believed that the information provided by Angela and witnesses (Liz was present when her father contacted the ambulance the day before her death and overheard him say he needed the ambulance to arrive and would ensure Angela was at home to see them) contradicted the information obtained from agencies. As a result, they believe the ambulance should have been dispatched.

1.8.44 They believe a comprehensive risk assessment should have been conducted in May 2023, when mum was in police custody. Furthermore, Nicole disclosed that her mum was in a stressful environment (police station), and they believe she would have exhibited distress-induced tic-ing. The family speculated that mum might have been tic-ing at the police station, mainly because she had been involved in a multiple-car collision, been assaulted, and was detained.

1.8.45 The police confirmed that Angela received an assessment while in custody and pre-release and that no self-harm concerns were present.

1.8.46 Nicole received updates from the author via telephone during the process. Nicole had secured the help of an AAFDA advocate.

1.8.47 The report was sent to Michelle and Nicole on 14 October 2024. On 1 November 2024, they expressed concerns via the advocate about Angela's inaccurate portrayal and areas they wished to be removed, as they were distressing for the family.

1.8.48 In addition, they sought to underscore that Angela's death was significantly influenced by the inability to obtain sufficient mental health support. They also stated that the police and agencies were aware of the domestic abuse between Angela and Matthew, but they did not intervene.

1.8.49 The author and advocate met to discuss this further on 8 November 2024.

1.8.50 The author acknowledged the comments and amended the report.

1.8.51 The author sent the advocate a revised version on 15 November 2024, and they agreed on the return date of 19 December 2024. The advocate requested an in-person meeting with the author on behalf of the family. However, the author did not receive any further communication from the advocate.

1.8.52 On 20 December 2024, the author texted Nicole to ask if she or Michelle had any further feedback on the revised version of the report. Nicole replied that she had met with the advocate on 18 December 2024, but they could not review the entire report due to its length. Nicole planned to complete the review in the New Year and would contact the Chair then.

1.8.53 On 30 January 2025, the advocate contacted the author to request an additional extension, which was granted. The advocate contacted the author on 3 February 2025 to inform them that Nicole had asked to withdraw from the review process. Nicole emphasised that Angela cared for her children and was a good mother.

1.8.54 The advocate and author agreed that the advocate would contact Nicole to inform her of the outcome after the Home Office quality assured the report.

1.9 Contributors to the Review

1.9.1 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 (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 Summary Report

Norfolk and Waveney Mind (N&W Mind) Mental Health Charity	Chronology
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust (QEH) General Hospital	Chronology and Short Report

1.10 The Review Panel Members

1.10.1 The independent members of this review's panel 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
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

1.11 Chair and Author of the Overview Report

1.11.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training in 2021 from AAFDA. She has worked in the NHS for over 20 years as a Mental Health Nurse with a particular focus on crisis work. She was employed as the Director of Safeguarding, Prevent, and the Domestic Abuse Lead for an NHS Trust in London.

1.11.2 Before this review, Parminder had no contact with Angela's family or friends and is independent of the participating agencies and NSCP.

1.12 Parallel Reviews

1.12.1 At the time of this report, the Coroner's inquest was still pending.

1.13 Equality and Diversity

1.13.1 During the review process, the review author and panel reviewed all protected characteristics under the Equality Act 2010.

1.13.2 Angela was of white British heritage and was fifty-two at her death.

1.13.3 The characteristics relevant to this review are age, sex, and disability.

1.13.4 According to Safe Lives[5], older adults may find it difficult to disclose domestic abuse, and many services fail to acknowledge that the issue affects individuals of all age groups. Nearly half of the older victims with disabilities endure abuse for twice as long on average before seeking assistance compared to those under sixty-one. However, domestic abuse agencies grossly underrepresent their elderly clientele.

1.13.5 The Office for National Statistics[6] released data on domestic abuse, including victim characteristics.

1.13.6 According to the data, domestic abuse victims were significantly more likely to be female than male in the year ending in March 2022, with 6.9% of women and 3% of males experiencing domestic abuse.

1.13.7 Furthermore, the data reports that 74% of the victims of domestic abuse-related offences recorded by the police were females. According to research conducted by Women's Aid[7]94.3% of domestic abuse perpetrators are men.

[5] https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse#:~:text=It%20can%20be%20extremely%20hard,whoever%20is%20responsible%20for%20it.

[6] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2022#age

[7] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf

1.13.8 Refuge[8] reported that the police receive a call regarding domestic abuse every 30 seconds. Refuge, however, reported that this accounts for only approximately one-quarter of the reports submitted to the police. Furthermore, domestic abuse is related to depression, and it is estimated that three women each week take their own lives because of domestic abuse.[9] The research highlighted by Hestia[10] supports this.

1.13.9 The University of Warwick and Refuge[11] study presented extensive and substantial evidence on the incidence of suicidal ideation among victims of domestic abuse. They emphasised risk factors such as depression, psychological distress, despair, hopelessness, difficulties with drugs or alcohol, childlessness, and cumulative experiences of abuse, particularly sexual abuse.

1.13.10 Women's Aid[12] also found that the need for mental health (MH) services continues to be common, with 35.1% of 31,396 service users reporting feelings of depression or suicidal ideation.

1.13.11 According to an analysis of domestic homicides[13], most domestic abuse suicide victims were female. At the same time, the alleged perpetrators were male and, most commonly, partners or ex-partners. MH issues were recorded in 94% of the reviews, and in almost half of the reviews, there was evidence of self-harm.

1.13.12 As evidenced by the data[14], domestic abuse is a gendered crime; although men are abused, women are more likely to face recurrent and severe types of abuse.

1.13.13 Angela experienced depression, anxiety, and tics. No cure is available for 'tics. Behavioural treatment[15] maybe recommended to alleviate the symptoms. Angela would yell "No" to do this.

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- To the advocate, the family has requested to withdraw from the review
- Members of the Norfolk Community Safety Partnership
- Agencies represented.
- Domestic Abuse Commissioner
- Local Police and Crime Commissioner

[8] https://refuge.org.uk/what-is-domestic-abuse/the-facts/
[9] https://refuge.org.uk/what-is-domestic-abuse/the-facts/
[10] https://www.hestia.org/blog/domestic-abuse-suicide
[11] https://nspa.org.uk/wp-content/uploads/2021/04/New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf
[12] https://www.womensaid.org.uk/wp-content/uploads/2021/12/Domestic-Abuse-Report-2022-Early-Release.pdf
[13] http://wrap.warwick.ac.uk/174206/1/WRAP-learning-legacies-analysis-domestic-homicide-reviews-cases-domestic-abuse-suicide-2023.pdf
[14] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-is-a-gendered-crime/
[15] https://www.nhs.uk/conditions/tics/treatment/

- A copy of the Executive Summary and Overview Report will also be published on the Norfolk Community Safety Partnership section of the Officer of the Police and Crime Commissioner's website

2.1 The Facts

2.1.1 The day before her death, Angela attempted to end her life by hanging; she had contacted Matthew, who, upon returning home, cut her down and called the ambulance service. He was instructed to contact the police. Police had not been called.

2.1.2 The next day, Angela was discovered deceased at her home by her mother.

2.2 Key Events from April 2020 to May 2023

April 2020

2.2.1 East of England Ambulance Service NHS Trust (EEAST) received a domestic abuse-related 999 call. Matthew was reported to have assaulted Angela, striking her in the head and face. A hospital visit was advised due to the assault's intensity. Angela declined and said she would consult her daughter and go if needed.

2.2.2 The police call revealed that Matthew started drinking after getting upset over a call with his mother. He reportedly assaulted Angela with numerous strikes to her face, causing significant swelling in her temples, forehead, and cheeks as he continued to drink. Matthew threatened Angela during the assault. The ordeal made Angela doubt she would survive

2.2.3 Police referred to the Domestic Abuse Safeguarding Team (DAST) are the Police safeguarding team in the MASH (multi-agency safeguarding hub) that can make referrals to other services such as Leeway and other DA services. DAST contacted Angela; she declined their support and requested that they contact her in a few days

2.2.4 Angela was heard at the Multi-Agency Risk Assessment Conference[16] (MARAC), no actions were specified.

2.2.5 Leeway made four unsuccessful attempts to contact Angela.

2.2.6 An Independent Domestic Violence Advocate[17] (IDVA, Leeway) spoke with Angela and offered her safe housing. Angela reported that Matthew was participating in Alcoholics Anonymous (AA) and was sober. The call ended when Matthew approached Angela. The IDVA updated the DAST.

May 2020

2.2.7 The IDVA spoke with Angela, who reported that Matthew had been sober for most days since his mother's death, and their three adult children were with them.

[16] https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf
[17] https://safelives.org.uk/what-is-an-idva

Although Angela acknowledged Matthew's aggression, she stated there was no pattern related to alcohol abuse. The DAST was updated.

2.2.8 The IDVA, further called Angela, reported that she was okay; however, talking was unsafe.

June 2020

2.2.9 The IDVA called Angela, received no response and sent a message. Angela responded to report that she worked part-time and was okay, but could not arrange a time/date to contact the IDVA.

2.2.10 The IDVA made three unsuccessful calls to Angela and closed her to the service in July 2020 due to minimal engagement.

September 2020

2.2.11 Police investigated a domestic abuse incident involving Matthew and Angela following an argument after a family barbecue. Angela reported Matthew's verbal abuse while he was intoxicated. She left to stay with her daughter. No offences were reported, and No Further Action (NFA) was taken.

February 2022

2.2.12 Angela informed her GP that she had discontinued mirtazapine, an antidepressant, because it made her feel tired.

March 2022

2.2.13 Medication review with the GP. Angela felt okay after discussing Hormone Replacement Therapy (HRT) and contraceptive pills for her depression. Despite experiencing night terrors, she wanted to cope without antidepressants and mentioned that her husband and friends noticed she looked healthier.

May 2022

2.2.14 EEAST received three 999 calls about Angela, who had reportedly overdosed on 30 diazepam tablets. The caller hung up, while a man, later identified as Matthew, was heard swearing, reporting that Angela had assaulted him but refused an ambulance. Angela screamed, prompting the ambulance crew to contact the police regarding safety concerns. Paramedics attended and described Matthew as intoxicated. Angela was reported to have a Glasgow Coma Scale (GCS, level of consciousness) score of 3 (lowest possible score); as a result, the police did not attend. Angela was transferred to the Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust (QEH).

2.2.15 Matthew was present when Angela was admitted to QEH and was still drowsy 12 hours later. A CT scan was recommended and reported as normal. Angela had overdosed on numerous medications, including diazepam (38 tablets) and paracetamol (12 tablets), along with alcohol. She expressed feelings of being treated poorly by her mother and husband, and inquired about involving the safeguarding team, but received no response. QEH had an alert for domestic abuse and MARAC from 2020.

2.2.16 Angela informed QEH she overdosed to "disappear." She was placed under Level 3, special observations[18]. She requested to return home that evening but was advised to stay and meet the mental health (MH) team the next day.

2.2.17 Matthew visited Angela in QEH, and she wanted to go when he left, too. After arguments near the ward door, her mother convinced her to stay for an MH assessment. Angela declined a Domestic Abuse, Stalking, and 'Honour'-Based Risk Assessment[19] (DASH), as she felt she did not need safeguarding. The ward doctor noted her mood had improved, though she reported waking up suicidal and never feeling good. She said Matthew had not hit her in three years, and she had not considered suicide or self-harm.

2.2.18 QEH referred Angela to the Mental Health Liaison Team (MHLT). Angela was hesitant to answer MHLT questions and stated she had overdosed following a family conflict and alcohol consumption, requiring ITU admission. Angela had self-referred and participated in well-being programs with a scheduled counselling appointment on 06.06.22. While she found her husband supportive, she felt frustrated with him since he did not grasp her MH issues. She denied alcohol abuse and was referred to the Crisis Resolution Home Treatment Team[20] (CRHTT) for continual mood and risk assessment.

2.2.19 A MH management plan was developed with the ward team, which included CGL and wellbeing group meetings. CRHTT was absent at discharge. Angela assured she would not overdose again and went home with Matthew that night. NSFT sent a letter to her GP outlining the contact.

June 2022

2.2.20 The well-being service wrote to the GP practice that Angela had attempted suicide one week earlier and was experiencing further suicidal thoughts with no intentions to act on these. Angela experienced significant depression and anxiety. The GP practice phoned Angela the same day the letter arrived. She reported having purchased diazepam online and used it and alcohol when she felt stressed.

2.2.21 The correspondence from CRHTT to the GP needed more clarity regarding the plan in place and whether Angela was receiving their services.

2.2.22 CRHTT referred Angela to Norfolk and Waveney MIND: *'Angela struggles with a low mood. She is working hard to try to maintain a routine. She is slowly returning to work and is trying to go to the gym twice a week, knowing this is good for her mental well-being. However, she struggled with a lack of motivation and would benefit from having a professional to help her maintain a routine.'* MIND contacted Angela, but no

[18] level 3. Within the eyesight of a staff member always, a staff member would always be in the bay.
[19] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf
[20] CRHTT provides access to 24/7 assessments and support managing acutely unwell service users within Norfolk and Suffolk. The primary objective of CRHTT is to reduce the need for admission into mental health acute wards whenever possible and stabilise service users, supporting a reduction of risk associated with acute phases of mental illness. Support from CRHT aims to enable service users to remain in an environment that is the least restrictive and the most conducive to promoting recovery.

response was received, and a letter of introduction to initiate communication was sent to her.

July 2022

2.2.23 MH services referred Angela to Change Grow Live (CGL), who arranged a telephone assessment with Angela.

2.2.24 Telephone review with the GP and Angela: She reported that after stopping mirtazapine, she felt emotionless and flat, causing her to experience MH issues. She said she had resumed drinking and was struggling to control it, and was using alcohol to aid sleep. She queried with the CRHTT and well-being service, which team should continue supporting her mental health care.

2.2.25 Angela attended her assessment with CGL. She disclosed increased alcohol consumption after her brother's death and mentioned her husband's "angry drinking." She expressed concerns about her anger and the wish to avoid hurting herself or others. She reported no physical health problems. Angela disclosed a history of overdosing on alcohol and diazepam and described her mood as fluctuating. She acknowledged drinking frequently but did not see it as a risk. After recognising alcohol's harmful effects, she cut back on her consumption. Discussions included the risks of alcohol and medication, as well as the dangers of excessive drinking.

2.2.26 Angela called MIND after receiving the letter to request phone support. She advised that she was assessed for CGL support and received well-being services.

2.2.27 The police received a report of a verbal argument between Mathew and Angela, who were both intoxicated. The dispute began over Angela's MH concerns, during which she reportedly hit Mathew in the face, but he was unharmed. After she left, Mathew locked the door, and Angela broke the front window when she returned. Several weeks earlier, Matthew informed the police that Angela had stabbed him in a hotel, causing minor injuries, but he opposed police involvement. Angela was arrested and taken into police custody.

2.2.28 The Liaison and Diversion (L&D, mental health) team saw Angela in police custody due to MH concerns. She declined an assessment but confirmed a referral to CGL and was discharged to her GP for support.

2.2.29 Angela had a telephone review with her GP, explaining she was arrested after a fight with her husband and was staying with her mother. She and Matthew had clashed over the weekend, prompting police involvement. Angela was waiting for a court appearance and felt blamed for the incident. Although she had been sober for a week, her husband’s return triggered a relapse and further disputes. Matthew had informed the Crown Prosecution Service (CPS) that she had not committed the reported offence and that the charges would be dropped. Angela agreed to separate from her husband while they managed their alcohol use. Angela was prescribed citalopram, an antidepressant and a letter from the MH service was received.

2.2.30 MIND called Angela, who requested one-to-one support and would travel to meet in person.

2.2.31 The well-being team referred Angela to the Community Mental Health Team[21] (CMHT, Norfolk and Suffolk NHS Foundation Trust, NSFT). Angela had severe anxiety, delusions, medication noncompliance, and alcohol abuse. The referral was accepted, and an appointment was scheduled for August 2022.

2.2.32 The CMHT MH assessment revealed marital and domestic abuse. Matthew was on a sports-related head injury team and exhibited challenging behaviour. Eight years ago, Angela reportedly sustained a head injury after Matthew slammed her head against a cabinet. Angela did not seek medical help. She experienced hallucinations when fatigued and reported alcohol misuse.

2.2.33 Angela disclosed she was recently arrested following her husband's report to the police. The assessment noted physical and vocal tics, with weekly suicidal thoughts, and Angela attended well-being sessions to help her cope. Angela was discharged from the CMHT to the GP, who requested that the GP refer her for a head CT scan and neurology, with the recommendation to re-refer to the CMHT after neurological tests. The GP was also asked to follow up on pre-menopausal blood tests. Angela declined a referral to the Pandora Project[22] for domestic abuse support.

September 2022

2.2.34 The GP received a letter from the CMHT and confirmed that a CT scan had been completed in 2017.

2.2.35 Angela met with the CGL Recovery Worker (RW) and reported a significant reduction in alcohol use since July 2022. After a medication overdose and hospitalisation, she limited herself to one glass of alcohol at night and a few more on weekends. Angela did not consider herself dependent on alcohol and wanted to understand her need for an evening drink. The agreed plan was for Angela to attend the Extended Brief Intervention[23] (EBI) groups.

October 2022

2.2.36 Angela missed two appointments with CGL and received automated SMS messages about her absences, requesting that she contact CGL. CGL decided to discharge her if no contact was made by 20.10.22. With no response, Angela was discharged, and her GP was notified.

2.2.37 CGL restarted treatment on 26.10.22, and Angela attended the EBI group session, which discussed personal growth. No risks were identified.

[21] CMHT comprise multi-disciplinary teams to work with adults over 25 in their own environments in a variety of ways to support service user's mental health recovery

[22] https://www.pandoraproject.org.uk/

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

November 2022

2.2.38 Angela attended the EBI group session that covered alcohol effects, problematic drinking, addiction, recovery, unit guidance, NHS advice, and reduction plans. There were no safeguarding concerns identified.

2.2.39 The RW contacted Angela after the EBI session. She shared that her heavy drinking stemmed from a May 2022 event for which she sought counselling. Angela mentioned having a toothache, getting her coil removed after quitting smoking, and experiencing hormonal issues. She also reported self-medicating.

2.2.40 The Emerging Futures (EF, part of CGL) service manager spoke with Angela about her suitability for EF counselling. Angela shared her struggles with early drug and alcohol use to manage her emotions, describing her feelings as constantly changing, as the 'figure eight'.

2.2.41 After a diazepam overdose that led to hospital admission, she spiralled into heavy drinking, feeling she had *"no life whatsoever."* She attributed the overdose to stopping her antidepressant medication, hormonal changes from removing her coil, and marital issues, which she labelled as a *"drink problem."*

2.2.42 Following her brother's death abroad, she experienced intense anxiety attacks, worsening her anxiety, alcohol use, and Tourette's symptoms.

2.2.43 Angela reported she found group work challenging, remembering a psychotic episode triggered by an invitation to join one.

2.2.44 Despite holding a significant role in her family business, her MH and substance misuse were unknown to colleagues. She expressed desperation for help and had reduced her alcohol consumption to five units daily, abstaining from connecting with her children, who had moved away, while grappling with feelings of guilt about her nightly drinking.

2.2.45 Angela and the EF manager had a call to discuss therapy days. After learning about her availability due to a five-week waitlist, the manager agreed to support Angela. The RW was updated.

2.2.46 Angela attended a Zoom meeting with the EF manager, mentioning she had one or two glasses of wine and felt no need for more. No new risks or safeguards were identified. Angela shared her childhood background, including her parents' separation when she was eighteen and her early life spent with her grandparents. She described her upbringing with strict family values, saying, *"If you create your bed, then you lie in it."*

2.2.47 As a young gymnast, she struggled with anxiety and later faced terror when hearing sirens, fearing for her brother's safety. After learning of his death abroad, she experienced nocturnal terrors that subsided after some time.

2.2.48 Angela's father died from alcohol dependency and throat cancer, and she acknowledged her husband's drinking issue while stating she did not have one.

2.2.49 Although financially secure and physically healthy, she felt a lack of meaning in life, longing for the vibrancy of her city life in her youth. She believed her path was predetermined, labelling herself a "*control freak*" with severe anxiety. They discussed how her life experiences shaped her behaviours, which might be unlearned.

December 2022

2.2.50 Angela had a face-to-face appointment at her GP practice, reporting an inconsistent mood. She used mirtazapine to sleep when needing to wake up early for work, but noted that the situation was more under control.

2.2.51 Angela met with the EF manager, and she reported drinking about ten units daily and attributed her impulsive actions and stress-related overdose risk to stress. She shared that her birthday was complicated, marked by the death of her daughter's horse, which added to her feelings of helplessness, especially regarding her daughter's grief.

2.2.52 Angela expressed high anxiety, 'ticing', and impulsive anger, often shouting at herself to avoid facing the day. She felt overwhelmed by her to-do list and recognised her struggles with empathy and the stigma surrounding her overdose. While feeling ashamed and powerless, Angela noted the need for change, but struggled to advocate for it. She connected her traumatic experiences, including her brother's death, to her current issues and was advised to consult a trauma specialist to help manage her feelings and work towards realistic lifestyle changes.

2.2.53 Angela reflected on how counselling differed from her work with the EF manager. She highlighted her method of controlling her surroundings and the diagnostic nature of her work, expressing a desire to move from understanding her habits and beliefs to incorporating them into her daily life. Angela emphasised the need for transformation and eliminating old habits and sought guidance on making decisions that would positively impact her future.

January 2023

2.2.54 Angela attended three EF counselling sessions, and no risks were highlighted.

2.2.55 **Risk summary completed by the RW**

- Higher risk of drinking – Engaging with Angela and good support from the GP
- Thoughts of self-harm – Engaging with Angela and good support from the GP

February 2023

2.2.56 A Zoom meeting with the EF manager reviewed Angela's counselling progress during the counsellor's leave. Initially resistant to counselling, Angela recognised its value despite her struggles to let the counsellor in, stemming from a background of severe

criticism. She discussed her loud arguments with her husband and the societal stigma of being perceived as "mental".

2.2.57 The EF manager advised her to establish calming routines, noting her concern about completing tasks while neglecting basic needs. Angela acknowledged the need for small changes to foster calm and mindfulness, realising she needed to let go of her daily concerns. They aimed to identify stressors and explore solutions through a cost-benefit analysis, comparing inaction to a proactive approach. She was reminded of her combined appointment with the RW and EF manager.

2.2.58 During a Zoom meeting led by the EF manager, Angela shared that she drank around forty alcohol units on weekends and wanted to abstain due to its negative impact on her mood and performance. She felt stressed managing both family and work, and recognised that her controlling behaviour caused conflict at home.

2.2.59 To protect her children from negative influences, Angela participated in breathing exercises, yoga, and Pilates and read a book titled 'Surrounded by Idiots' to improve family communication.

2.2.60 Angela attended two counselling sessions, and no risks were highlighted.

2.2.61 Angela attended her RW and EF manager consultation and discussed her alcohol consumption. She mentioned, *"I am doing really good right now, making efforts not to drink in the week,"* although she sometimes drank on weekdays. Angela valued autonomy and order during the week but saw Saturdays as *"her weekend,"* which she described as sometimes leading to chaos. She typically drank half a bottle of wine on Fridays and Saturdays and acknowledged that alcohol harmed her mental health, but expressed ambivalence and wanted to enjoy her weekends.

2.2.62 During the session, Angela called herself and her husband *"alcoholic"* and identified herself as a binge drinker. She began using non-prescribed diazepam four weeks ago to manage panic attacks, but was denied access recently. They discussed the risks associated with stopping benzodiazepines (diazepam) and potential addiction, which she acknowledged and was determined to avoid. Angela recognised the 'chaos' in her life, including a past overdose that led to hospitalisation.

2.2.63 While she sought better mental health and emotional control, she admitted that she and her husband could argue when drunk, although it had been nearly two years since he physically harmed her. Her busy social and business calendar often kept her structured, and she avoided behaviours harmful to her mental health. Current risks included substance misuse, alcohol poisoning risk, and polydrug use, while protective factors were her family support, work, counselling, and GP involvement.

March 2023

2.2.64 Angela contacted the EF manager to discuss her sleep issues, suspecting she might have Attention Deficit Hyperactivity Disorder[24] (ADHD) due to sedation from a

[24] https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/

nicotine patch. The EF manager recommended she see her GP or fund a private assessment. She was advised to reduce alcohol use and abstain from adjusting her MH medications.

2.2.65 The police responded to a report of a domestic altercation involving a mother and daughter. The mother had a minor cut on her finger but declined to have it photographed. Matthew entered the scene, raising his hands, stating he needed to be arrested or he would erupt. He was subsequently arrested for common assault.

2.2.66 Matthew was in custody after being arrested for assaulting two women. He was verbally abusive to the L&D team and refused to communicate, appearing heavily intoxicated.

2.2.67 Angela attended three EF counselling sessions and reported at the third that she had fought with her husband after drinking too much. She spent a few days with her mother to reflect on their relationship.

April 2023

2.2.68 Angela spoke with two GPs on the phone after a conflict with her mother and husband last weekend, where her anxiety led her to shout at them. She reported her son was staying with her at home, experiencing severe tics, and felt overwhelmed. She misinterpreted the GP's unexpected call as a family request.

2.2.69 Angela attended two EF counselling sessions; the first was cut short due to concerns about her husband's cardiac risk.

2.2.70 Her GP called Angela while driving her husband home from Norfolk and Norwich University Hospital (NNUH). She reported feeling stressed and requested an increase in citalopram.

May 2023 (20 days before Angela's death)

2.2.71 EEAST received a 999 call from Matthew. Angela's speech was reported to be slurred, and she had overdosed. Angela had told Matthew not to send help as she would not be there. EEAST attended the location and found no one at the scene. The police were notified. Records indicated Angela and Matthew left after an argument.

2.2.72 The police found Angela. She reported that she and Matthew had argued about finances and her worsening mental health. While Matthew visited his father, Angela overdosed on diazepam. She was later involved in a road traffic collision (RTC) and was reportedly assaulted by members of the public. Matthew was informed of her arrest and custody. The police transported Angela to QEH before taking her to the police station.

2.2.73 At QEH, she was intoxicated, having potentially taken 14x5mg of diazepam after arguing with her husband about his heart operation. Angela reported drinking a bottle of wine and taking diazepam to calm down. Police were called after she hit a car while driving; Angela reported she had been assaulted.

2.2.74 Nicole and her family questioned why MH specialists did not assess Angela. Angela had been seen at QEH and stated she had no suicidal thoughts. At the time of her police custody, the police indicated that no MH service was in the police station. However, she was seen by a healthcare practitioner and asked about self-harm plans, and Angela responded no.

11 days before Angela's death

2.2.75 Angela told the EF manager that Matthew was in a virtual ward at home, with the hospital checking on him every two hours. Feeling overwhelmed, she considered going to an MH hospital and expressed concerns about her will to live. She had taken six diazepam and drank wine before driving. With diazepam's adverse effects while driving, she reconsidered and decided to end her life.

2.2.76 After running out of diazepam, Angela drove to the supermarket for Tequila and Nytol. This led to an RTC where she hit seven cars and crashed into a garden. After being attacked by the fence owner, she called 999 and was arrested for Actual Bodily Harm. Despite being within the legal drinking limit, she lost control of her car after misusing diazepam.

2.2.77 Angela expressed feelings of isolation and sadness, considering suicide as an escape. The EF manager recognised her situation as a plea for help and discussed the emotional consequences of her diazepam misuse. Angela linked her negative emotions with her substance use and felt the need for self-sufficiency to cope with her husband's violence.

2.2.78 After a conversation about her risks, Angela acknowledged her fluctuating moods and worry about her husband's return home. The EF manager provided the crisis team (mental health) and Samaritan's contact numbers and advised her to see her GP due to her dependence on diazepam.

2.2.79 Angela reported feeling alone, embarrassed, and unable to envision a future. The EF manager noted several risks, including alcohol and diazepam availability, poor impulse control, a history of suicide attempts, and her need to care for Matthew on a 'virtual ward', at home awaiting a hospital bed.

10 days before Angela's death

2.2.80 Angela's presentation raised concerns, prompting the EF manager to attend the morning "flash meeting." The manager was informed they would be contacted afterwards. The flash minutes noted: *'For safeguarding, see CRiiS: (Patient electronic record)'*.

6 days before Angela's death

2.2.81 The RW called Angela regarding the EF manager's concerns. Angela reported no suicidal thoughts and disclosed she sometimes said *"these things but did not mean it."* The RW assessed no urgent risk and planned a follow-up.

2.2.82 Angela acknowledged her diazepam use in EF counselling, expressing, while laughing, that others would be better off without her.

4 days before Angela's death

2.2.83 Email from EF manager to the RW: *"Hi, Following our conversation X, I called Angela, and she has stated she has no suicidal ideations and relayed that her counselling sessions had come to an end and she wanted more sessions. I explained that CGL abides by safeguarding procedures and processes. As she had disclosed to her counsellor that she "felt like taking her husband's life rather than her own," we are obliged to report this as potentially others are in danger. "Angela said it in jest my husband is due to have a triple heart bypass and I am going to be here to care for him." The information was disclosed in X May 2023 and shared with the X team by X and again by you. Please, can either you or I call the police 101 in relation to this? X is her recovery worker and has an appointment booked with her today. Regards X."*

2.2.84 No call was made to the police.

2.2.85 Angela was contacted by a new RW who introduced themselves. Angela was cordial and expressed gratitude. She expected to be discharged after EF counselling. She discussed her husband's upcoming cardiac bypass and the RTC and awaited police reports.

2.2.86 The RW acknowledged her stress, but Angela seemed unconcerned. She mentioned suicidal thoughts to the EF manager but denied them to the RW, showing interest in more appointments. Angela reported drinking fourteen units of alcohol on her days off. She texted that her phone battery died and would return the call, but no follow-up call was made.

3 days before Angela's death

2.2.87 Angela informed the RW by text that she could not attend the appointment due to work. The meeting was rescheduled, and she received an automated message with the new date.

1 day before Angela's death

2.2.88 An uncategorised 999 call to EEAST reported an individual unable to stay still or provide an address. The caller stated they would contact the police, and the call was abandoned.

2.2.89 The police received a report of a verbal dispute between Matthew and Angela concerning a new car.

Two emergency calls were made to EEAST, reporting a cardiac arrest. Angela's mother discovered her deceased.

Overview

3.1 Analysis of Agency Involvement

3.1.1 This section explores the agencies' involvement with Angela.

An analysis of Angela's interactions with the subsequent agencies has been conducted:

1. Change Grow Live
2. GP Practice
3. Norfolk and Norwich University Hospital
4. Norfolk Constabulary
5. Norfolk and Suffolk NHS Foundation Trust
6. Queen Elizabeth Hospital NHS Foundation Trust

Change Grow Live (CGL)

3.1.2 Angela was assessed in July 2022 to determine whether she required assistance in regulating her alcohol usage. Angela disclosed during the assessment that she consumed alcohol on two to four occasions each month, with an average daily intake of fourteen units. During the assessment, it was determined that Angela had a pattern of binge drinking. Angela's objective was to minimise her alcohol use and reserve it for social events exclusively.

3.1.3 To mitigate the health risks associated with alcohol, Alcohol Change UK[25] recommends that men and women limit their consumption to fourteen units per week. Furthermore, they suggest spreading this amount over at least three days.

3.1.4 After the assessment, Angela was assigned to the non-alcohol-dependent pathway, and EBI groups were made available to assist her in addressing her binge drinking. Angela initially disengaged from CGL and was discharged in October 2022. However, she contacted CGL after being discharged, and the case was reopened six days later. The following day, she had her first EBI session.

3.1.5 The National Institute of Health and Care Excellence, Alcoholic Disorder Diagnosis and Management[26] recommends treatments to include EBI. EBI is implemented through motivational enhancement therapy or motivational interviewing. The sessions should run between twenty and thirty minutes. They should assist participants in reducing their alcohol consumption to low-risk levels, avoiding risky behaviour caused by alcohol consumption, or contemplating abstinence. Consequently, CGL was adhering to the suggested course of action.

3.1.6 In November 2022, Angela's RW determined that she would benefit from counselling and, as a result, requested that the EF service manager assess her for this. Angela was placed on the counselling waiting list, and it was mutually decided that she would discontinue the EBI sessions as the counselling would fulfil her treatment

[25] https://alcoholchange.org.uk/alcohol-facts/interactive-tools/check-your-drinking
[26] https://www.nice.org.uk/guidance/q s11/documents/briefing-paper

requirements. As Angela awaited the start of her counselling session, the EF manager offered her one-on-one support. The panel considered this to be good practice.

3.1.7 EF provides psychosocial groups and counselling services. CGL was coordinating Angela's treatment for substance abuse and risk assessment. Collaborative work was evident between the two services.

3.1.8 Angela initially disclosed thoughts of suicide to the EF manager in May 2023 during a conversation about a previous incident in which she had intended to drive to a mental health unit but changed her mind. She stated that she had planned to end her life but was stopped by the police following a car accident.

3.1.9 In addition to ensuring Angela had a safety plan, the EF manager provided her with information regarding support services (the Crisis Team and the Samaritans). However, they believed that the determinants of her well-being (such as her husband returning home from the hospital and feeling she would need to provide care to him) were increasing, while her protective factors (such as the risk of losing her driver's licence) were decreasing.

3.1.10 The EF manager conveyed this information to the CGL RW (through email and the morning Multi-Disciplinary Team (MDT) meeting). CGL staff followed up with Angela on two occasions. On both occasions, Angela negated the idea that she was overwhelmed by her current situation, refrained from divulging or affirming any thoughts of self-harm, and planned further consultations with CGL.

3.1.11 Angela attended a risk assessment telephone appointment with her RW thirteen days before her death, which marked the last meaningful interaction she had with CGL. Angela continued to engage in binge drinking, which resulted in a variable tolerance and an increase in alcohol consumption during the times she was drinking. Angela disclosed that she did not consume alcohol daily, but when she did, she consumed no more than fourteen units. A half-bottle of tequila or gin.

3.1.12 Angela disclosed that she was purchasing illicit diazepam. Angela was provided with harm minimisation advice regarding the risks of combined diazepam use and binge drinking. The concurrent use of these sedatives may lead to respiratory depression, unconsciousness, or fatality.

3.1.13 The panel stated that the risks should have been communicated to Angela's GP to ensure that they were aware of her thoughts of ending her life and her diazepam use. CGL was informed that Angela maintained a positive rapport with her GP; hence, she was expected to have provided consent to share the information if asked.

3.1.14 The Department of Health and Social Care[27] has issued guidance about exchanging information for suicide prevention. This should have been considered to ensure that the GP was aware of the risks, particularly about her online acquisition of diazepam.

3.1.15 Angela disclosed to the RW that she was attending EF counselling sessions to address her difficulty in managing her emotions. Angela disclosed that she was no longer experiencing the suicidal thoughts she had shared over the phone with the EF manager.

3.1.16 Understanding the causes of suicidal ideation can be facilitated using talking therapies. They can also assist in considering coping mechanisms and resolution strategies for these emotions.

3.1.17 Angela and the RW discussed her emotions over her husband's physical health, which required her to care for him, and how she operated the family business alone. Angela did not indicate any concerns regarding domestic abuse during the scheduled session.

3.1.18 In England and Wales, 5.0 million residents aged five years and older provided unpaid care in 2021.[28] According to a survey conducted by Carers UK and reported by the Care Quality Commission[29], unpaid carers identified three challenges: coping with stress and responsibility (71%), adverse effects on their physical and mental health (70%), and the inability to allocate time for personal and professional development (66%).

3.1.19 As a result, providing care and support to carers is necessary. Section 10 of the Care Act 2014[30] ensures that carers can obtain a carer's assessment. Angela was not referred for this by CGL, and her GP was not informed of her feelings about providing care to her husband.

3.1.20 Twelve days before Angela's death, the RW and Angela exchanged text messages to reschedule their next appointment, given that Angela informed the RW that she was working on the initial day proposed.

3.1.21 Angela's treatment plan for the previous three months included counselling sessions to examine her belief system on relationships (specifically her belief that family should stick together no matter what) and to assist her in developing alcohol-free coping mechanisms.

3.1.22 Angela was scheduled to attend a counselling session with EF the day following her death.

3.1.23 CGL highlighted the key findings as follows:

[27] https://www.gov.uk/government/publications/consensus-statement-for-information-sharing-and-suicide-prevention/information-sharing-and-suicide-prevention-consensus-statement
[28] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/unpaidcareenglandandwales/census2021
[29] https://www.cqc.org.uk/publications/major-reports/soc202021_01f_increased-strain
[30] https://www.legislation.gov.uk/ukpga/2014/23/section/10

a) Services managers of both CGL and EF have defined the roles and responsibilities of each organisation for sharing and handling risk information, which is embedded in the EF contract and shared with all staff affected.
b) The CGL Services Quality and Performance Lead created a "handover" document that an RW should complete before leaving the organisation to highlight relevant risk information and the treatment plan to the new RW. All managers are to ensure this is completed and sent to them before the RW departs.
c) Designated Safeguarding Leads (DSL) developed a training package for staff on the identification and management of suicidal ideation, how to present the information to formulate a comprehensive plan and the roles and responsibilities regarding recording these consultations.

GP Practice

3.1.24 Angela was a registered patient at the GP practice for over two decades and had a positive rapport with the staff.

3.1.25 Angela presented to the practice with recurrent anxiety, verbal and physical tics, panic attacks, depression, menopause, and intermittent alcohol use. Angela was known to be under the care of CGL. Her GP practice referred Angela to mental health services on two separate occasions in 2015 and 2018.

3.1.26 During the review period, Angela attended twenty consultations with her GP, of which eighteen were conducted via telephone. Throughout the GP consultations, numerous discussions centred around mental health

3.1.27 Due to COVID-19, the use of telemedicine in all health and social care services increased.

3.1.28 According to the research[31], the use of telemedicine to treat depression has increased access to care, particularly for patients residing in remote areas.

3.1.29 A further study[32] examined communication and discovered that doctors and patients reported that telephone consultations hindered communication. Both parties were frustrated by the absence of nonverbal indicators, which hindered assessment and relationship development. The study acknowledged the practical advantages of telemedicine, such as eliminating travel, waiting in buildings, and job absences. However, it considered these gains negligible importance and continued to result in substandard communication.

3.1.30 According to another study[33], most patients preferred in-person appointments.

[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8367159/
[32] https://www.rcpjournals.org/content/futurehosp/9/2/154#:~:text=The%20quantitative%20results%20for%20patients,inferior%2C%20with%20the%20exception%20of
[33] https://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/s12911-023-02348-4

3.1.31 The research centred on patient autonomy, interpersonal relationships, and communication. Angela had developed a positive relationship with her GP practice; nevertheless, as previously mentioned, effective communication is hindered by the lack of nonverbal cues and the significance of patient autonomy in facilitating timely service access and advocating for patient choice.

3.1.32 Most of the telephone calls to Angela occurred out of hours.

3.1.33 Angela's disclosure that she was staying with her mother prompted the GP, who was aware of the domestic abuse in the home, to agree that this was the most suitable course of action and to ensure that both parties had alcohol under control before her return home. The practice did not consider signposting or sending Angela information for domestic abuse services.

Norfolk and Norwich University Hospital (NNUH)

3.1.34 Matthew was referred to NNUH for specialised cardiology input.

3.1.35 The virtual ward at NNUH administered Matthew's care. Through the virtual ward programme, patients can complete therapy, recuperate from hospitalisation, or be monitored before surgery from the convenience of their homes. The virtual ward team uses innovative medical technology to ensure that patients continue to get medical attention from the hospital while being closely monitored remotely at home. Matthew was deemed suitable for virtual ward management.

3.1.36 The virtual ward staff maintained regular contact with Matthew by telephone or video call and supplied him with medical equipment. Staff attempted to contact Matthew at home in early May 2023; Angela responded, and transport and Matthew's medication were subjects of discussion.

3.1.37 Eleven days before Angela's death, a dialogue with Matthew revealed that he had left the county for dental treatment in February 2023 and disclosed a dispute with his wife. No documentation existed on the disagreement.

3.1.38 Matthew stated during a telephone conversation ten days before Angela's death that he was under a great deal of stress due to his wife's mental health concerns; she had overdosed and collided with eight vehicles. He stated that he would provide the virtual ward with his address upon his return, as he would stay with his daughter.

3.1.39 Matthew disclosed his heightened stress levels and separation from his wife, Angela, nine days before her death. He stated his wife was afflicted with numerous mental health challenges, including overdoses, anxiety, and depression, and was arrested over the weekend. Having moved in with his daughter, he perceived himself to be in an unstable situation.

3.1.40 Matthew had returned home seven days before Angela's death and enquired about specific domestic duties he would perform exclusively in his wife's presence.

3.1.41 The day before Angela died, the hospital recorded the following:

Matthew was distraught on the phone as he had been having issues with his wife due to her mental health. He reported that she had crashed the car after taking diazepam, and she did not receive any mental health support from the police. He noted that he had left the house, and she had sent a message stating that she was going to hang herself, so he returned home to find her, and he cut her down. She was conscious, and she left the house, he believed, to go to the shop to buy alcohol and tablets to take another overdose. Matthew reported that he followed her through the village but did not have his GTN spray, so he returned home to collect it before going to find her. Matthew was on the call to the virtual ward at this time, and he was advised to call 999 as his wife would need to be assessed for both her physical and current mental state.

3.1.42 Matthew informed the virtual ward that evening that he would spend the night with his daughter because his wife had locked him out of the house. According to his account, he attempted to contact an ambulance for his wife, but they refused to attend because she was wandering the streets while intoxicated or carrying alcohol. They recommended that he contact the police, but he declined. His wife had returned home, and her mother was en route. Matthew consented to communicate with the virtual ward if any medical complications arose at night.

3.1.43 According to the NNUH's website[34], one in every three women and one in every five males are victims of domestic abuse. The NNUH has trained workers to function as champions and assist in critical areas.

3.1.44 The champions have an expanded repertoire of knowledge and abilities, enabling them to provide counsel, direction, and assistance to their teams regarding managing domestic violence and abuse. They will assist when concerns about the hospital's patients and staff are expressed. There were no such champions on the virtual ward. Norfolk Integrated Domestic Abuse Service (NIDAS) provides ongoing training for health staff, and the ward can access the hospital safeguarding team and champions from other wards.

3.1.45 A resource[35] for health professionals was developed by the Department of Health, which also reported that in England and Wales, domestic abuse affects nearly two million individuals aged sixteen and older annually. That equates to one in every six men and one in every four women. Early detection is crucial in addressing domestic abuse; consequently, routine enquiries and selective questioning should be employed when concerns that may be related to domestic abuse are received.

3.1.46 The Norfolk County Council[36] provides additional guidance to promote disclosures.

[34] https://www.nnuh.nhs.uk/news/2016/09/new-domestic-abuse-champions-introduced-at-nnuh/
[35] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DometicAbuseGuidance.pdf
[36] https://www.norfolk.gov.uk/safety/domestic-abuse/information-for-professionals/encouraging-disclosures

3.1.47 In addition to the absence of domestic abuse enquiries, safeguarding adult considerations were overlooked. Matthew disclosed that he had been locked out of his home and that his wife's mental illness and arrest had contributed to his heightened stress.

3.1.48 The Local Government Association[37] emphasised the roles and responsibilities of safeguarding adults within the health and care sector. One of the desired outcomes should be the prevention of abuse and neglect and the promotion of well-being. Matthew received emotional support from NNUH throughout his phone calls.

3.1.49 Angela had expressed concern that she would be required to care for Matthew while he awaited surgery; Matthew's statement that he would only perform domestic duties in Angela's presence seems to have confirmed this.

3.1.50 The review revealed that Angela needed to be provided with communication regarding her responsibilities or whether she was entrusted with caring for Matthew. Matthew did not identify Angela as a carer; consequently, the virtual ward was unaware of her concerns.

Norfolk Constabulary

3.1.51 The police national computer highlighted the following:

- Matthew was convicted of Battery against Angela and assault of an emergency worker concerning an incident in 2020, resulting in a suspended sentence.
- Matthew was convicted of battery against Angela in 2013, which resulted in a fine.
- In 2009, Matthew received a simple caution for criminal damage against Angela and a caution for ABH against their wife (does not state if this is Angela) in 2005.

3.1.52 The contact details are within the combined timeline.

April 2020 (Assault Occasioning Bodily Harm / Threats to Kill (domestic related)

3.1.53 Matthew was arrested, interviewed and testified that he could not recall anything. He stated that Angela and he had been drinking alcohol together. He had no memory of any altercations. His recollection was limited to leaning out of the window and seeing the police, followed by his arrest.

3.1.54 A Domestic Abuse, Stalking And 'Honour'-Based Violence[38] (DASH) risk assessment was performed and determined to be "high." Angela contributed some information to the risk assessment but did not wish to support a prosecution. She expressed feeling frightened, "not on a day-to-day basis but today", and stated she was *"afraid*

[37] https://www.local.gov.uk/safeguarding-adults-roles-and-responsibilities-health-and-care-services
[38] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

of being assaulted by him again." She characterised Matthew as alcohol-dependent with mental health issues and a *"head case."*

3.1.55 Victim Support[39] identified one of the significant barriers to engagement with the legal system for survivors and victims seeking to engage with it: specific individuals may mistrust it or fear the police.

3.1.56 Angela also told CGL regarding her conviction that *"you make your bed, lie in it"* and that *"families remain together."*

3.1.57 Women's Aid highlighted the factors that contribute to some women struggling to leave an abusive relationship. Additionally, this may shed insight into why they feel unable to support a prosecution.

- Danger and Fear
- Isolation
- Shame, embarrassment or denial
- Trauma and low confidence
- Practical reasons

3.1.58 The Domestic Abuse Safeguarding Team (DAST) conducted a secondary risk assessment, which determined that the level of risk remained high. Angela identified alcohol as the catalyst for Matthew's aggressive and abusive behaviour. Angela acknowledged that Matthew's conduct is atypical and that she is at risk. She wished to remain in the relationship, and safety precautions were advised, including dialling 999; Angela also had a local friend with whom she could communicate.

3.1.59 Object markers were placed on Angela's mobile phone and home address. MARAC and IDVA referrals were discussed and executed. The CGL number was given to Matthew. Angela stated that she intended to remove all alcoholic beverages from the home, and the police confirmed that neither party were known to mental health services.

3.1.60 The CPS agreed to charge Matthew with battery and assault of an emergency worker.

September 2020 (Domestic abuse investigation- Verbal argument between Matthew and Angela)

3.1.61 The attending officer completed a medium-risk DASH risk assessment. Angela declined to participate in the assessment; hence, the DASH was executed at the officers' discretion.

July 2021 (Domestic abuse investigation – Matthew called the police and stated he needed them to attend, or he would kill Angela)

[39] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

3.1.62 Matthew was obstructive and challenging to understand due to his intoxication. Matthew declined to disclose Angela's whereabouts.

3.1.63 Angela used Matthew's phone to call the police following their attendance. She stated that she was en route to her mother's home; she was well and had no complaints. She declined to provide additional details but stated that they had a verbal altercation and Matthew had created a mess in the kitchen; consequently, she wished for him to sober up and clean the mess in the morning. She reported being exhausted by his behaviour and the effort required to clean up after him. No violations were identified or reported.

3.1.64 The DASH risk assessment was assigned a medium rating; the officers had to rely on their professional judgement as Angela was not home when they attended. DAST concluded its secondary risk assessment, which graded the situation as medium risk. It stated that while highly intoxicated, Matthew called the police to report that his partner, Angela, was provoking him to the point where he would kill her if they did not arrive. Placement of markers on Angela's phone. The exact risk was complex to ascertain due to the absence of a statement, and Angela was absent during police attendance.

May 2022 (Adult Protection Investigation, and a male reported he had been assaulted)

3.1.65 Angela was unconscious when the police attended her address. Matthew reported that Angela had overdosed because she had been afflicted with depression for a decade after her brother's death. Matthew reported that Angela made physical contact with him while he was attempting to assist her after the medical episode she experienced due to the overdose.

July 2022 (Minor wound without intent)

3.1.66 Upon arrival, officers met with Matthew, who was characterised as "quite intoxicated." At first, he intended to support the prosecution's case against Angela, who had allegedly struck him in the face. No injuries were observed. Matthew changed his mind and evicted police officers from the premises. He implied he would relocate to a different address the following morning but declined to specify the location.

3.1.67 The attending officer conducted the DASH risk assessment and assigned it a medium risk after Matthew declined to engage. DAST completed secondary safeguarding, and it remained at a medium risk. It provided an account of Angela's mental health issues, which precipitated the dispute. Angela then delivered a blow to the victim in the face, causing no injury after the escalation of the argument.

3.1.68 Matthew stated that he had attended Alcoholics Anonymous (AA) previously. Markers were affixed to Matthew's phone and address, and he was provided CGL information. He was also informed that ManKind (domestic abuse service) could support him should he need it.

3.1.69 Matthew declared his wish for Angela to return home for him to be able to assist her with her alcohol use and mental health difficulties. Angela's recent overdose was also referred to the Police Mental Health Advice Team (MHAT), and confirmation was obtained via email that Liaison and Diversion (L&D) had assessed Angela.

3.1.70 Angela was arrested, and no further action was taken after examining the body-worn footage. It was determined that menopause likely contributed to Angela's declining mental health.

March 2023 (Domestic abuse investigation – two females reported a verbal argument and a minor wound without intent)

3.1.71 Angela was spoken with once she was sober, and she stated that she inflicted the minor injury herself while intoxicated and that she had not been the target of any aggressive assaults. The absence of substantiating evidence for the complaint precluded any additional action.

May 2023 (Domestic abuse investigation – Verbal altercation between Angela and Matthew)

3.1.72 Angela had left the home and reported to have taken an overdose and crashed her car. Following her arrest, Angela was released on police bail. Angela was referred to a health care professional (HCP) while in custody and was deemed competent to be questioned; nevertheless, the HCP noted that Angela had a great deal going on in her life, including familial issues that were negatively impacting her mental health.

3.1.73 The police completed a DASH risk assessment of the reported victim, Matthew. He declined to participate, and officers described the home environment as volatile. It is expected that the history of domestic abuse perpetrated by Matthew against Angela would have been considered; the panel indicated that there was a lack of professional curiosity regarding this matter.

3.1.74 L&D did not see Angela because the service was unavailable during her custody hours.

The day before Angela died.

3.1.75 The relationship between Angela and Matthew was reported to be sporadic for a considerable period. Angela and Matthew had a dispute the night before; she had been arrested for drug driving a few weeks previously and had expressed interest in purchasing a new car. This resulted in a dispute, and Matthew, awaiting surgery, departed to avoid stressful situations.

3.1.76 Later, he received a phone call from Angela in which she declared her intention to end her life. When Matthew returned home, he found her with a scarf around her neck and cut her down. Matthew departed following a second dispute.

3.1.77 Matthew contacted Angela's mother to inform her that she must care for her daughter. In addition to requesting an ambulance, Matthew reported that Angela had attempted suicide but left the home. The ambulance call handler informed him that their attendance was impossible without an address for Angela.

3.1.78 Angela's mother drove to Norfolk and spoke with Angela on the phone. Her mother returned home and said she would visit her the following day. Upon her return the next day, Michelle found her daughter's body.

Norfolk and Suffolk NHS Foundation Trust (NSFT)

3.1.79 Angela's GP referred her to Access and Assessment[40] for mental health support on two separate occasions: in 2015 and 2018. The first referral was closed upon receipt, and the second was closed following an initial assessment with Angela, as it was determined that she should continue to be under the supervision of her general practitioner.

3.1.80 In April 2022, Angela had an initial contact with the Wellbeing Service[41]. However, this appointment was not completed before her overdose, which necessitated an assessment with the mental health liaison team (MHLT) in May 2022.

3.1.81 MHLT referred to the crisis resolution home treatment team (CRHTT), who visited Angela at home on 1, 2, 4 and 6 June 2022. The initial home visit revealed bruises on Angela's arm, and she disclosed that her marriage was "volatile." An additional appointment was scheduled to discuss these safeguarding concerns further; however, Angela's husband was present until the final appointment on 6 June 2022, when she was ultimately observed alone. She disclosed that her husband was verbally abusive when he consumed alcohol. She did not report any current physical violence (none in the past 3.5 years). No action followed this disclosure. She was discharged to the Wellbeing Service and CGL.

3.1.82 In May 2021, the House of Commons Library[42] released a briefing paper examining the role of healthcare services in preventing domestic abuse. It was emphasised that research has established clear connections between domestic abuse and mental health in both directions. Individuals with severe mental health issues are at a significantly increased risk of experiencing domestic abuse and sexual violence. In contrast, exposure to domestic abuse can result in mental health issues such as post-traumatic stress disorder and depression.

3.1.83 The paper quoted Baroness Williams of Trafford

[40] The Access and Assessment Service is for individuals over the age of 25 and provides advice and assessment on all mental health conditions to make the appropriate referrals to other mental health teams.
[41] The Wellbeing Service provides psychological interventions to people aged 16 and over. It follows the National Institute for Health and Care Excellence (NICE) Stepped Care model.
[42] https://researchbriefings.files.parliament.uk/documents/CBP-9233/CBP-9233.pdf

"You cannot decouple domestic abuse from mental health trauma". Surely, the two go hand in hand, not only for the woman—it is usually a woman—who is suffering abuse at the hands of an abusive partner but also, usually, for her children, who feel those effects and the trauma for a very long time, if not the rest of their lives."

3.1.84 On 13 June 2022, Angela contacted the First Response Service[43] (FRS) to express her feelings of feeling unsafe and unsupported. The CGL referral was pursued, and Angela was informed they would contact her the following day. She was also advised to wait for the Wellbeing Service assessment.

3.1.85 The Wellbeing Service initially declined the referral due to the level of risk, and it was forwarded to the community mental health team (CMHT), which also declined it. Nevertheless, the Wellbeing Service agreed to meet with Angela and saw her twice in June and July 2022.

3.1.86 Angela had informed Nicole that she did not wish to leave Matthew. Angela had been in a relationship with Matthew for most of her life, and the prospect of beginning a new chapter without him may have induced anxiety in her. Angela informed Nicole that she had experienced low confidence and a history of trauma. She reported to NSFT that she felt unsafe and unsupported.

3.1.87 Some of the factors that prevent women from leaving or accessing domestic abuse services were emphasised by Women's Aid[44]:

- Danger and Fear: 41% (37 of 91) of women killed by a male partner/former partner in England, Wales and Northern Ireland in 2018 had separated or taken steps to separate from them. Eleven of these 37 women were killed within the first month of separation, and 24 were killed within the first year (Femicide Census, 2020).
- Isolation: Isolation leads women to become extremely dependent on their controlling partner.
- Shame, embarrassment or denial: Victims may be ashamed or make excuses to themselves and others to cover up the abuse.
- Trauma and Low confidence: Victims have minimal freedom to make decisions in an abusive relationship; they are often traumatised and regularly told, 'You couldn't manage on your own; you need me'. Fear is constant, and they live in a world of everyday terror.
- Practical reasons: Asking for help is not easy. Misunderstandings about domestic abuse often prevent professionals from knowing what to do, how to talk about it or where to direct women disclosing abuse.

3.1.88 Following her arrest in July 2022, Angela was seen by L&D. Angela did not wish for an assessment, so no further referrals were made.

[43] NHS 111 Option 2 is a helpline for people of all ages in Norfolk and Suffolk who need urgent mental health support.
[44] https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/women-leave/

3.1.89 Ten days later, Wellbeing assessed Angela and referred her to the CMHT. As outlined in the key events, she received an assessment in August 2022.

3.1.90 The NSFT Safeguarding Team did not collect and evaluate feedback on its safeguarding training to understand its effectiveness. However, this has since changed, and the team now collects and analyses feedback after each training session. This may result in developing more effective training and improving the current training.

3.1.91 Additionally, the Safeguarding team has a designated safeguarding trainer responsible for enhancing and expanding the current training programmes available to NSFT practitioners.

3.1.92 The safeguarding team has expanded and is currently reviewing the support provided to safeguarding and domestic abuse champions and the delivery of safeguarding supervision throughout the Trust to ensure that all practitioners are confident and competent in their safeguarding responsibilities. The knowledge gained from this and other reviews will facilitate the development of these provisions.

3.1.93 An update to the Domestic Violence and Abuse policy is presently underway. Upon completion, it will be disseminated throughout the Trust to ensure that all teams have a physical copy and that it is accessible internally.

3.1.94 The IMR found that enhanced collaboration between CGL and NSFT to develop combined treatment and care plans is necessary whenever feasible.

3.1.95 The CMHT Operational Policy requires distinct referral criteria to assist practitioners in referring patients to the CMHT.

3.1.96 A greater emphasis will be placed on the recognition of domestic abuse indicators without disclosure, and additional domestic abuse training will be made available to all practitioners throughout the Trust.

3.1.97 It is believed that NSFT did not capitalise on opportunities to protect Angela from the domestic abuse she was enduring. Had practitioners been more assured in their ability to identify the indicators that Angela was providing, they could have prioritised Angela's need for domestic abuse support at an earlier stage in her care.

3.1.98 Angela stated that she did not necessarily perceive her current circumstances as abusive. This is likely due to the absence of physical abuse that had been present in the relationship previously and the fact that opportunities were missed to more thoroughly explore this with Angela and respectfully challenge her perception of her relationship. Angela may have acknowledged the need for change and support with the assistance of others, which could have benefited her mental health and overall quality of life.

3.1.99 The Trust provides all practitioners with sufficient domestic abuse information and resources, and there are numerous examples of good practice in Angela's care concerning domestic abuse. However, there were still multiple instances in which the response could have been significantly enhanced. This implies that the understanding and awareness of domestic abuse and safeguarding are inconsistent among practitioners and teams. NSFT must determine the factors contributing to this disparity in knowledge and process to understand how it can be improved and addressed.

Queen Elizabeth Hospital NHS Foundation Trust (QEH)

3.1.100 Angela, in May 2022, was hospitalised through the Emergency Department due to a substantial polypharmacy overdose involving alcohol.

3.1.101 The emergency department's electronic documentation system displayed a notification that a MARAC had occurred in 2020. Staff members were thus informed of prior incidents of domestic abuse. Angela responded negatively to the enquiries that were posed upon her admission to the ward regarding any abuse. Angela declined the safeguarding team's request to engage her in a DASH risk assessment.

3.1.102 Angela was granted time alone, away from family members, to reflect on her emotions and left with the DASH. However, upon recovering, she wished to return to Matthew. She refuted any allegations of abuse occurring within the previous three years, did not wish to complete the DASH and declined any recommendations for support.

3.1.103 Angela was assessed by the MHLT and referred to the CRHTT. Two days later, she was discharged home.

3.1.104 Angela's second attendance was in early May 2023, after her arrest. It was discovered that she was intoxicated and had possibly consumed fourteen 5mg diazepam tablets within the previous several hours.

3.1.105 Angela disclosed that she overdosed due to an altercation with her husband, who was angry that his heart operation had been cancelled. While driving down a tight street, she collided with a car, and the police were dispatched. She stated that she was assaulted.

3.1.106 It is documented in the medical records, namely in the social history section, that Angela acknowledged her intermittent consumption of alcohol and cocaine. Angela was declared medically healthy and subsequently readmitted into police custody.

3.1.107 The mental health liaison team operates around the clock as a specialised service, has a positive working relationship with the safeguarding team and communicates any relevant concerns or information in the interest of patient/public safety.

3.2 Analysis of Terms of Reference

3.2.1 The Terms of Reference (TOR) are analysed in this section to confirm that they have been addressed and met.

TOR 1: Identify good practices where responses may have exceeded the required standards.

Analysis

Change Grow Live

3.2.3 CGL noted this within TOR 12; they also highlighted Angela's need for counselling, expedited with the EF manager providing cover.

GP Practice

3.2.4 The GP practice noted the following:

- Consent was explicit in the medical records during discussions and interventions.
- A smoking cessation medicine was prescribed for Angela; however, it was found to have a significant contraindication when combined with her other prescribed medication. The GP practice promptly identified this, notifying the Smoke-Free Norfolk service and Angela and then recommending an alternative medication. The GP responded promptly, within two days.
- An obstacle to Angela's access to her regular HRT medicine necessitated a gynaecology appointment, completed on the same day Angela received a follow-up phone call.
- Doctors within the practice attempted calls outside of regular business hours when Angela's phone was unanswered.
- Staff members have received training on domestic abuse, and the practice has designated leads for safeguarding and domestic abuse.
- The surgery has an up-to-date policy for Domestic Abuse and Violence.

Queen Elizabeth Hospital NHS Foundation Trust

3.2.5 QEH granted Angela time away from her family upon admission to review the DASH risk assessment. She had initially declined, and allowed her to seek clarification or support.

Norfolk and Suffolk NHS Foundation Trust

3.2.6 Wellbeing exhibited tenacity in its challenge of CMHT's decision to decline referrals to their service. Their knowledge and experience from working with Angela convinced them to accept a referral.

3.2.7 CRHTT continued to try to meet with Angela independently, without her husband's presence, to address the concerns she had expressed regarding potential domestic abuse.

TOR 2: Were Angela's service responses affected by the COVID-19 pandemic (review appropriate contact/response with current impact)?

Analysis

3.2.8 A report exploring the impact highlighted isolation as a significant risk factor for victims of domestic abuse and the lack of face-to-face contact.[45]

3.2.9 As victim-survivor isolation increased, so did their safety requirements. The literature found that the safety of survivors was one of the most significant worries of practitioners, particularly considering the lack of face-to-face support and the heightened risk posed by perpetrators. According to studies, it was more challenging for women to make private phone calls, and victims of stalking were more vulnerable when they left the house.[46]

3.2.10 A study also discovered that restrictions kept victims in abusive situations and that partner and family abuse worsened. In addition, the lockdown permitted the perpetrators of domestic abuse, controlling, and coercive behaviour to increase or hide their abuse.[47]

Change Grow Live

3.2.11 CGL, throughout the pandemic, continued to be accessible to service users when the situation demanded. Throughout Angela's engagement with CGL, she encountered no impediments to using services.

GP Practice

3.2.12 The GP practice emailed their patients throughout the specified period, containing information regarding staff absences attributable to COVID-19. On three separate occasions, it was determined that the pandemic affected services:

- From 26 January to 9 February 2022, the pharmacy experienced a staffing shortage, which decreased operating hours. Patients were instructed to contact the pharmacy via email to receive responses to their enquiries and requests.
- Staffing resources were an issue in January 2023, although this was not deemed to impact patient care. Patients were provided with information advising the use of face covers during appointments.
- Staff shortages necessitated adjusting the dispensary's operating hours on 2 May 2023.

3.2.13 During the COVID-19 pandemic, most patient assessments were conducted via telephone following government directives, but in-person assessments were

[45] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_PanLizc_Report_FINAL.pdf
[46] https://www.womensaid.org.uk/wp-content/uploads/2021/11/Shadow_PanLizc_Report_FINAL.pdf
[47] https://www.ukri.org/about-us/how-we-are-doing/research-outcomes-and-impact/esrc/how-the-covid-19-lockdowns-affected-the-domestic-abuse-crisis/#:~:text=Key%20findings%20and%20recommendations&text=domestic%20abuse%20problem-,restrictions%20kept%20victims%20in%20abusive%20relationships%20for%20longer,partner%20and%20family%20abuse%20increased

facilitated to ensure adherence to patient care standards. Angela received eighteen consultations over the phone during the designated time frame, which were outside of business hours, leading to substituting telephone conversations for in-person appointments.

Norfolk and Suffolk NHS Foundation Trust

3.2.14 The records do not suggest that the COVID-19 pandemic impacted the care provided or the decisions made regarding Angela's care at NSFT.

TOR 3: How readily was Angela able to use the services?

Analysis

3.2.15 The percentage of victim-survivors who contact the police is low, at 20%, but the use of health services is nearly universal, especially among those with complicated needs. In 2016, nearly 500,000 victim-survivors sought medical care for abuse-related issues. Research from Safe Lives indicated that over 10% of those with acute physical injuries faced a medium risk of harm from domestic violence, while about 23% are at the highest risk. Nearly half (46%) of high-risk victim-survivors had visited their GP in the past year. Domestic violence and abuse are linked to one in eight suicide attempts among women in the UK, resulting in roughly 10,000 attempts and nearly 200 fatalities annually. [48]

3.2.16 Before seeking help, high-risk victims endure domestic abuse for an average of 2.3 years, while medium-risk victims endure it for three years.[49]

3.2.17 Older victims of domestic abuse are more likely to have endured the abuse for extended periods before receiving assistance, and 85% of victims unsuccessfully sought help from specialists five times annually on average before receiving effective aid to end the abuse.

Norfolk Constabulary

3.2.18 During Angela’s police arrest in May 2023, following the RTC, Angela was deprived of access to L&D (commissioned by NSFT) because their service was not operational. Subsequently, a service has been commissioned to assume this responsibility.

Change Go Live

3.2.19 Angela was allocated to the EBI programme. This indicated she would have a named individual with whom she may seek further assistance. From October 2022 to July 2022, Angela's interaction with CGL was irregular, and she only attended some of the scheduled appointments.

GP Practice

3.2.20 Angela did not experience any barriers to accessing her GP practice. The practice also called Angela out of hours.

[48] https://safelives.org.uk/sites/default/files/resources/Health%20Pathfinder%20Full%20Technical%20Report%20-%20March%202021.pdf
[49] https://safelives.org.uk/policy-evidence/about-domestic-abuse/how-long-do-people-live-domestic-abuse-and-when-do-they-get

Norfolk and Suffolk NHS Foundation Trust

3.2.21 Angela obtained support from the Wellbeing Service after submitting a self-referral. The response was prompt, with an initial email and a subsequent assessment six weeks later. This corresponds with the anticipated wait time from referral to assessment for the Wellbeing Service.

3.2.22 Angela received immediate mental health assessments and support from L&D (July 2022) and MHLT (May 2022) after being referred by the Police and the ITU (May 2022). L&D referred Angela to CRHTT, and the support was provided within one day of the referral.

3.2.23 CMHT initially declined referrals from the GP and Wellbeing; however, Angela was seen by CMHT within five weeks of acceptance. According to the CMHT Operational Policy, 95% of patients are expected to wait at most 28 days for an assessment after a referral. This is the sole instance where Angela waited longer than 28 days.

TOR 4: How did your agency respond to the information that Angela may have been a victim of domestic abuse?

Analysis

3.2.24 According to the National Institute for Health and Care Excellence[50] all healthcare professionals should receive training to identify early warning signs of domestic abuse, inquire safely and compassionately, respect patient confidentiality, and respond appropriately to a disclosure. Furthermore, they should provide recommendations regarding disclosures of domestic abuse.

Change Grow Live

3.2.25 During the initial assessment conducted by CGL in July 2022, Angela was queried regarding her present experience of domestic abuse. Angela had always responded negatively to this enquiry. As part of their risk assessment, all new CGL service users are questioned on domestic abuse, harm by others, and harm to others.

3.2.26 Following her re-engagement with CGL in November 2022 and subsequent provision of virtual and telephone support from the EF manager (during which she awaited her first counselling appointment), Angela disclosed for the first time that marital disputes were a source of stress in her life. Angela disclosed that she and her husband would both drink alcohol, which could escalate into violent outbursts that would require the assistance of the police.

3.2.27 Neither EF nor CGL responded to Angela's disclosures.

GP Practice

3.2.28 There are two instances in which the GP practice appears to have addressed domestic abuse and violence throughout the specified period. The GP advised

[50] https://cks.nice.org.uk/topics/domestic-abuse/management/managing-domestic-abuse/

Angela on 11 July 2022 to stay with her mother out of the county and to refrain from entering the family home while alcohol was considered a concern. Domestic abuse was not addressed during this session.

3.2.29 Angela disclosed to her GP on 2 September 2022 that the CMHT had enquired whether she had post-traumatic stress disorder because of alcohol usage and domestic abuse. This was corroborated by a letter from the CMHT to the practice in which Angela disclosed domestic abuse throughout the marriage with Matthew.

3.2.30 Although there is evidence that Angela received continuity of care throughout the specified period by her GP practice, there are no documented conversations with her concerning potential domestic abuse and violence, nor are there any sources of information being shared with her or her being referred to appropriate support services.

3.2.31 The recommendation made was in response to Angela's disclosure that she had been arrested for assaulting Matthew and would be staying with her mother, a plan that the GP approved.

3.2.32 The GP stated that their impression of Angela and her husband over the years was that they were a committed couple. Their consumption of alcohol resulted in disputes and intermittent instances of violence among them. The GP indicated that after years of speaking with them individually and collectively, they had concluded that alcohol was an issue they both faced; the instances of intermittent violence were not discussed.

Norfolk Constabulary

3.2.33 The police referred Angela to MARAC in 2020, in addition to affixing object markers to her mobile phone and address.

3.2.34 Research regarding DHRs[51] identified a recurring theme of professionals not being confident or curious enough to ask questions about domestic abuse, suicide, or the possible link between the two. In addition, concerns were raised about the suitability of risk assessment tools to accurately identify and quantify the risks associated with controlling behaviour, hopelessness, and suicidal ideation.

3.2.35 Reliance on professional judgement to mitigate these shortcomings in risk assessment is particularly problematic where training around suicidality is partial, and resourcing is limited, with many inexperienced and overwhelmed responders who administer these tools.

Norfolk and Suffolk NHS Foundation Trust

3.2.36 MHLT and Wellbeing were both aware of Angela's admission to the hospital on 31 May 2022 because of an overdose that occurred "following a family dispute".

[51] http://wrap.warwick.ac.uk/174206/1/WRAP-learning-legacies-analysis-domestic-homicide-reviews-cases-domestic-abuse-suicide-2023.pdf

3.2.37 MHLT spoke with Angela, who disclosed that her husband is "supportive but becomes angry and frustrated with her due to his lack of comprehension of her mental health issues." This assertion is contradictory, and there is no indication in the records that MHLT attempted to delve deeper into the meaning of Angela's statement. For instance, how did he provide support, and how did his frustration and anger manifest?

3.2.38 Angela was seen by Wellbeing one week after the overdose, and there is no trace of any further discussion regarding the potential domestic abuse she may have experienced. Nevertheless, there is a record that the incident was discussed; it was not further investigated to consider abuse.

3.2.39 There was no record that either service considered conducting a DASH risk assessment with Angela, nor was there any evidence that either agency sought advice from NSFT's internal safeguarding team or discussed the domestic abuse concerns with their wider team, line manager, or safeguarding champions.

3.2.40 The NSFT Domestic Violence and Abuse Policy mandates that all disclosures or concerns regarding domestic abuse be followed up by liaising with other relevant professionals (including the NSFT safeguarding team) and with the completion of a DASH risk assessment.

3.2.41 Consequently, in this case, an opportunity was likely missed to gain a more comprehensive understanding of the circumstances surrounding Angela's relationship with her husband and the potential impact on her mental health.

3.2.42 Angela was arrested on 10 July 2022 after she broke a window in response to an altercation with her husband. Angela disclosed to the mental health nurse that she intended to "use a knife to remove her husband's eye."

3.2.43 Despite the information above, the L&D Service and the Wellbeing Service did not address domestic abuse as a theme in their assessments or directly with Angela. The NSFT safeguarding team was not consulted to guide potential domestic abuse.

3.2.44 Angela disclosed domestic abuse to the CMHT during her initial assessment in August 2022. Although CMHT provided Angela with a referral to a local domestic abuse support agency (Pandora Project), they did not conduct a DASH with her.

3.2.45 They did not seek additional guidance or advice from the NSFT safeguarding team, their safeguarding champion, the wider team or the line manager.

3.2.46 The CMHT made the clinical decision to refer to the GP before any further mental health support was offered, and they did inform the GP of the domestic abuse in as much detail as they had.

3.2.47 CRHTT saw Angela at her home in June 2022. They observed that she had bruising on her arm and that she discussed having a "volatile" relationship with her husband.

Due to her husband's presence at home, CRHTT could not delve deeper into this matter with her.

3.2.48 To engage in an open dialogue with Angela regarding their concerns, CRHTT made numerous phone calls and three additional endeavours to meet with her in person without her husband's presence.

3.2.49 Angela was seen independently of her husband on 6 June 2022; she stated that the bruises were acquired during a visit to the hospital and that her husband had not perpetrated any recent physical abuse (the most recent instance of physical abuse was reported to have occurred 3.5 years prior). Nevertheless, Angela did admit that her husband was verbally abusive while under the influence of alcohol. This disclosure was not further investigated, and no additional discussions regarding domestic abuse and the potential need for support services were conducted.

3.2.50 The records suggest that Angela had assured the practitioner that her husband was loving and supportive and that there were no current concerns. This implies that the practitioner may have been oblivious that emotional or verbal abuse is still classified as domestic abuse and would necessitate safeguarding measures for Angela.

3.2.51 This contact was preceded by two multi-disciplinary team (MDT) meetings with CRHT, during which they emphasised the necessity of further investigating the potential for domestic abuse and safeguarding. There was no documentation of any subsequent MDT meetings or discussions between practitioners within CRHTT regarding safeguarding or domestic abuse after this final visit.

3.2.52 Angela's disclosure should have prompted additional safeguarding considerations, including the offer to complete a DASH risk assessment and provide domestic abuse support services referrals.

3.2.53 Angela would have been required to consent and participate in any or all of these, but they should have been presented and discussed with her. By failing to do so, it is possible to infer that a health professional validated their own (potential) understanding that verbal abuse would not be considered domestic abuse.

TOR 5: During Angela's engagement with your agency, did your agency have any alternatives for perpetrator disruption or victim safety planning? If not, what hurdles prevented their implementation?

Analysis

Change Grow Live

3.2.54 When domestic abuse is suspected, CGL staff will try to obtain the victim's trust and permission before referring them to the relevant agency and providing support. Angela disclosed during her counselling session that she and her husband occasionally engaged in violent outbursts after heavy alcohol consumption; however, this was not considered sustained domestic abuse by the staff.

3.2.55 This is not in line with the definition of domestic abuse as stipulated in the Domestic Abuse Act 2001: *" …and it does not matter whether the behaviour consists of a single incident or a course of conduct".*

3.2.56 The staff's conclusion additionally hindered their capacity to explore the disclosure of domestic abuse and aid Angela in obtaining support services or understanding her entitlement to protection from harm, as stipulated in Article 3 of the Human Rights Act 1998 (the right to be free from inhuman and degrading treatment).

GP Practice

3.2.57 The GP practice did not discuss the reported instances of violence or consider domestic abuse within the relationship. The practice concluded that alcohol was the primary factor.

Norfolk Constabulary

3.2.58 The police provided Angela with information on safety planning, DASH risk assessments were executed, and Matthew was provided with details for CGL. Matthew was convicted of battery in 2020, 2013, and 2005.

3.2.59 Norfolk Constabulary utilise a range of pathways when dealing with perpetrators of domestic abuse.

3.2.60 The Domestic Abuse Perpetrator Partnership Approach (DAPPA) is a multi-agency approach to addressing domestic abuse within Norfolk, managing perpetrators of domestic abuse and thereby protecting the most vulnerable victims.

3.2.61 Police and key partners work together to tackle behaviour and break the cycle of abuse. Using evidential calculations generated by the Recency, Frequency, Gravity (RFG) matrix, they identify perpetrators who present the most serious or repeated risk of harm.

3.2.62 DAPPA will also consider appropriate referrals from police and partner agencies for perpetrators not identified through the matrix but who present significant risks that would benefit from the active involvement of several agencies.

3.2.63 DAPPA develop robust multi-agency risk management plans around perpetrators using a problem-solving approach with a full menu of tactical options.

3.2.64 Recognising the strong links between increased stalking behaviour and domestic homicides, the DAPPA team also provide advice and support for officers looking to obtain Stalking Protection Orders (SPOs) and oversee the management of these perpetrators once the court has granted an SPO or interim SPO.

3.2.65 The DAPPA team work closely with local officers to complete disruption visits to SPO subjects, check compliance with their restrictions and ensure notification requirements are completed, or breach proceedings instigated.

3.2.66 They also maintain victim contracts with those named on the SPOs following the victim's wishes. The team consists of trained ISACs (Independent Stalking Advocates) who can recognise escalating stalking behaviours and provide appropriate advice and safeguarding to victims.

3.2.67 When dealing with male perpetrators of domestic abuse, officers can refer to Project CARA (Conditional Cautioning & Relationship Abuse). This is a conditional cautioning pilot for specific standard and medium-risk domestic abuse offences funded by the Office of the Police and Crime Commissioner for Norfolk.

3.2.68 Norfolk Constabulary has been granted special permission by the Director of Public Prosecutions (DPP) to implement Project CARA (Conditional Cautioning and Relationship Abuse), which will see some domestic abuse perpetrators given Conditional Cautions before compulsory attendance on a two-day workshop.

3.2.69 Norfolk is introducing such a scheme, building on the success of similar Project CARA pilots elsewhere in the country. It would improve the criminal justice response to domestic abuse victims through enhanced risk management and holding offenders accountable for their actions.

3.2.70 Rigorous criteria will be in place before a perpetrator is assessed for a CARA course, including the express wishes of the victim, and there is no evidence of coercion or control.

3.2.71 When dealing with female perpetrators of domestic abuse, officers can refer to the Red Snapper scheme, a conditional cautioning approach for relevant perpetrators who meet the necessary criteria.

3.2.72 The scheme offers the chance to suspend prosecution for standard to medium-risk female offenders in an intimate relationship who commit a one-time offence.

3.2.73 The conditional caution disposal option for female domestic abuse offenders allows addressing key behaviours early.

Norfolk and Suffolk NHS Foundation Trust

3.2.74 CMHT offered Angela a referral to the Pandora Project during her assessment; however, she declined. A referral to any domestic abuse support service is not permissible in the absence of consent. However, the records do not indicate that Angela was provided with domestic abuse support at any other point during her tenure under the care of NSFT, whether as a victim or perpetrator.

3.2.75 NSFT has a Domestic Violence and Abuse policy that emphasises the importance of providing referrals and signposting to the appropriate domestic abuse support agencies in the event of any concern regarding domestic abuse. Angela was not offered referrals from the other NSFT services, and there were no records that safety planning concerning domestic abuse was conducted with her by any service.

TOR 6: Does your agency have procedures and policies for identifying and responding to domestic abuse? Have you considered whether these assessment tools, processes, and policies are adequate?

Analysis

Change Grow Live

3.2.76 CGL policy on domestic abuse was last reviewed in 2020. CGL staff are trained in domestic abuse, and a Domestic Abuse Champion(s) is assigned to each service.

3.2.77 As expected of an alcohol and drug service, the first risk assessment focuses primarily on an individual's substance usage and physical and mental health. However, domestic abuse, whether perpetrated or experienced, is also taken into consideration and frequently reassessed.

GP Practice

3.2.78 The GP practice's domestic abuse policy was implemented in May 2023. The practice has implemented the policy template that Norfolk and Waveney Integrated Care Board developed in collaboration with the Office of the Police and Crime Commissioner for Norfolk and specialised domestic abuse services.

3.2.79 The policy addresses staff training needs for the practice, including the detection of domestic abuse, the procedure to be followed when domestic abuse is disclosed during a consultation, organisational contacts for referrals, and safeguards for staff members who are victims of abuse.

3.2.80 Since Angela's death, the practice has appointed staff to the positions of safeguarding leads, which include a lead for safeguarding adults and a champion for domestic abuse.

Queen Elizabeth Hospital NHS Foundation Trust

3.2.81 QEH reported having a detailed policy on domestic abuse for both staff and patients. On the trust's intranet, there are pages explicitly devoted to domestic abuse.

3.2.82 There are a few Domestic Abuse Champions inside the trust who can assist staff who are helping victims of domestic abuse. The safeguarding level 3 training covers a wide range of subjects, such as professional curiosity, referral channels, the concept of "think family," and the numerous types of abuse that children and adults may encounter, including domestic abuse.

3.2.83 The police and QEH adhered to their policies.

Norfolk and Suffolk NHS Foundation Trust

3.2.84 The Domestic Violence and Abuse policy and the Safeguarding Adults at Risk of Abuse policy are readily accessible to all staff.

3.2.85 The Domestic Violence and Abuse policy was revised in November 2021 and is currently being reviewed while remaining active. The Safeguarding Adults at Risk of Abuse policy was reviewed in February 2024.

3.2.86 The NSFT Safeguarding Team also supports and promotes safeguarding champions throughout the Trust. These champions are staff members responsible for advocating for safeguarding issues within their teams and providing relevant and up-to-date safeguarding knowledge for their wider team.

3.2.87 Domestic abuse champions are included in this group, who provide support and guidance to staff and ensure that they are informed about domestic abuse issues.

3.2.88 The NSFT Safeguarding Team regularly reviews the function of safeguarding and domestic abuse champions and the most effective support methods. Currently, the NSFT Safeguarding Team does not maintain records that would enable them to determine whether any of the teams involved in Angela's care had a safeguarding or domestic abuse champion assigned at the time.

3.2.89 Although this was a prerequisite for all teams at the time (and continues to be so to this day), there are no records in Angela's care that indicate a safeguarding or domestic abuse champion was consulted. This suggests that the champion role was not utilised as intended, regardless of whether the team had one. NSFT must consider the obstacles that impede this.

3.2.90 The NSFT Safeguarding Team provides safeguarding supervision to all Band 7 and Band 8a practitioners with supervisory responsibilities to others, a requirement established by both the Trust and the CQC.

3.2.91 Regrettably, the Safeguarding Team does not maintain any records indicating whether supervision was being accessed by staff within the teams working with Angela at the time.

3.2.92 The NSFT Safeguarding Team is accountable for providing mandatory level 3 safeguarding adults training to all staff members throughout the Trust.

3.2.93 At the time of this review, the training included a significant amount of domestic abuse content that emphasised the importance of being aware of the signs of domestic abuse, even if a patient does not disclose or is unaware that they are a victim.

3.2.94 Three practitioners who were directly involved with Angela when indicators of domestic abuse were raised were known to comply with their level 3 safeguarding adults training at the time; two were known to be out of compliance. This emphasises that the training may not be effective in fostering a sense of confidence among individual practitioners in identifying the signs of domestic violence and determining the appropriate course of action to take when concerns are raised.

TOR 7: Was information promptly communicated with all relevant parties during the period covered by this review?

Analysis

Change Grow Live

3.2.95 CGL became aware that Angela had operated her vehicle while intoxicated with the explicit purpose of ending her life. This should have been relayed to Angela's GP.

GP Practice

3.2.96 The GP records exhibited transparent and timely correspondence concerning matters of physical health, as exemplified by the consultation of a consultant gynaecologist concerning hormone replacement therapy. Additionally, the GP and Norfolk and Suffolk NHS Foundation Trust, which offers mental health services, maintained effective contact.

3.2.97 There were no documented recordings of conversations between the involved parties and the GP practice concerning the possibility of domestic violence and abuse occurring between Angela and her husband throughout the specified period.

Norfolk Constabulary

3.2.98 The police shared the information with the MARAC in 2020.

Norfolk and Suffolk NHS Foundation Trust

3.2.99 Communication was generally prompt and appropriate for all relevant parties in most cases, as indicated by the records. It was presumed that Angela was aware of the referrals on her behalf, although she may not have necessarily agreed with the strategy.

3.2.100 On one occasion, Angela contacted FRS to express her feelings of being unsupported. The discussion resulted in Wellbeing contacting Angela soon after.

3.2.101 FRS pursued the referral to CGL, who confirmed they would speak with Angela the following day. This seemed to alleviate Angela's feelings of being unsupported at the time, and no records indicate that she conveyed this sentiment to any practitioner in NSFT again.

3.2.102 It is uncertain whether the CRHTT practitioner who met with Angela in person to address safeguarding concerns in her husband's absence informed the broader MDT of Angela’s comments regarding verbal abuse and their determination that there was no longer a safeguarding concern to be addressed.

3.2.103 Wellbeing and CMHTT engaged in a professional challenge when Wellbeing believed that CMHTT should reevaluate the referral for Angela, which they had initially rejected. Nevertheless, the record does not indicate that CMHTT responded, and Wellbeing subsequently submitted a referral for Angela to access their support.

It is conceivable that Angela may have been granted access to a CMHTT assessment sooner had CMHTT reconsidered the referral they declined at this juncture.

TOR 8: Were collaborative discussions held to review risk factors such as alcohol, mental illness, prescription drug misuse (including obtaining such drugs illegally), carer responsibilities, menopause, and domestic abuse?

Analysis

3.2.104 The University of Manchester[52] indicated that risk assessment methods in isolation do not effectively forecast the future risk of self-harm or suicide. Ninety-five per cent of research studies failed to predict future risk accurately.

Alcohol

3.2.105 An examination of DHRs[53] unveiled the subsequent vulnerabilities that were present in the victims: A total of 34% were associated with mental ill health issues, 28% were afflicted with alcohol use disorders, and 22% were reported to use illicit substances. An analysis of mental health issues revealed that 16% had suicidal ideation, 14% had attempted suicide, and 14% experienced depression or anxiety.

3.2.106 According to the above, 71% of perpetrators were recognised as vulnerable, with mental illness being the most prevalent, followed by alcohol misuse and illicit substance use issues.

Change Grow Live

3.2.107 The CGL MDT reviewed Angela on three separate occasions. The first was when it was determined that her alcohol consumption had escalated to the point where she required the assistance of a CGL Alcohol RW in addition to ER support. The second and third occasions were when Angela did not attend two group sessions.

GP Practice

3.2.108 Alcohol consumption was addressed in GP consultations. They provided guidance and support, including the advantages of limiting and avoiding alcohol consumption. Domestic abuse was related to alcohol consumption.

3.2.109 Although the GP practice knew that Angela was receiving support from CGL, no documentation existed of collaborative talks between these services and Angela. Letters were used to transmit information between services.

Mental Health

3.2.110 Safe Lives Research Findings[54] indicate that a significant correlation exists between mental health issues and experiencing domestic abuse. Additionally, mental illness increases the likelihood of abuse perpetration.

[52] https://sites.manchester.ac.uk/mash-project/risk-assessment-tools/
[53] https://www.gov.uk/government/publications/key-findings-from-analysis-of-domestic-homicide-reviews/key-findings-from-analysis-of-domestic-homicide-reviews
[54] https://safelives.org.uk/sites/default/files/resources/Spotlight%207%20-%20Mental%20health%20and%20domestic%20abuse.pdf

3.2.111 Domestic abuse frequently eludes detection within mental health services despite the significant correlation between the two, and domestic abuse services are not necessarily qualified to assist with mental health issues.

3.2.112 Mental health issues increase the likelihood that a survivor is suffering from several disadvantages. Additionally, perpetrators who have mental health problems are more likely to have substantial additional demands. The Domestic Abuse Report 2024[55] further supported this.

GP Practice

3.2.113 Interventions for mental health were prevalent in GP consultations throughout the period under review. The GPs shared Angela's perspective regarding mental health challenges and considered both pharmacotherapy and talking therapies as potential treatments. There is consistent evidence that during the specified period, the GP collaborated with Angela to explore several antidepressant drugs that would promote her mental well-being with minimal adverse effects.

3.2.114 Angela sought assistance from mental health services through two channels: self-referred to the Wellbeing Service and referred by the GP practice. Although no documentation existed to support multidisciplinary conversations among these providers, the GP practice did obtain discharge and update reports from mental health services.

Norfolk Constabulary

3.2.115 In May 2023, Angela was arrested following an RTC involving several vehicles. She had taken an overdose with the intent to end her life. A mental health assessment was not conducted at the police station due to the non-operation of the L&D service during the period of her custody.

Adult Social Care

3.2.116 Adult Social Care was informed by the police that Angela had been reported missing and that she and Matthew had recently experienced a difficult period during which they had a financial dispute. Angela's deteriorating mental health had been noted.

3.2.117 Adult Social Care were informed that Angela, who had overdosed, had been left behind after Matthew had left the home to stay with family.

3.2.118 Adult Social Care was informed that she had been located, transported to the hospital, and arrested; she was in custody on suspicion of assaulting a member of the public and had been involved in multiple vehicle collisions.

3.2.119 Adult Social Care did not provide a follow-up or consider a referral to mental health services concerning her deteriorating mental health and overdose.

[55] https://www.womensaid.org.uk/evidence-hub-annual-audit-2024/

East of England Ambulance Service

3.2.120 Matthew called the ambulance the day before Angela's death to request their assistance. The ambulance did not arrive because the caller did not provide the location or name of the individual, as documented by their log. In the presence of Liz, daughter Matthew initiated the call and provided his address, adding that he would ensure Angela was present at home before the arrival of the ambulance. He stated instead that the ambulance had advised him to contact the police. No police report was made.

3.2.121 The ambulance dispatch was called as Angela had attempted to end her life. Hence, it is expected that a medical emergency arises rather than the need for the police. However, had the police been contacted, S136[56] of the Mental Health Act 1983 could have been invoked. Angela was reported to be in a public area, and the S136 possesses the jurisdiction to detain an individual and transport them to a place of safety for a mental health assessment. Therefore, it is expected that the ambulance service could have assisted the caller in contacting the police, given that Matthew stated he was distressed and concerned for Angela's safety at the time of the call.

Prescription Drug Use

3.2.122 A study[57] exploring older women living and coping with domestic abuse revealed an increased number of women over the age of fifty who experience domestic abuse in silence due to being disregarded by health professionals. Additionally, three-quarters of the female participants in the study characterised their physical and mental health as "very poor," employing coping techniques that included long-term and excessive alcohol consumption, as well as prescription and over-the-counter medications.

3.2.123 Over the specified period, there is an indication that Angela altered her medication prescription in some way, either by modifying the dosage, discontinuing the medication without consulting her healthcare provider or procuring benzodiazepine online.

Norfolk and Suffolk NHS Foundation Trust

3.2.124 MDT meetings were conducted at CRHTT on 6 and 9 June 2022 to discuss their treatment and care plan. After considering safeguarding concerns, a strategy was devised to attempt to see Angela independently of her husband.

3.2.125 The team was resolute in their pursuit of conversing with Angela independently, and they continued to contact her every week. Regrettably, the safeguarding concerns were dismissed when Angela was finally seen alone, and there was no record to indicate that the practitioner who reviewed her communicated this information to the rest of the MDT. This could have prompted a challenge from another practitioner who believed additional enquiries with Angela were necessary.

[56] https://www.legislation.gov.uk/ukpga/1983/20/section/136
[57] https://pubmed.ncbi.nlm.nih.gov/23469739/

3.2.126 Wellbeing attempted to communicate directly with CMHTT to address the support they believed was necessary for Angela. However, the records indicate that this email was not responded to, and a subsequent referral was necessary for CMHTT to support Angela.

3.2.127 Angela was known to be open to CGL as a means of addressing her alcohol concerns. MHLT confirmed this during her appointment in May 2022 and again by CRHTT during a new referral to CGL in July 2022.

3.2.128 Angela experienced domestic abuse and mental health issues that were frequently precipitated by alcohol. The subject was addressed in nearly all her interactions with NSFT. However, no record of NSFT ever conversing with CGL regarding collaborative working. The only instance of communication was when Angela contacted FRS to express her feelings of being unsupported, and FRS contacted CGL to confirm a scheduled contact for the following day. Agencies may have overlooked an opportunity to develop a shared support plan for Angela.

3.2.129 Following Angela's initial assessment, CMHTT referred her to her GP. This was the final interaction between NSFT and Angela before her death. There is no indication that CMHTT enquired about the issues with any other agency or service before deciding to refer to GP care and discharge from NSFT, despite her history of recent engagement with Wellbeing and CRHTT, where domestic abuse and alcohol dependency were identified as significant concerns.

3.2.130 The decision to refer to the GP was consistent with CMHTT's Operational Policy, which explicitly states that a patient does not meet the criteria for CMHTT support when the primary need is an acquired head injury. Consequently, further investigation was necessary before CMHTT could provide its service.

3.2.131 However, it is believed that the secondary concerns of domestic abuse and alcohol concerns could have been addressed by other services to ensure that Angela received the necessary support before discharge. The CMHTT Operational Policy also emphasises the importance of collaborating with other agencies, specifically Drug and Alcohol Services, to meet secondary needs.

3.2.132 Angela's mental health may be affected by menopause, which the CMHTT discussed with her. Their discharge letter to the GP requested support in conducting additional medical investigations.

Queen Elizabeth Hospital NHS Foundation Trust

3.2.133 Angela was admitted to QEH in May 2022 after an intentional drug overdose. Her GP contacted Angela in June 2022 after she was discharged. Angela disclosed during the appointment that she was procuring non-prescribed diazepam tablets via the Internet and intermittent cocaine use as a means of treatment for instances of becoming overwhelmed.

3.2.134 Although advice was given to Angela to reduce her alcohol use, and she was referred to the crisis team, there were no documented instances that emphasised the risks associated with the use of diazepam. Diazepam is available exclusively by prescription and should not be combined with alcohol, as doing so could result in respiratory complications and an increased likelihood of developing an addiction to the drug.

Caring Responsibilities

Change Grow Live

3.2.135 Angela informed CGL that she anticipated being responsible for the care of Matthew, who had been discharged home and placed on a 'virtual ward' while awaiting his surgery.

3.2.136 The hospital told the independent author that Matthew did not necessitate family intervention and that he was being monitored online, including regular phone contact. The hospital confirmed no discussion regarding caregiving was had with Angela; advice on what to watch out for and when to contact services was provided.

GP Practice

3.2.137 The GP practice confirmed that the consultations did not discuss carer responsibilities. Nevertheless, each partner's influence on the other was acknowledged for the duration of their marriage.

Menopause

3.2.138 Ava[58] notes that midlife women experience domestic abuse at comparable rates to younger women but have more significant obstacles when attempting to get specialised help. Menopausal symptoms may be exacerbated in the presence of domestic abuse and vice versa. As both the victim and the perpetrator age, the research adds that the pattern of abuse shifts from physical and sexual assault to psychological abuse and nonviolent controlling behaviours.

3.2.139 Ava highlighted: *'Menopause impacts women's relationships, and domestic abuse may impact menopause symptoms, with negative symptoms or experiences compounding or obscuring one another.'*

GP Practice

3.2.140 During GP appointments, HRT and menopause were frequently discussed. The GP promptly addressed Angela's concerns and effectively coordinated with colleagues to determine the optimal course of treatment.

Norfolk Constabulary

3.2.141 Matthew informed the police that Angela was experiencing menopause symptoms, and the GP confirmed she was being treated for this. The police had highlighted that menopause was also a factor in Angela's mental health.

[58] https://avaproject.org.uk/wp-content/uploads/2021/10/Research-briefing-Menopause-and-DA-2.pdf

TOR 9: What were this situation's most significant considerations and decision-making opportunities? For example, are reviews and decisions based on professional expertise, evidence and knowledge held by organisational and multi-agency policies and procedures?

Analysis

Change Grow Live

3.2.142 Concerning Angela's increased alcohol consumption, a determination was reached eleven days before her death to reestablish assistance from the Alcohol RW. Angela disclosed to the EF manager that she had suicidal thoughts at the time of the car accident that resulted in her arrest. Although the CGL staff contacted Angela by telephone, upon reflection, a more advantageous course of action would have been to conduct the conversation in person.

GP Practice

3.2.143 Angela received consistent care from her GP practice during the period under review. She saw only two GPs throughout the twenty consultations. The GPs seemingly attempted to establish a rapport with Angela, an element that is recognised to promote the patient's willingness to disclose instances of domestic abuse.

3.2.144 The GP practice maintained follow-up with Angela via telephone consultations outside of business hours. Angela exhibited swift responsiveness to messages received after her initial intentional overdose, and she was promptly reached.

3.2.145 During interventions centred around menopause and smoking cessation, the GPs swiftly consulted with specialists and communicated with Angela to apprise her of any modifications to her management strategies.

3.2.146 Although the GP practice responded promptly and comprehensively to issues mentioned during consultations, the records show that each concern was treated in isolation, without regard for the bigger picture. By adopting a trauma-informed approach, professionals might have been able to discern the factors that contributed to Angela's alcohol usage and non-compliance with prescribed medication.

East of England Ambulance Service

3.2.147 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.”

3.2.148 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.

3.2.149 The ambulance service did not contact the caller further to obtain additional information or provide support for contacting the police.

3.2.150 The EEAST review 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.

Norfolk and Suffolk NHS Foundation Trust

3.2.151 Before agreeing to assess Angela, CMHT declined numerous referrals. Before Wellbeing submitted a final referral, the decision to decline a referral from L&D was challenged by Wellbeing, which was subsequently accepted.

3.2.152 There was a lack of clarity in the records regarding the rationale behind CMHT's previous rejections of referrals. It was unclear why the situation only justified their acceptance when it did.

3.2.153 Angela's presentation during her time with NSFT did not appear to vary significantly, and she remained consistent in her discussions of her mental health concerns and experiences. Consequently, it is unclear whether the referral criteria for CMHT were effectively understood by either (or both) CMHT and the referring party in each case.

3.2.154 The CMHT Operational Policy specifies criteria that would not satisfy their criteria, but does not explicitly detail criteria that would satisfy them. This may result in varying interpretations of the service's offer.

3.2.155 Angela was under the care of CGL, and she discussed alcohol during nearly every interaction she had with NSFT. It is unclear why a conversation was never initiated with CGL to explore a collaborative approach to Angela's care, given the known impact of her alcohol use on her mental health and her relationship with her spouse.

3.2.156 No service adhered to the process and policy regarding disclosures of domestic abuse. Angela was not encouraged to engage in further discussions regarding her relationship by MHLT when she disclosed information that could have suggested domestic abuse (e.g., her husband became angry and frustrated due to her mental health).

3.2.157 Subsequently, when a disclosure of domestic abuse was made to CRHTT, a DASH risk assessment was not provided and safeguarding advice was not sought. After Angela disclosed her abuse, CMHT provided her with a referral to domestic

abuse support services, which is consistent with the Domestic Violence and Abuse policy of NSFT. Nevertheless, there was no indication that Angela received any subsequent or ongoing assistance after declining this referral.

3.2.158 It is conceivable that the practitioners who worked with Angela were unaware of the indicators of domestic abuse that should have been considered. Some may have been unaware that verbal abuse is regarded as domestic abuse even in the absence of current physical abuse.

TOR 10: Could anything else have been done, and if so, would it have had influence?

Analysis

Change Grow Live

3.2.159 CGL indicated that an in-person consultation might have been more effective. Assessing an individual's physical and psychological presentation in person is preferable.

GP Practice

3.2.160 During the specified period, Angela mentioned domestic abuse to her GP on one occasion. She stayed with her mother during that period, constituting a reasonably safe setting. However, no further information or advice regarding domestic abuse services was discussed.

3.2.161 The GP IMR highlighted recommendations that underscore the importance of conducting routine enquiries into domestic abuse for all patients receiving maternity and mental health services. Additionally, selective inquiries should be conducted when there are indications of abuse, such as recurrent presentations with symptoms of stress, anxiety, self-harm, or psychosomatic distress, intentions or attempts at suicide, and the probability of substance abuse, including increased alcohol and prescribed antidepressants.

3.2.162 During the review period, the GP practice had no records of a selective enquiry into domestic abuse.

Norfolk Constabulary

3.2.163 Angela was seen by the HCP while in police custody; she should have been referred for L&D support, given that she disclosed that her home environment was negatively impacting her mental health.

3.2.164 The L&D service is restricted to the hours of 0800-1800, and Angela's arrival occurred beyond this time frame.

3.2.165 This service gap has been brought to light, and a charity-funded initiative known as the "Night Owl Service" has been established to assist women and children in custody. This service is offered between 3 pm and midnight.

Queen Elizabeth Hospital NHS Trust

3.2.166 QEH confirmed funding has been secured for a hospital-based IDVA. The IDVA will engage with hospital staff and patients but will also be able to conduct follow-ups in the community.

East of England Ambulance Service

3.2.167 A call was placed to the ambulance by Matthew the day before Angela's death. They were not, however, provided with the location or identity of the caller or individual in question. The ambulance service placed no additional phone calls to confirm whether Matthew had initiated communication with the police or whether their presence was required.

Norfolk and Suffolk NHS Foundation Trust

3.2.168 It is conceivable that Angela's care would have been improved by implementing a collaborative approach with CGL. Angela did not receive a specific, long-term treatment plan from NSFT despite the numerous interactions she had with the organisation.

3.2.169 CRHTT provided Angela with safety planning and short-term treatment to address the immediate concern. However, their assessment determined that CGL and Wellbeing were more appropriate, and she was referred on.

3.2.170 Wellbeing prioritised the development of a safety plan with Angela. However, they soon realised they were not the appropriate service to meet her needs and believed that CHMTT was better equipped. Consequently, Angela was once again referred to CHMTT without a long-term treatment plan.

3.2.171 Angela was left without a clear action plan to address her mental health, despite several months of contact with mental health practitioners, after CMHTT assessed that her previously untreated head injury needed to be investigated and potentially treated before they could build any treatment plan for her. This was an appropriate outcome from their assessment.

3.2.172 Angela was repeatedly assured that CGL was an appropriate agency to engage with. However, she was also advised that she would benefit from additional support from NSFT, whether through CRHTT, Wellbeing, or CMHTT.

3.2.173 While waiting for the appropriate agency to become clear or available, it is conceivable that a joint approach could have been taken to ensure that Angela was left with a clear plan to address both her alcohol dependency and her mental health simultaneously rather than treating them as separate issues with separate action plans if CRHTT or Wellbeing had been linked in with CGL.

3.2.174 It is conceivable that NSFT could have provided domestic abuse support at a much earlier stage if a DASH had been conducted with Angela during her initial appointment with MHLT or during subsequent discussions regarding her relationship with CRHTT or Wellbeing.

3.2.175 It is believed that other agencies, such as the police, were already aware of the historic domestic abuse between Angela and her husband (Angela did inform CRHTT of this fact herself). It is also presumed (although not confirmed) that other professionals may have offered Angela domestic abuse support programmes in the past.

3.2.176 Therefore, it is uncertain how much of a positive impact this would have had on Angela, given that she declined a referral for specialised support when offered. Nevertheless, it is essential to recognise that victims of domestic abuse frequently endure significant abuse before they are willing to accept assistance.

3.2.177 Had Angela been encouraged to discuss her relationship openly and had the impact of the domestic abuse on her mental health and overall well-being been appropriately explored, it is possible that she would have been receptive to receiving support.

3.2.178 Due to the absence of any current physical violence, it is also feasible that Angela may not have identified her current circumstances as abusive. Regrettably, this was likely confirmed by the fact that CRHTT did not delve deeper into the matter with her when she disclosed that she was currently experiencing verbal abuse from her husband.

3.2.179 Angela may have been supported in reevaluating her current circumstances for herself to identify the abuse she was still experiencing if this had been discussed sensitively at this juncture.

TOR 11: Were there challenges with your agency's capacity or resources that hindered your ability to deliver services to Angela, the alleged perpetrator, or other pertinent individuals? In that case, did these concerns hamper the agency's collaboration with other agencies?

Analysis

Change Grow Live

3.2.180 No capacity constraints impeded CGL's ability to support Angela.

GP Practice

3.2.181 The COVID-19 pandemic impacted the methods by which GP practices could interact with their patients, reducing face-to-face encounters to those deemed "clinically necessary" and relying on telephone contact for others[59].

3.2.182 Healthcare that could not be provided by secondary care, i.e., planned or elective care, urgent and emergency care, or mental health care, was held by GP surgeries. This increased the workload, alongside a decreasing number of full-time,

[59] https://www.bma.org.uk/media/5816/bma-covid-review-report-3-june-2022.pdf

fully qualified GPs since 2015, leading to increased pressure on already limited staffing resources.

3.2.183 The most recent data (December 2021 to May 2023) about appointment durations in General Practice indicates that 35% of appointments at GP Practices within Norfolk and Waveney Integrated Care Board are completed in less than 10 minutes, 25% are completed in an undetermined amount of time, and 40% are completed between 11 and 60 minutes[60].

Norfolk and Suffolk NHS Foundation Trust

3.2.184 The records do not suggest that the service provided to Angela was substantially influenced by NSFT's capacity at the time. Due to a last-minute staffing issue, Angela was occasionally provided with a telephone contact rather than a face-to-face appointment. However, this was consistently followed by a face-to-face appointment within a few days, as was deemed appropriate. It is unlikely that these minor modifications would have had a negative impact on Angela's care.

TOR 12: Are there lessons to be learnt from the case regarding how your agency preserves and promotes the welfare of victims or how it finds, reviews, and manages the risks posed by perpetrators? Where could the method be improved? When interacting with other agencies and resources, are there repercussions for working practices, training, management, and supervision?

Analysis

Change Grow Live

3.2.185 CGL noted the following:

- CGL noticed that even though the risk was handled efficiently in each interaction with Angela, there is no agreement or pathway between CGL and EF regarding the roles and responsibilities connected with risk management and sharing. The EF manager refrained from communicating their concerns to the GP or mental health services, as they believed it was their responsibility to forward this information to CGL for further investigation. CGL did not notify the GP or mental health services about Angela's suicidal thoughts, as this was not deemed a matter of concern during their discussion with her.
- Following consultations with staff, it was established that there is no standardised process for transferring service user information to a new RW.
- CGL Safeguarding policies are clear where a present and impending risk of suicide is apparent. In instances devoid of an impending risk, the policy does not guide how to manage suicidal ideation. Consultation is feasible using Designated Safeguarding Leads (DSL); nevertheless, CGL found that the DSL was not fully aware of the risks, impeding their ability to offer advice.

60 https://app.powerbi.com/view?r=eyJamesIjoiMTQ4NjZjYjMtM2VlZS00NWFlLTlmOWEtYzE1MDQ0NDZiZjQ4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllIiIsImMiOjh9

Furthermore, it was ascertained that the responsibility for incorporating notes after a DSL consultation is not explicitly delineated.

- CGL revealed a deficiency in comprehension regarding risk management in the absence of an urgent and present risk.

GP Practice

3.2.186 The GP practice noted the following:

- Following Angela's death, the practice conducted a Learning Event, which looked at the patient's care and whether there were any learning points.
- The practice assigned a Domestic Abuse Lead in November 2023, who completed a 2-day course.
- The practice fully implemented its Domestic Abuse Policy in November 2023.
- Throughout the allocated period, there would appear to be a focus on individual areas of intervention rather than a more holistic approach.
- On the occasion Angela did disclose domestic abuse, there did not appear to be any follow-up questioning or onward signposting to domestic abuse services.
- On the occasions Angela disclosed purchasing prescription medication over the Internet, there does not appear to be any further questioning or making Angela aware of the associated risks.
- While the information was shared via reports and letters, there was potential for broader conversations between the practice, CGL, and NSFT, which may have increased understanding of the risks and offered a cohesive approach to Angela's care.

Norfolk Constabulary

3.2.187 The police reported that custodial staff in Norfolk and Suffolk had been reminded (via collaborative efforts) via electronic mail of the importance of completing appropriate safeguarding referrals for all detainees identified as vulnerable.

Norfolk and Suffolk NHS Foundation Trust

3.2.188 NSFT has implemented sufficient policies and procedures to protect patients from domestic abuse. Consequently, it is crucial to understand why these processes were not adhered to in Angela's case, the obstacles that impeded their implementation, and how we can rectify this. This will ensure that all practitioners are well-informed about the indicators of domestic abuse to be on the lookout for and the necessary actions to take when these indicators are detected.

3.2.189 The Suicide Timeline, developed by Jane Monckton Smith, identified eight stages which may support learning in responding to victims/survivors of domestic abuse.

The stages are[61]:

1. **The perpetrator has a history of abuse.**
   Matthew was convicted of Battery against Angela and assault of an emergency worker concerning an incident in 2020, resulting in a suspended sentence.

   Matthew was convicted of battery against Angela in 2013, which resulted in a fine.
   In 2009, Matthew received a simple caution for criminal damage against Angela and a caution for ABH against their wife (does not state if this is Angela) in 2005.

2. **The relationship starts quickly or intensely.**
   N/A

3. **There is a relationship dominated by control.**
   Angela did not report control by Matthew; the abuse was primarily concerned with physical and emotional assault.

4. **The victim starts to disclose as they become more distressed by abuse or violence.**
   Angela disclosed to CGL at the beginning of May 2023 that she believed self-reliance was the sole means by which she could manage the abuse “rained down” on her by her husband. Angela disclosed that she felt obliged to care for her husband while he was on the "virtual ward".

5. **The victim actively seeks help from agencies like the Police, Mental Health Services, GPs, or Independent Domestic Violence Advocates.**
   All organisations that interacted with Angela were aware that she was a victim of domestic abuse at the hands of her husband.

   Extensive research has examined the reasons survivors feel unable to seek assistance. These factors may include fear, geographic location, gender, and age.[62].

6. **The victim starts talking about ending their life as abuse and stalking are persistent and intense.**
   Twice before her death, Angela attempted to end her life. Both incidents—the driving collision and her attempted hanging the night before—did not lead to an assessment by mental health services.

7. **The victim says they feel completely trapped by the perpetrator and will never be free.**
   According to Angela, families stay together, and since you create your bed, you should lie about it.

[61] https://twitter.com/JMoncktonSmith/status/1495129374886174728
[62] https://kpu.pressbooks.pub/nevr/chapter/why-do-survivors-not-report-to-police/

It is difficult to dismiss the importance of psychological elements, especially when prevalent gender norms and expectations of independence, authority, and family responsibilities are typically linked to abuse dynamics. Survivors may feel psychologically dependent on the perpetrator. Angela stated that she needed to care for Matthew, and Matthew declared that he would not perform domestic tasks in his absence. Therefore, psychological elements are essential and can be linked with dominant gender norms and expectations of independence, authority, and family obligations.

8. **There is a suicide.**

TOR 13: Can agencies identify areas where national or local recommendations to the present legal and policy framework could be made?

Analysis

Norfolk and Suffolk NHS Foundation Trust

3.2.190 Collaboration between alcohol support services and mental health services.

3.2.191 The alcohol support service in Norfolk is commissioned independently of the mental health service. This may have contributed to the fact that no practitioner within NSFT considered attempting to contact and liaise with CGL, and potentially vice versa.

3.2.192 There is a well-established correlation between alcohol misuse and mental health, which suggests that a collaborative approach from both agencies would be advantageous to Angela's treatment and care.

TOR 14: The reports should address any equality and diversity concerns relevant to the victim and alleged offenders, such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and motherhood, race, religion and belief, sex, and sexual orientation.

3.2.193 Please refer to section 1.13

4.1 Conclusion

4.1.1 The purpose of the review is to determine the circumstances behind the death of Angela in May 2023 and 'articulate life through the eyes of the victims.'[63]

4.1.2 Angela and Matthew had been together for more than thirty years. Angela administered the family business and disclosed that her coworkers were not aware of her mental health challenges. Michelle stated that Angela's three adult children had succeeded in life, and she was proud of them.

[63] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

4.1.3 Since the late 1990s, Angela and Matthew have had intermittent encounters with the police related to domestic abuse.

4.1.4 Angela discontinued taking mirtazapine in February 2022 due to feelings of lethargy and emotionlessness, and in March 2022, the Mirena Coil was removed.

4.1.5 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 make this decision. To mitigate potential adverse effects such as dizziness, anxiety, and nausea, it is advisable to reduce the dosage of mirtazapine gradually.[64]

4.1.6 Removal of the Mirena coil may result in mood swings as a potential adverse effect[65].

4.1.7 Angela took a significant overdose in May 2022, necessitating ITU intervention and subsequent hospitalisation. Angela had stated that this was an attempt to end her life. She disclosed that both her mother and husband had mistreated her, and QEH made an unsuccessful attempt to conduct a DASH risk assessment.

4.1.8 Angela was referred to CRHTT and discharged with ongoing support from her GP, with whom Angela reported a positive rapport. Nonetheless, the letter to the GP did not make it apparent that CRHTT was not involved with Angela.

4.1.9 Angela became involved with CGL in July 2022. She was allocated an RW and counselling with EF as she initiated the use of alcohol for sleep aids and mood regulation.

4.1.10 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.

4.1.11 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.

4.1.12 Angela disclosed to CGL that she felt obligated to care for Matthew after his discharge home and his placement on a "virtual ward."

4.1.13 The Virtual Ward Team had not spoken to Angela and was unaware she was providing care to Matthew. The Virtual Ward Team had placed Matthew under round-the-clock remote monitoring, meaning Angela was not required to provide him with care.

[64] https://www.nhs.uk/medicines/mirtazapine/common-questions-about-mirtazapine/#:~:text=Your%20doctor%20will%20probably%20recommend,feeling%20anxious%2C%20dizzy%20or%20sick
[65] https://www.drugwatch.com/mirena/removal/

4.1.14 Angela was involved in an RTC 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.

4.1.15 Angela reported to Matthew that she had overdosed and drank alcohol; he informed the police, who transported her to QEH, where she reported no mental health concerns, low mood or suicidal ideation. She was subsequently returned to police custody. The HCP at the police station reviewed Angela. However, she was not referred to L&D as they were not on duty while detained. The police sent a referral to adult social care concerning the above, including that Angela had taken an overdose. No further action was taken.

4.1.16 Angela disclosed to CGL her suicide attempt; CGL did not disclose this to her GP, further preventing an assessment of her mental health.

4.1.17 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.

4.1.18 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. Therefore, Angela was not seen by agencies, and subsequently, her mental health and risk were not assessed.

4.1.19 Matthew requested Michelle to drive to Norfolk and care for Angela after a verbal altercation with Angela. However, during her journey, Michelle called Angela and agreed to visit her the following day.

4.1.20 Michelle discovered Angela deceased during her visit the following day.

5.1 Lessons to be Learnt

5.1.1 The review identified the following themes to be drawn from this review:

Response to Disclosures of Domestic Abuse

5.1.2 In April 2022, the Department of Health and Social Care published guidance[66] 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.

[66] https://www.guidelines.co.uk/public-health/responding-to-domestic-abuse-guideline/456939.article

People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.'

5.1.3 The Norfolk Community Safety Partnership, Norfolk Safeguarding Children 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.

5.1.4 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

5.1.5 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.

Alcohol, Mental Health and Domestic Abuse

5.1.6 There is a correlation between alcohol and criminal activity, including domestic abuse. It is a component of the risk trilogy: substance use, alcohol misuse, and domestic abuse are risk factors that heighten the potential for serious harm.

5.1.7 Alcohol was cited as a common theme in a sample of thirty-nine DHRs, with fifteen identifying the victim as experiencing alcohol problems and fifteen with both the victim and perpetrator.[67]

5.1.8 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 AVA[68] may provide a baseline for good practice.

5.1.9 The review highlights the critical intersection between mental health and domestic abuse, emphasising the need for improved identification, intervention, and multi-agency collaboration. Mental health challenges increase both victimisation and perpetration risks.

5.1.10 Domestic abuse often goes undetected in mental health services, and domestic abuse services may lack the expertise to address mental health concerns.

5.1.11 GPS played a central role in Angela's mental health care, but limited multidisciplinary coordination and information sharing between services were inadequate.

[67] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf
[68] https://avaproject.org.uk/wp-content/uploads/2016/09/Alcohol-Concern-AVA-guidance-on-DA-and-change-resistant-drinkers.pdf

5.1.12 Angela's distress in custody, as noted by her daughter Nicole, may have manifested through stress-induced tics, highlighting the impact of extreme trauma on her mental health. Despite the police confirming that no self-harm concerns were present during her assessment, this may not have fully captured her psychological distress, particularly after experiencing a collision, assault, and detention.

5.1.13 The situation highlighted the necessity of mental health assessments in custody settings, which are designed to identify and resolve subtle yet significant signs of distress to prevent further deterioration. The Liaison & Diversion service was unavailable during Angela's detention.

Caregiving Responsibilities and Domestic Abuse

5.1.14 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.

Suicide and Domestic Abuse

5.1.15 According to the Lancet[69], 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.

5.1.16 A significant risk factor identified in the five-year national suicide prevention strategy is domestic abuse.[70]

5.1.17 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.

5.1.18 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.

5.1.19 Level 1 Zero Suicide Alliance and Level 2 Half-Day Suicide Prevention Course Training—No More Suicides[71] is an available resource for all frontline practitioners.

[69] https://www.thelancet.com/action/showPdf?pii=S2215-0366%2822%2900151-1
[70] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028/suicide-prevention-in-england-5-year-cross-sector-strategy
[71] https://no-more.co.uk/training/

5.2 Recommendations

Individual Agency Recommendations

5.2.1 Change Grow Live

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

5.2.2 East of England Ambulance Service

2.1 Guide call handlers regarding mental health patients who are on the move.

2.2 Highlight the dangers of inaccurate information.

5.2.3 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.

Multi-Agency Recommendations

5.2.4 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[72] as best practice for responding to domestic abuse and to inform 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.

5.2.5 Recommendation Two: Alcohol, Mental Health and Domestic Abuse

[72] https://www.standingtogether.org.uk/blog-3/pathfinder-toolkit

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.

CGL, 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.

5.2.6 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 recognition of trauma associated with intimate partner violence, familial violence, 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 Norfolk[73] is offered in Norfolk.

NNUH and Norfolk Constabulary

3.c Discharge planning and release from custody must ensure that appropriate documentation is provided for the individual being discharged/released and that provisions are made to ensure safe discharge/release.

5.2.6 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.

[73] https://carersmatternorfolk.org.uk/

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.

Acronyms

AA	Alcoholics Anonymous
AAFDA	Advocacy After Fatal Domestic Abuse
ADHD	Attention Deficit Hyperactivity Disorder
CARA	Conditional Cautioning & Relationship Abuse
CBT	Cognitive Behaviour Therapy
CGL	Change Grow Live
CMHT	Community Mental Health Team
CRHTT	Crisis Resolution Home Treatment Team
DAPPA	Domestic Abuse Perpetrator Partnership Approach
DARDR	Domestic Abuse-Related Death Review
DAST	Domestic Abuse Safeguarding Team
DHR	Domestic Homicide Review
DPP	Director of Public Prosecutions
EBI	Extended Brief Intervention
EF	Emerging Futures
FRS	First Response Service
GSC	Glasco Coma Scale
HRT	Hormone Replacement Therapy
IDVA	Independent Domestic Violence Advocate
ISA	Independent Stalking Advocates
ITU	Intensive Therapy Unit
L&D	Liaison and Diversion
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
MH	Mental Health
MHLT	Mental Health Liaison Team
NCSP	Norfolk Community Partnership
NFA	No Further Action
NIDAS	Norfolk Integrated Domestic Abuse Service
N&W Mind	Norfolk and Waveney Mind
QEH	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
RFG	Recency, Frequency, Gravity
RTC	Road Traffic Collision
RW	Recovery Worker
SPO	Stalking Protection Orders