APPENDIX H: ONE PAGE SUMMARY

1. Domestic Homicide Review

Norfolk Office for Police Crime Commissioner commissioned this DARDR following Simon taking his own life in January 2022.

2. Case Summary

Simon was aged 42 at the time of his death. In January 2022, police were called to a report of a possibly deceased male inside a car at a public car park. Police and ambulance service attended and found Simon with a handwritten note to Thomas stating 'sorry' and an email had been sent to him. Emergency services attempted CPR, but life was pronounced extinct. Found inside the car was prescription methadone prescribed to Simon, and other tablets prescribed to a third party.

3. The Facts – an overview

Simon was one of four children, three boys and one girl. His parents had passed away and he remained very close to his sister.

Simon had lived in Norfolk with his Thomas for several years. Having met in 2008, they were married in 2014.

In 2016, Simon and Thomas had fostering responsibility for three children associated with a previous relationship of Simon's (Year 2000), with who they had periodic contact growing up.

The children moved on after a few years.

Simon and Thomas were business partners, with Simon leading a local care agency.

Simon was a man who had lived with mental and physical health for many years, having been diagnosed with bipolar affective disorder and chronic fatigue syndrome. In the years before his death, he was undergoing a series of diagnostic testing for a range of symptoms. He had also been prescribed methadone and having developed a methadone dependency had successfully addressed this challenge.

There was a history of failed attempts to take his own life including 2004 an overdose, and in 2005 by carbon monoxide poisoning, two attempts in 2006 and suicidal ideation in 2015 was linked with financial worries.

He was severely impacted by the passing of his mother (2014) and passing of his father (June 2021).

Whilst there had been no recent attempts to take his life since his relationship over the last few years with Thomas was difficult, and Simon wanted to have a divorce, whilst Thomas wanted to try and make it work.

The review identified that Simon had several health worries, appeared to be fearful of losing other close relatives, learned from Thomas that he had financial worries and that the relationship between Simon and Thomas was not happy.

Simon's family made an allegation of controlling and coercive behaviour after Simon's death that was investigated by the police and subject to no further action.

4. Learning Points

Professional Curiosity, Recognition and Response: Simon had significant contact with healthcare professionals and whilst he never raised concerns about domestic abuse, he was never asked about feelings of safety, nor did domestic abuse feature as part of routine screening.

4. Learning Points

Domestic Abuse - National Accreditation Standards for Counselling Services: Simon and Thomas both saw private counselors accredited by different organisations. Whilst domestic abuse (DA) did not feature and was not asked about, an examination of guidance notes for agencies showed opportunities to improve the identification of DA and raise the status of DA and ensure counselors are equipped to recognise and respond to DA.

Individual vulnerabilities: Importance of recognising individual stressors as contributory factors in understanding death by suicide, together with broader universal factors such as suicide and domestic abuse rates in LGBTQIA+ communities necessitating awareness raising across professionals, and to be taken account of when conducting equalities impact assessments and devising future domestic abuse and suicide prevention strategies.

Equalities and Intersectionality: The review highlighted the importance of completing Equalities Impact Assessments to inform strategy and service provision and shone a light on the intersection of sexuality and gender in respect of domestic abuse and suicide rates in the gay community, but also from the perspective from Simon's family that reinforced a need to raise awareness of DA in gay male relationships.

5. Good Practice

GP: (a) Simon benefitted from seeing the same GP over a period of time (b) positive working relationships between GP and 'Change Grow Live' to help Simon to successfully deal with methadone dependency

NNUH: Domestic abuse champions across hospital are a positive initiative.

Specialist male and LGBTQIA+ IDVA: Recognised as a positive development for marginalised communities.

Information Provision: Development of bespoke LGBTQIA+ material is welcomed.

6. Recommendations

R1: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.

R2: Update the template DA policy, bringing it up to date with changes in legislation, so as to encourage professionals to recognise indicators of, and routinely ask about domestic abuse.

R3*:* The Home Office are to seek to raise the status of domestic abuse (DA), exploring the potential of regulating private counsellors to ensure that DA is specifically cited within training requirements, and policy to ensure counsellors are equipped to recognise and respond to domestic abuse.

R4: NCSP: Seek to raise awareness of the intersection of an individual's stressors (*mental health, financial worries, bereavement*) and wider factors (*DA and suicide rates within LGBT communities & unconscious bias*) across health professionals and local counselling services, that empowers those professionals to be able to recognise and respond appropriately to patients/clients.

R5: NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's private counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.

R6: NCSP: The learning from this review is shared across the partnership to raise awareness of domestic abuse, links to suicide, risk of intersectionality for gay male victims and all the learning opportunities raised.