NORFOLK COMMUNITY SAFETY PARTNERSHIP

DOMESTIC ABUSE RELATED DEATH REVIEW EXECUTIVE SUMMARY

Report into the death of Simon.

January 2022

Independent Chair and Author: Mark Wolski

Date of Completion: April 2024

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Norfolk Community Safety Partnership (NCSP) in reviewing the circumstances of the death of Simon, a resident in Norfolk, who took his own life in January 2022.

1.2 The basis for undertaking the review was an allegation made by family suggesting that Simon's partner Thomas had been abusive to him throughout their relationship, and that he had known Simon was going to take his life and could have prevented the tragic events.

1.3 The following pseudonyms have been used in this review to protect the identity of Simon's partner, family, and friends. These have been agreed with family.

Table 1

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Simon	Deceased	42	White British
Thomas	Partner	60	White British
Margaret	Sister of deceased	u/k	White British
Doris	Aunt	u/k	White British

1.4 The coronial process has not been concluded. The coroner took the decision to await the conclusion of this review. The medical cause of death was recorded as 'Methadone Toxicity'.

1.5 The NCSP reviewed the circumstances against the criteria set out in the Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews and the chair of the CSP determined that a DHR should be undertaken. The Home Office was notified on 17th February 2022.

1.6 The timeframe for this DHR was agreed as from January 2019 until Simon's death in January 2022. The period was selected to encompass a sufficient period to understand Simon and Thomas's relationship and by reference to Simon's medical chronology. The panel retained the option for extending the relevant period to encompass a period when they had parental responsibility for children associated with a previous relationship of Simon's. This was dependent upon on their engagement which was not possible.

2. CONTRIBUTORS TO THE REVIEW

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

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

Table 2

Agency	Trace of Simon	Trace of Thomas	Input
GP Practice	Yes	Yes	Chronology and IMR
Norfolk and Norwich University Hospital	Yes	No	Chronology and IMR
Norfolk Constabulary	Yes	Yes	Chronology and factual report
Norfolk Children's services	Yes	Yes	N/A
Change, Grow, Live	Yes	No	Chronology and factual report

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

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

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Table 3

Name	Agency	Role
Mark Wolski	Chair	Independent Chair/Author
Amanda Murr	OPCC – Norfolk	Assistant Director Policy and Partnerships
Angela Johnson	NNUH	Named Nurse Safeguarding Children and Domestic Abuse Lead
Charlotte Richardson	NIDAS	Service Manager *(From Panel 4 in lieu of Sandy Lovelock)*
Gary Woodward	N&W ICB	Designated Professional for Safeguarding Adults
Liam Bannon	OPCC – Norfolk	Community Safety Manager
Mark Brooks	Mankind Initiative	Chairman
Maria Karretti	N&W ICB	Named GP for Safeguarding Adults
Matthew Armitage	Change, Grow, Live	Complex Needs & Think Family Team Leader, Designated Safeguarding Lead
Pippa Hinds	Norfolk Constabulary	Detective Superintendent, Safeguarding & Investigations Command
Sandy Lovelock	Leeway Domestic Violence and Abuse Services	Temporary Accommodation Coordinator
Sue Marshall	Public Health Norfolk	Safeguarding and Partnership Manager
Tina Chuma	NNUH	Lead Professional for Safeguarding Children and Vulnerable Adults

3.2 The review panel met on six occasions.

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

4. AUTHOR OF THE OVERVIEW REPORT

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

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 This review aims to identify the learning from the suicide, and for action to be taken in response to that learning with a view to preventing people taking their own life that is associated with

domestic abuse and to ensure that individuals experiencing domestic abuse are identified and better supported. Specific key lines of enquiry were agreed by the panel as follows.

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

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

5.3 Case specific lines of enquiry included the following.

A. Analyse the **communication and co-operation** which took place within and between agencies regarding Simon.

B. Analyse the opportunity for agencies to identify and **assess risk of domestic abuse** or **suicide ideation/self-harm**, including what would have enabled or hindered disclosure.

C. Analyse agency **responses to any identification of domestic abuse or suicide ideation/self-harm.**

D. Analyse organisations' **access to specialist domestic abuse agencies**.

E. Analyse the **policies, procedures, and training** available to the agencies involved, with regard to domestic abuse, self-harm/suicidal ideation.

F. Analyse any evidence of **seeking help**, as well as considering what might have **helped or hindered access to help and support**. *(That includes what barriers there were to Simon, Thomas, friends, and family seeking help)*

G. Explore the **strategic approach to domestic abuse in respect of male victims** and those in same sex relationships.

H. The extent to which **Covid-19** effected agency involvement with Simon.

I. **Equalities**: The Review Panel will consider all protected characteristics

6. SUMMARY CHRONOLOGY

6.1 Simon had lived in Norfolk with his partner Thomas for several years. They met in 2008 were married in 2014. Children linked with a previous relationship of Simon's lived with Simon and Thomas from 2016 before moving on a few years later.

Family Perspective (Sister - Margaret)

6.2 Margaret described Simon as an exceptionally caring person, who would do anything for anybody and was dedicated to his work, caring for children with complex needs.

6.3 Margaret painted a picture of a man who had been controlled by Thomas, including preventing him from sleeping, blocking his car in, who constantly told Simon what to do, and who made distasteful comments to him when the family were round.

6.4 It was apparent there were numerous stressors in Simon's life that included the impact of bereavements including Simon's mother, his father and Margeret's son. Simon was also beset with ill-health and a significant stressor was Thomas's refusal to sign divorce papers.

Family Perspective (Aunt – Doris)

6.5 Doris described Simon, as 'the most loving, generous person that any person could wish to have around. He loved his family; he would do anything for anybody.

6.6 She described Simon and Thomas as being opposites, Simon as caring and Thomas as not being demonstrably caring/affectionate. She described a controlling and emotionally abusive relationship as opposed to physically abusive. She said that Thomas went for Simon as soon as people had left the house. She described accounts of him preventing Simon sleeping, resulting in Simon frequently leaving the house to sleep. She also described, controlling what Simon did, such as blocking the drive with his car, when Simon was due to go out socially.

6.7 She describes periods of grief including when her own son was diagnosed with cancer, and Simon had been immensely supportive, and then when Simon's father was in hospital and passed away. She felt that Thomas did not provide the support Simon needed.

6.8 Doris said that Simon had been trying to leave the marriage for many years, had filed for divorce about 4 years ago. This couldn't proceed as Thomas refused to sign the divorce papers. Matters did change and Simon was waiting for the divorce to come through when he took his own life.

Friends Perspective (Summary from friends of Simon and Thomas)

6.9 Simon was described an incredibly bright man, intelligent and who followed the care industry with great interest. He was also described as being a very generous person whether in the workplace or entertaining. It had been clear to friends that he had a close relationship with his parents, and particularly his mother. Hence, he had been badly affected by the loss of his mother and the father.

6.10 A reflection from friends was that Simon had appeared to be the person in charge and the relationship had been unhappy for some time, with Simon sometimes disappearing, such as when he went to Scotland by himself one week. He would sometimes go and sleep on the floor of his dad's bungalow, or in a lodge that was owned by the company.

6.11 One friend commented that Simon was just immensely sad, that reflects the other friends comment about Simon having felt all alone.

6.12 Friend did not witness any domestic abuse, physical, emotional, or otherwise.

Simon's voice

6.13 Simon left a note apologising to Thomas and sent a long email summarised below.

Simon first apologised to the emergency services, explaining that whilst he appeared to have a privileged life, it had been a life full of sadness and trauma, and a belief that there was further trauma to come.

He continued with a note to the pathologist about the pain he had been experiencing, providing a description of symptoms and Simon's sense that the pathologist would find something.

Simon then wrote to his uncle and aunt (who the chair met in a family meeting in March 2024), explaining how difficult he would find it to lose them.

He wrote to Thomas that he should take notice of what his behaviour does, but that he did not blame Thomas, but that what he wanted was to be taken care of 'just a little bit'.

Simon then said all he wanted was a hug from his mum and to be told everything would be ok, and that the only thing that would have come close was for Thomas to have done the same and to look after him.

General Practitioner (GP)

6.14 Having registered at the practice in 2013, during the relevant period he had multiple contacts during the relevant period, initially related to tapering off opiate dependency related to longstanding generalised pain relief, thereafter, related to non-specific symptoms that required undergoing several diagnostic screening tests. No formal diagnosis was arrived at, though Epstein Barr virus traces were found (A viral infection which commonly causes glandular fever[1]).

Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

6.15 Simon was an NNUH patient under different specialties as an outpatient and day case patient between January 2019-January 2022. Simon was seen by the Gastroenterology, Ear Nose Throat (ENT), and Neuro-Physiology teams for varying symptoms that included management of Night sweats; pain in his neck; abdominal cramps; diffuse muscle spasms; at times chest pain and muscular tightness around the left side of his chest which would then temporarily gradually spread to the arms, abdomen, legs, and jaw; fatigue; frequent loose stools. He underwent various tests and investigative surgical procedures which came back negative and clear from any new serious medical diagnosis. Simon's symptoms were managed with various medication to help to manage them.

Counsellor for Simon

6.16 Simon's counsellor has declined to become involved and asked the chair not to contact her. The chair is therefore unable to comment on her engagement with Simon but can comment on the ethical standards of counsellors in accordance with the body to whom she was accredited by the British Association for Counselling & Psychotherapy

Counsellor for Thomas

6.17 Thomas's counsellor saw him on four occasions between September and October 2021. The reason for seeking counselling was because his soon to be ex-partner (Simon) had accused him of being a narcissist, and Thomas wanted to understand himself better. She found him to be a self-sufficient, stoic character who kept his emotions and real self-hidden.

7. CONCLUSIONS AND KEY ISSUES

7.1 Simon was a man who had lived with problems related to his mental and physical health for many years, in 2005 having been diagnosed with bipolar affective disorder and in 2008 with chronic fatigue syndrome. Agency records do not show any concerns regarding his mental well-being during the relevant period.

7.2 Simon had previously attempted to take his own life, including in 2004 an overdose resulting in his admission to hospital under the Mental Health Act, in 2005 an attempt by carbon monoxide poisoning, and two attempts in 2006 through overdoses. The panel noted research reporting previous attempts as a risk factor that did not diminish over time.

[1] Source: Epstein-Barr virus - Newcastle Hospitals NHS Foundation Trust (Accessed January 2025)

7.3 Simon endured multiple sources of stress. He was significantly impacted by the passing of his mother (2014) with whom he was very close, the subsequent passing of his father (June 2021) and cousin (August 2021).

7.4 Simon's losses, and closeness to his aunt Doris who was unwell, was an additional source of anxiety to him, in that he feared further bereavements, as was apparent from the note he left stating "All I am left with is more pain and trauma to come, and I've reached the end of my tolerance".

7.5 Simon had lived with other worries in addition to relationship problems with Thomas. In the last two years of his life, Simon had successfully wrestled with dependency on prescribed medication related to pain relief, the side-effects of which brought more pain, discomfort, and difficult symptoms to manage. In addition, he underwent tests for long-standing symptoms, for which no clear diagnosis ever resulted. It is also apparent from the note Simon left that he was convinced that he had a serious illness.

7.6 Proximate to when Simon took his own life it was established there was a director's loan against the company with a significant amount owed to HMRC. Simon had previously expressed suicidal ideation in 2015 when dealing with HMRC.

7.7 It is clear from the testimony of everyone, that the relationship between Simon and Thomas was in difficulty. It is a matter of fact that immediate family members made an allegation against Thomas of controlling and coercive behaviour after Simon took his own life. The police concluded their investigations and no further action resulted.

7.8 Whilst on the one hand family allege, controlling behaviour, in the form of sleep deprivation, preventing Simon having access to his car and reportedly telling Simon what to do; on the other hand, friends described Simon having been the person in charge.

7.9 Simon had had been advised by his sister to go to the police, but he had said to her they would not listen to a man. She felt had he been a woman as opposed to a gay man, the police may have listened. Whilst recognising additional barriers facing the LGBTQIA+ community, it has not been possible to conclude this was a factor in Simon's case, though the review acknowledged an ongoing need to address these barriers.

7.10 One element of control that Thomas had over Simon, related to the fact that Thomas would not cede to Simon's request for a divorce, refusing to sign divorce papers. Thomas acknowledges this fact, and this is cited within witness statements to the police. Undoubtedly their business venture also bound Simon and Thomas together financially, though there is no evidence to suggest that Thomas exerted financial control over Simon, as he was able to book holidays and travel freely, such as a holiday in the December before he took his life.

7.11 Whilst it has not been possible to identify a trail of abuse, speaking to family and friends shone a light on the relationship and Simon's needs. Simon wrote in his suicide note, "Thomas if anything can be drawn from this is that you sit up and see what your behaviour does. I don't blame you as such. That would be childish. I have begged you to take care of me just a little bit. I love you so very dearly I would literally do anything for you. I get that you always do what is best for you and that if you ignore and pretend, you're not the problem that it means someone else will sort the problem." One person described Simon, 'as the most loving person that any person could wish to have around.' Conversely, Thomas has been described as 'stoic' and undemonstrative. In some ways, it is arguable that Simon and Thomas's emotional needs were different, with Simon needing love in a more demonstrable manner.

7.12 The review therefore recognises the concurrent nature of several stressors in Simon's life that are pertinent to him taking his life. It is not possible to conclude any one factor weighed more heavily on Simon's mind.

7.13 The review has also shone a light about domestic abuse within gay male relationships, in terms of higher rates of domestic abuse, victims being less likely to know where to access support in rural communities as opposed to city environments. These are concluded as being important research that demonstrates the need for ongoing awareness raising that is being undertaken locally.

7.14 The panel also considered how the intersection of other factors relevant to Simon such as; - rates of domestic abuse in LGBT communities' – rates of suicide in LGBT communities, - research linking suicide to impact of domestic abuse and possible unconscious bias where domestic abuse is framed as a woman's issue. Whilst not concluding any impact, the panel recognises the importance of raising awareness of these factors in tackling domestic abuse.

7.15 The panel reflected on (a) the role of private counsellors who had been involved with Simon and Thomas and (b) the number of counsellors in the Norfolk area, as an opportunity to further raise the status of domestic abuse within that profession locally and better integrate them into the systemic approach to tackling domestic abuse.[2]

Professional Curiosity, Recognition and Response

7.16 Simon had 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. This was applicable to his GP practice and secondary care at the local hospital where he had several outpatient appointments.

7.17 Simon and Thomas both had contact with independent counsellors accredited by different agencies. The extent to which domestic abuse is referenced across each agency is different, one with more overt guidance, one more reliant on safeguarding guidance. In both cases there appears to be an opportunity to raise the status of domestic abuse, its links to suicide and adapt policies to reflect current understanding, statutory guidance as well as incorporated indicators of domestic abuse in accordance with QS116.

Counselling - National Accreditation Standards for Counselling Services

7.18 The different approach by agencies that accredit private counsellors suggests that the status of domestic abuse would benefit from being elevated and subject to national standards for professionals who through counselling practice are likely to meet clients living with domestic abuse.

7.19 The number of private counsellors working in Norfolk provides an opportunity to integrate them into the systemic approach to tackling domestic abuse.

Equalities and Intersectionality

7.20 The review shone a light on barriers facing gay men in seeking help through research cited within the report and through the testimony of Simon's sister who reported that he had said police would more likely have believed him, if he were a heterosexual male, reinforcing a need to raise awareness of domestic abuse in gay male relationships.

7.21 The intersection of sexuality and gender is relevant in this case as when his sister had told him that he should speak to the police, his response suggested he would not be believed because he was a gay man. The panel recognised from the breadth of research the intersection of domestic abuse and suicide rates in the gay community, as well as other relevant research about accessing support in rural communities.

[2] A local register shows there are 294 registered counsellors in Norfolk. Counselling in Norfolk - Counselling Directory (counselling-directory.org.uk)

7.22 The review acknowledges the commissioning of specialist male and LGBTQIA+ advocacy services locally as good practice but highlights the importance of completing an equalities impact needs assessment and associated action plan for future iterations of domestic abuse strategies.

8. LESSONS LEARNED

8.1 The review identified several learning points that build upon agency IMRs, engagement with family/friends and agencies responsible for accrediting private counsellors. The points below summarises opportunities described above in section 7. Recommendations are relevant to agencies unless otherwise described and have been considered against a background of agency and policy developments that has mitigated the need for more recommendations. This review has also considered the recommendations of another local DHR that mitigated the need for further recommendations from this review. (DHR Sarah)

- 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.
- 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.

9. GOOD PRACTICE

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

GP

9.2 Simon benefitted from seeing the same GP over a period of time, and this is acknowledged as good practice.

9.3 There was good partnership working between the GP and CGL in facilitating a conversation between CGL and Simon.

NNUH

9.4 Role of DA champions in hospital is recognised as good practice.

Service Provision

9.5 The provision of a specialist male IDVA and an LGBTQIA+ IDVA are recognised as good practice.

Information provision

9.6 The development of bespoke information for LGBTQIA+ communities is welcomed.

10. RECOMMENDATIONS

10.1 Local IMR Recommendations

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

GP Practice

- To raise GP awareness of NICE guidance and Faculty of Pain Medicine guidance on supporting people who wish to withdraw from methadone and other opioids including regular review and recognising the withdrawal symptoms and how to enquire about these.
- To raise GP awareness of the existence of intimate partner violence among lesbian and gay couples and its incidence can be higher than that among heterosexual couples.

11.2 Overview Report Recommendations

The following recommendations have been agreed by the panel.

R1	**Recommendation 1**: NCSP to ensure that an EINA and action plan is completed in relation to future Domestic abuse strategies.	NCSP
R2	**Recommendation 2:** 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.	GP/ICB
R3	**Recommendation 3:** 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. And in so doing consider the role of regulated counsellors taking part in statutory reviews.	Home Office
R4	**Recommendation 4:** 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.	NCSP
R5	**Recommendation 5:** NCSP are to develop a coordinated awareness raising campaign to domestic abuse across the county's counsellors ensuring they are equipped to recognise and respond appropriately to domestic abuse.	NCSP
R6	**Recommendation 6:** 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.	NCSP

Appendix A – Statement of Independence

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

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

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

Appendix B: Glossary

Abbreviation / Acronym	**Full meaning**
AAFDA	Advocacy After Fatal Domestic Abuse
BACP	British Association of Counselling and Psychotherapy
CGL	Change Grow Live
CSEW	Crime Survey England and Wales
DHR	Domestic Homicide Review
EINA	Equalities impacts needs assessment
GP	General Practitioner
ICB	Integrated Care Board
IDVA	Independent Domestic Violence Advocate
IMR	Individual Management Review
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
N & W	Norfolk and Waveney
NCSP	Norfolk Community Safety Partnership
NIDAS	Norfolk Integrated Domestic Abuse Service
NNUH	Norfolk and Norwich University Hospital
UKPC	United Kingdom Council for Psychotherapy

Appendix C

1. Domestic Homicide Review

Norfolk Office for Police Crime Commissioner commissioned this DHR 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 whom 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 (continued)

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.

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.

Police: good secondary supervision, leaflets for responders on support agencies

5. Recommendations

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

R2: ICB/GP to 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.