Domestic Abuse Related Death Review
Celia/December 2022
Executive Summary

Author: Dr Liza Thompson

Commissioned by: Cumberland Community Safety Partnership

Review completed: July 2024

EXECUTIVE SUMMARY

1. The Review Process

1.1 This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Celia, a resident of Town A, prior to her death in December 2022.

1.2 Celia was found by her daughter and husband deceased at home, an inquest into her death held on 6th June 2023 concluded that she had died by ligature suspension while under the influence of a very high blood alcohol level.

1.3 The Cumberland Community Safety Partnership, the review panel, and the Independent Chair extend their condolences to Celia's family and friends.

1.4 This DARDR examines the involvement that organisations had with Celia from 1st December 2021 until Celia's death.. However, for context purposes agencies were also required to provide information pertaining to domestic abuse, mental health and/or alcohol misuse from 2011 onwards.

1.5 Celia was not the victim of a homicide (where a person is killed by another). However, this review is framed by the 2016 Home Office Domestic Homicide Review Statutory Guidance which states:

> "Where a victim took their own life 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 The key reasons for conducting a Domestic Abuse Related Death Review (DARDR) are to:

a) establish what lessons are to be learned from the domestic homicide about the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between organisations, how and within what timescales will be acted on, and what is expected to change;
c) apply these lessons to service responses including changes to policies and procedures as appropriate; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;

[1] Para.18 DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

1.6. In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Cumberland Community Safety Partnership Panel meeting was held on 13th February 2023. It agreed that the criteria for a multiagency review DARDR had been met and this review will be conducted using the standard Home Office methodology.[2] That agreement has been ratified by the Chair of the Cumberland Community Safety Partnership and the Home Office has been informed.

2. Contributors to the Review

2.1. Each of the following organisations contributed to the review.

Agency/ Contributor	Contribution	Source of information
Cumbria Constabulary	IMR	Red Sigma – intelligence and crime system accessed Sleuth – intelligence and crime system prior to Red Sigma also accessed Police works – case and custody system accessed
NHS Northeast and North Cumbria Integrated Care Board (ICB) – for Primary Care	IMR	Clinical case records accessed Interviews with Celia's GP
NHS Lancashire and South Cumbria Integrated Care Board – For North Cumbria Integrated Care	IMR	reviewed Celia's medical records for attendances to ED, back to 2011 – were accessed. Celia's sickness and absence records provided by HR – back to 2011 – were accessed. Occupational Health information was provided back to 2017 - However, the NCIC occupational health record system does not go back further than this date.

[2] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

		Interviews were carried out with managers and senior managers, clinical leads and clinicians, and HR staff.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust		Electronic records accessed. Interviewed clinicians and manager of services engaged with Celia.
Northwest Ambulance Service	IMR	**Patient Record Form -** a clinical record form, describes incidents and medical treatments C3 – search database, storing all incidents – linked to addresses. Electronic Referral Information Sharing System (ERISS) – this records all referrals made by NWAS clinicians and alerts received from external agencies. From November 2022, Cleric replaced ERISS Cleric – this system is connected to the NHS Spine.[3] ADASTRA – an electronic database used by NWAS NHS 111 service. Redbox VM recorder - System for storing and recording all 999/111/PTS calls into NWAS
Victim Support	IMR	Accessed files from NGCM Case recording system

3. Review Panel Members

3.1. The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Celia. It also

[3] A major component of the health and social care IT Infrastructure in England. This is a digital central point, allowing the exchange of information across local and national NHS systems.

included a senior member of the Cumberland Community Safety Team an independent advisor from a Victim Support.

Agency	Name	Job Title
	Dr Liza Thompson	Independent Chair
Cumberland Community Safety Partnership	Hayley Bishop	Area Planning Manager Community Development Team
Cumbria Constabulary	DC Sarah Edgar Fae Dilks	Detective Constable Safeguarding Hub Detective Inspector Safeguarding Hub
NHS Northeast and North Cumbria Integrated Care Board (ICB) *for Primary Care*	Molly Larkin Kate Allen	Assistant Director of Nursing (Safeguarding North Cumbria) Safeguarding Designated Nurse across lifespan Deputy Designate for Safeguarding Adults
Lancashire and South Cumbria Integrated Care Board – For North Cumbria Integrated Care	Kelly Short	Designated Nurse Adult Safeguarding
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Caroline Bainbridge	Named Nurse for Safeguarding and Public Protection
North West Ambulance Service	Sharon McQueen	Safeguarding Practitioner
Cumberland Council	Georgina Ternent	Public Health Manager
Cumberland Council	Mary-Claire Telford	Domestic Abuse Strategic Lead
Victim Support	Danielle Thomson	Team Lead & Accredited IDSVA

3.2. Panel members hold senior positions in their organisations and have not had contact or involvement with Celia. The panel met on five occasions during the DARDR.

4. Author of the Overview Report

4.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

4.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent

publications examine the experiences of abused mothers within the child protection system.

4.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews.

5. Terms of reference for the review

5.1. The Review Panel first met in April 2023 to consider draft Terms of Reference, the scope of the DARDR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

5.2. The following specific issues were identified by the panel and formed the basis of the panel's analysis of Celia's involvement with agencies leading to her death.

i. *Were Celia's employers and/or colleagues aware of the domestic abuse – how did they respond to this – was this in line with their policies?*

ii. *What can be learned from this case about the links between domestic abuse and suicide?*

iii. *How was Celia's risk of suicide identified/assessed/responded to?*

iv. *What trauma informed policies and processes do agencies have in place and how were these utilized when responding to Celia?*

v. *Were agencies aware of Jim's coercive control – how did they respond?*

vi. *How can an understanding of Celia's experiences assist with future understanding of coercive control?*

vii. *What can we learn about the correlation between Jim's coercively controlling behaviour and Celia's declining mental health. Were his behaviours ever identified, or considered, when assessing her risks of harm from her own actions – either through alcohol misuse or suicide/self-harm.*

viii. *What can we learn about the correlation between chronic pain/physical health and mental health?*

ix. *What do we know about Celia's work life, and how being signed off sick may have affected her mental health further.*

6. DHR Methodology

6.1. The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Celia. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

6.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DARDR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Celia during the period covered by the review.

6.3. Due to Celia being an employee of the Emergency Department where she was also treated following overdoses and during mental health crisis', it was agreed at the commencement of the review that her employers North Cumbria Integrated Care (NCIC) should not complete their own IMR. It was therefore agreed that Lancashire and South Cumbria Integrated Care Board would participate in the review on behalf of NCIC. The panel would like to thank Lancashire and South Cumbria Integrated Care Board for their assistance.

6.4. The full subject of the review was Celia. Due to the nature of Celia' death, which did not directly involve a third party, the panel were restricted regarding the information available to them. The review will include some information pertaining to Jim's involvement with Cumbria Constabulary and Victim Support following allegations of assaults upon Celia, however the panel had no legal basis in which to request Jim's general information from health and social care agencies.

7. Summary Chronology

7.1. From 2011 onwards, Celia had a high recorded sickness level – with over thirty period of sickness, sometimes being signed off work for weeks at a time.

7.2. Celia has been supported back to work through various Sickness Monitoring processes and was seen by her GP regarding issues linked to alcohol misuse, mental ill health and chronic pain following a back injury. Despite there being disclosures from Celia regarding her homelife, there was no exploration about domestic abuse by her employer or by health care professionals.

7.3. Celia suffered numerous bereavements over the years, however there was no exploration around the links between loss and suicidal ideation. Celia started to mention suicide in late 2018, this was following the death of her father-in-law, and her husband sustaining a serious head injury after falling down the stairs.

7.4. The COVID-19 National Lockdown from March 2020, through to the end of 2021, had a significant impact on healthcare professionals' mental wellbeing, and at this point Celia was already struggling with mental and physical health issues.

7.5. In May 2021, Celia had an abnormal liver function test, which was linked to excessive alcohol use. In July 2021, Celia was diagnosed with Cauda Equina[4] and in November 2021, Celia underwent bilateral decompression surgery.[5]

7.6. In late December 2021, Celia's daughter called police due to an incident where she stated her parents were "arguing" and although this had happened before, this was the worst it had been. Officers attended and Celia and Jim were both intoxicated. Celia stated that Jim had slapped her following an argument. Jim was arrested and taken from the address. Officers remained with Celia who declined to give a statement. A DASH RIC[6] was carried out and graded as standard risk.

7.7. On 2nd October 2022, police were called by Celia due to an assault on her by Jim. She stated they had both been out drinking in town, and upon arrival back home there had been in incident whereupon Jim had slapped Celia. Officers attended, and Jim was arrested. Jim stated that Celia always caused issues when she had been drinking. He was recorded on Body Worn Video as saying "it's happened again" and "been there before". Celia is recorded as being very distressed, she told officers that Jim said Celia had ruined his life and that they should never have got re-married. Celia declined to completed DASH questions, she was not asked about mental health, suicidal ideation or alcohol issues.

7.8. Jim admitted to slapping Celia. An Evidence Review Officer[7] was used to review the investigation and decided that rather than a No Further Action decision, the Pathways[8] out of court disposal route, on a deferred caution[9] would be taken. Celia was consulted on this decision.

7.9. On 4th October 2022, Jim was accepted onto the Pathways Programme, on a deferred caution for eight weeks. He took part in phone call appointments each week for this period and completed a Remedi[10] approved programme to address his behaviour. During these sessions, he identified that he sometimes struggled with communicating with Celia, and this sometimes made him anxious. A referral was made to Turning the Spotlight, to help develop better communication. Signposting was also given to Jim regarding his mental health and alcohol use. Jim successfully completed the programme on 28th November 2022.

[4] A medical emergency that happens when an injury or herniated disk compresses nerve roots at the bottom of the spinal cord.

[5] A type of surgery used to treat compressed nerves in the lower (lumbar) spine.

[6] See table at s.7

[7] Responsible for evidence review, informing appropriate and consistent case outcomes decision making, ensuring high level of file build and evidentiary quality. Supporting front line officers with advice on National File Standards (NFS) and current CPS charging standards.

[8] The Pathways Programme offers eligible offenders the chance to have charges and cautions deferred on some lower-level offences. These can be deferred cautions or deferred charges.

[9] A caution is appropriate if the offender admits to a minor offence, this is not a criminal conviction but it does remain on the record

[10] Restorative Justice | Remedi (remediuk.org)

7.10. Following an initial conversation with Turning the Spotlight, Jim declined to continue with the programme.

7.11. On 18th October 2022, Celia was assessed by the Crisis Team, following disclosures of suicidal ideation to her GP. Her history of depression was identified, and increased "life stressors" were recorded, along with a reference to work related stress and physical health issues. There was no mention of domestic abuse or alcohol misuse. Celia was directed to her GP for a medication review.

7.12. On 19th October 2022, following the police referral to Victim Support, the Independent Victim Advocate (IVA) tried to call Celia to offer her support. Jim answered the phone and asked the IVA to call back tomorrow to speak to Celia. This call was outside of the forty-eight-hour scope for initial calls following referrals. The call was made sixteen days after the referral was received, and twelve days after the phone number was provided by police. Also, best practice should a male answer a call where intended recipient is female is for the IVA to end the call without speaking or advise that it was a wrong number. The IVA tried to call Celia on 24th and 25th October 2022, using a different number to the one provided by police. The new number was unobtainable. It was clarified that the number provided by police had belonged to Jim.

7.13. 25th October 2022, Celia spoke with an on-call GP and stated that she was significantly struggling with the pain, that she was using naproxen and a proton pump inhibitor[11] but was finding it difficult to cope and was drinking 1-2 bottles of wine each evening after work and this was becoming problematic. An appointment was booked with her own GP and, in the meantime, Celia was prescribed codeine.

7.14. The following day, Celia took an overdose of naproxen, paracetamol and codeine, along with wine. Celia's daughter called an ambulance, although she was not with Celia, they had been on a phone call and Celia had disclosed to her daughter what she had done. The call handler tried to call Celia, and when she was unable to get through, she passed this to a mental health specialist to make a call. This was still unsuccessful, however Celia's daughter called again an hour later to state her sister was with Celia, who was slipping in and out of consciousness. The call was upgraded to the highest category response, upon arrival the crew gave Celia oxygen which helped her to recover consciousness. She would not engage with the crew, and stated that she wanted to die, although could not state any reason for the crisis. Celia did not want to go to ED as she worked there, however the crew assessed her as lacking capacity to make this decision and she was taken to hospital in her best interests. In hospital, Celia told staff that the trigger for the overdose was "issues at home" but did not want to discuss further. Celia was assessed as high risk of further self-harm, and there was a reference at 7pm that a DASH and MARAC should be completed, however a further note to state that these would be inappropriate in the resus area as her work colleagues were visiting her, along with other patients and their families

[11] This is a medicine that reduces the production of acid in the stomach and helps to treat ulcers and acid reflux. This class of drug is often prescribed alongside anti-inflammatories, such as naproxen and ibuprofen, to protect the stomach from irritation.

around the area. A plan was made to complete the questions when she was no longer in the resus area. However, this is the last entry from nursing staff about the DASH/MARAC, which was not actioned throughout the course of the admission.

7.15. The NCIC Psychiatric Liaison Team (PLT) met with Celia. She was in a state of distress, attributed to psychological state and physical pain. It is recorded that she was not regretful of the overdose, which she stated was intentional. She was unable to continue with the PLT assessment due to being in distress. The mental health assessment matrix remained incomplete, the suicide risk tool was not completed, and no assessment of risk due to domestic abuse, alcohol or chronic pain were made. Assessment categories were completed, however these were incorrect, for example the question about historic anxiety stated no, despite there being a long-documented history of anxiety. Within the triage assessments, a section regarding, "Issues to be explores through questioning" was not completed – this includes discussions about external factors, which would have been another opportunity to ask about domestic abuse. The outcomes of appropriately completed assessments may have altered the discharge support for Celia surrounding not only domestic abuse, but also alcohol misuse, her mental health and chronic pain.

7.16. The same day, the IVA tried again to call Celia, and was not successful.

7.17. Celia was seen by PLT at 1am on 27th October 2022, whilst still in ED. She was still vomiting and drowsy. Celia declined the suggestion that an admission to a mental health crisis ward would be beneficial. Celia was seen again by PLT at 3am, she remained in high levels of pain and was unable to fully engage with a mental health assessment. Celia told PLT staff that Jim was attending a mandatory Pathways programme due to abusive behaviour.

7.18. This would have been an ample opportunity for the DASH and MARAC referral to be completed, however there is no evidence to suggest this had been undertaken or handed over from nursing staff. This was a missed opportunity to refer onto a specialist domestic abuse service, or to request support from the NCIC Trust Health Independent Domestic Violence Advisor (HIDVA).

7.19. Celia was seen again by the PLT at 6am and 9.30am – and no actions were taken around the disclosures of domestic abuse, despite Celia discussing these matters on each occasion that she was seen. At 1.30pm, a Multi-Disciplinary Team (MDT) met to discuss a plan for Celia, which included support for her alcohol, however no plans were made regarding the disclosed domestic abuse. Celia's GP was updated regarding the plan.

7.20. GP Practice A called Celia on 28th October 2022, she was home, and it was agreed that she would start on a new medication, the GP would contact again in one week, with a face-to-face appointment booked in two weeks.

7.21. On 31st October 2022, the IVA closed the case, as they had not been able to speak with Celia.

7.22. On 1st November 2022, the Pathways Support Worker called and spoke to Celia, as part of the Pathways Restorative Justice process, to ask if she would like to have any input into the programme. She declined this.

7.23. Also on 1st November, Turning the Spotlight sent Jim a text message, to offer a space on the programme. He replied that he was currently busy and would contact them when he was ready. He did not contact back, and therefore Pathways were advised that Jim had not worked with Turning the Spotlight and the case would be closed.

7.24. On 4th November 2022, Celia's GP contacted her as planned, Celia stated that the pain was manageable, she denied thoughts of self-harm and stated she had been abstaining from alcohol. She was due to return to work on a phased return.

7.25. On 10th November 2022, Celia went back into work, as part of the phased return. It is alleged that a colleague could smell alcohol on her breath, and she was asked to go home. She was scheduled to work from 7am to 1pm and had been sent home at 10am. Celia later told a work friend that she had not been drinking that morning, however had drank the night before and this could have been why she smelt of alcohol. There was a general feeling amongst Celia's work colleagues that the situation was not handled very well. They questioned why she was allowed to drive herself home if there was a suspicion that she was intoxicated. Celia's friend told the Chair that she believed that management had no idea what to do. This was Celia's friend's perception, and the Trust do have a Substance Misuse Policy for management to follow.

7.26. The GP called Celia that day for a further follow up, Celia told her about the work situation and that had consumed two bottles of wine and was sitting by a river contemplating jumping in. The GP alerted the police, who located Celia. Celia told officers "I just want to die; I could just jump in the river and be swept away". She had also consumed codeine and sertraline. Celia did not want to go to Hospital A ED because she was embarrassed to be seen by those she worked with. However, officers took her to ED, spoke discreetly to the receptionist and the ward sister, who assured officers they would safeguarding Celia while she was in ED. Her family were informed.

7.27. Once in ED, Celia was assessed by PLT and agreed to an informal admission to Mental Health Unit, due to continued risk to herself. Celia was admitted to the Unit at 6pm, however by 8pm she stated she would like to return home. She indicated that she was uncomfortable on the Unit as patients she had cared for were present.

7.28. The following day, the medical team reviewed Celia considering her request to be discharged. It was agreed that she would have weekend home leave, her daughter was involved in these conversations. It was agreed that Celia would receive telephone support during the weekend. Celia was called that evening at 5pm and 8pm – no concerns were raised.

7.29. On 14th November 2022, it was agreed that Celia could remain at home, with support from the Crisis Team, and that a referral to alcohol services and the Persistent

Physical Symptoms Service as part of this discharge plan. There is no evidence that these referrals were made by the Crisis Team, and there was a lack of consideration of risk of alcohol misuse while Celia was at home.

7.30. The GP practice made the Persistent Physical Symptoms Service referral on 15th November 2022, having been asked by Celia to do so, following the Crisis Team mentioning the service to her.

7.31. Celia was visited at home by CNTW Crisis Team on 16th November 2022. They were aware of the assault on Celia by Jim, however they did not discuss domestic abuse during their visits to Celia. She had a medical certificate for an absence from work until 12th December 2022, she had an Occupational Health appointment booked, in order to explore the option of a less stressful work environment. Celia denied alcohol use.

7.32. The Crisis Team visited Celia on 18th November 2022, the family told Crisis Team staff that Celia was still using alcohol, she denied this, became upset and left the room. Crisis Team called the following day, and Celia apologised for the day before, she admitted to drinking and denied any suicidal ideation. Celia agreed to a referral to Recovery Steps[12] which was completed the same day.

7.33. A phone call was made to Celia by the Crisis Team on 21st November 2022, no concerns were raised. A home visit was undertaken by the Crisis Team the following day, Celia discussed support from Occupational Health and contact with her GP. Celia denied any further suicidal ideation.

7.34. The Crisis Team called Celia on 23rd and 24th November 2022, no concerns were raised. The Crisis Team attempted to discuss domestic abuse with Celia, but she would not discuss this stating that it was all in the past and their relationship was now good.

7.35. On 24th November 2022, a Senior Clinician reviewed Celia's case record and agreed to liaise with Celia's family when making plans. There was a series of actions to be taken, including chasing up the Recovery Steps referral, exploring domestic abuse with Celia, to consider completing a DASH and possibly a MARAC referral, and for a review regarding discharge from the Crisis Team.

7.36. The Crisis Team visited Celia on 28th November 2022, she reported to be managing well and felt that her mood had improved. She denied alcohol use, but the team suspected that she had been consuming alcohol. She stated that she did not want support from alcohol services.

7.37. The Crisis Team called Celia's daughter on 29th November 2022; however, they were asked to call back another time. The team also spoke to Jim, who stated no concerns about Celia.

[12] Recovery Steps Cumbria – Humankind (humankindcharity.org.uk)

7.38. The Crisis Team called Celia on 1st and 2nd December 2022, an attempt was made to discuss domestic abuse, however Celia stated no concerns about this, and declined referrals to specialist support.

7.39. The Crisis Team visited Celia on 5th December 2022, Jim and Celia's daughter were present at time throughout the appointment. Celia is recorded as having slurred speech; however, she denied alcohol use. She spoke about a phased return to work, stating she felt supported by work. Celia's daughter raised a concern about Celia's continued use of alcohol and agreed to be assessed for carer support. It was good practice to offer Celia's daughter a carer assessment. Celia stated she did not need further support from Crisis Team.

7.40. The next day, the Crisis Team called Celia's daughter to organise a carer assessment, however they were unable to get through.

7.41. The following day, the Crisis Team contacted Celia to discuss continued support, which Celia stated she no longer needed. The Crisis Team told Celia they would continue to contact her daughter to arrange a carer assessment, and Celia agreed to engage with Recovery Steps. Celia was discharged from the Crisis Team.

7.42. The following day, a 999 call was made by Celia's daughter, her mother was not cold and was not breathing. An ambulance was dispatched and upon arrival recorded that Celia was deceased.

7.43. What was of note was that the attending Senior Paramedic documented within the history of the event that Jim had returned home, and found Celia suspended from the stairs. He had released the ligature from her neck and then had driven to collect their daughter. She had returned to the home with Jim, and she had called for the ambulance.

8. Conclusions

8.1. Celia was working in a high-pressure role, whilst living with domestic abuse, and chronic pain. In addition to this, she self-medicated with alcohol, which led to her being treated for alcohol related issues in her workplace. Celia was also sent home for smelling of alcohol, following a period of sickness, which led to further intoxication and suicidal ideation, requiring Celia to be conveyed to the Emergency Department where she worked. Celia's mental health was further affected, from the shame of her work colleagues treating her, seeing her intoxicated and being mentally unwell.

8.2. Celia was treated as an in-patient at CNTW's Mental Health Unit. She was admitted alongside patients she had treated in ED, which she did not feel comfortable about, and was therefore treated by the Crisis Team at home.

8.3. Celia was discharged from the Crisis Team, following her assurance to them that she was well and not using alcohol. This was despite Celia's family raising a

concern with the Crisis Team that Celia was still using alcohol, and also observations by the team that she could have been under the influence of alcohol.

8.4. Celia took her own life the day before she was due to return to work following this period of absence.

8.5. Celia's employers and colleagues appeared to know about the domestic abuse from Jim, however there was a lack of response from her employers regarding this. On the second occasion they were involved, the police response did not follow procedure.

8.6. There appeared to be a lack of recognition of how the compound issues which Celia faced, raised her risk of suicide. Cumbria has a suicide rate of 15.5 people per 100,000 which is higher than the national average of 10.4 people per 100,000. Cumbria has the second highest rate of suicide amongst local authorities in the Northwest of England and is in the quartile of local authorities with the highest rates of suicide in England.

8.7. As a county, Cumbria has two further DHR's due to be published which pertain to healthcare/emergency workers who have taken their own lives in the context of domestic abuse.

8.8. In December 2023, the Northeast and North Cumbria Suicide Prevention Plan 2024-2029 was launched. This plan includes a commitment reducing the risk pf suicide in key high-risk groups, which includes people who have self-harmed or had attempted suicides, and who live with partner violence – both of which were Celia's experiences. The plan also commits to tailoring approaches for specific groups, again this includes people living with partner violence. Learning from this review, and ither similar reviews in Cumbria should be fed into suicide prevention plans, allowing lessons from Celia's death to support developments in making the future safer.

9. Lessons to be Learnt

9.1. A major lesson to be learnt from this review is the identification of suicide risk.

9.2. The recently released National Suicide Prevention Strategy provides a reminder that "suicide is everyone's business, and everyone has a role to play in suicide prevention."[13] As has been discussed above, Celia was not identified as a suicide risk throughout her engagement with health and social care agencies.

9.3. The National Strategy cites domestic abuse and bereavement as high-risk indicators for suicide. those who have made previous attempts, or self-harmed are also identified as high risk. People who use alcohol self-medicate are at higher

[13] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

risk, because of alcohol lowering their awareness and increasing their risk-taking behaviours. All these characteristics were plain to see in Celia.

9.4. In addition to these high-risk indicators, Celia was off sick from work which was also a place where she socialised. This led to her isolation from support networks. She was also very proud of her job and felt great shame when she was treated by her colleagues when intoxicated and suicidal. These elements would have exacerbated her risk of suicide.

9.5. Celia completed suicide the day before she was due to return to work following a period of sickness which began when she was sent home on suspicion of being intoxicated at work. The significance of this should not be dismissed.

9.6. Cumbria Constabulary

9.6.1. Cumbria police have procedures and policies in place; however, officers did not always adhere to them when responding to Celia.

9.6.2. Since Celia's death, Cumbria police have invested in the "DA Matters" training programme delivered by Safe Lives. The training addresses much of the learning emerging from the DARDR. In particular, the training highlights the identification of controlling and coercive behaviour, the impact of this on a victim's mental health, and the importance of the accurate completion of a DASH with the victim.

9.6.3. On 2nd October 2022, when responding to the call from Celia regarding an assault by Jim, DASH questions were not asked of Celia, and her mental health was not explored. The officer interacting with Celia did not seek to establish a rapport with her, for example he stood up the whole time he was speaking to her, and this may have affected her confidence to confide in him further.

9.6.4. The case file documents were not easy to find on the police systems, as they were not stored in the relevant folders on the Evidence Drive. This was against protocol.

9.6.5. Following the incident in November 2022, police should have sent a referral to NCIC under the People in Positions of Trust protocol.

9.7 GP Practice A

9.7.1. Information sharing within the GP Practice team is very important, and clinicians meet to discuss any cases of concern, particularly with the on-call team who have a morning and afternoon team meetings for a handover. The practice has also recently incorporated a large white board in the back office to allow non-sensitive information sharing amongst staff.

9.7.2. GPs should feel able to enquire about domestic abuse, even when a patient is reluctant to discuss the matter. A GP safely and routinely enquiring about domestic abuse at each appointment may lead a patient to feel comfortable in opening up about their experiences.

9.8. NCIC

9.8.1. Celia was not regularly asked about domestic abuse, either as a patient or as an employee. Routine enquiry was expected practice during the scoping period for this review, however since Celia's death, NCIC has undertaken a significant amount of dedicated training and have produced numerous resources to support staff in carrying out routine enquiry, and in using their professional curiosity. The auditing of the NCIC campaign "how safe do you feel" has been made as a recommendation from this review.

9.8.2. The NCIC staff who spoke with the IMR author highlighted the need for enhanced training for line managers and Occupational Health staff, to equip them to have difficult conversations about domestic abuse, mental health and substance misuse. Training should include completion of DASH, use of professional curiosity, and trauma informed application of policies and procedures. Within the training, awareness of the possible shame and stigma for employees accessing ED or any other NCIC services, should be interwoven into the learning.

9.8.3. There was also a lack of supervision highlighted through the review. Clinical supervision should be made available, along with safeguarding supervision processes. This will help towards dismantling the culture of "getting into trouble when things go wrong" and develop a more proactive response throughout ED. It would appear from reviewing the Trusts available resources, that ample support is available from the Safeguarding Team, and therefore the learning should be focused on raising awareness of this available support, in order to develop a culture where staff – including management - feel able to ask for help.

9.8.4. There was a lack of interagency communication between NCIC AND CNTW regarding the completion of a DASH, and in turn recognising Celia as a victim of domestic abuse. This meant that once Celia was out of the hospital setting, the Crisis Team attending to Celia at home were unaware of the possible dynamics in the home.

9.9. CNTW

9.9.1. Celia disclosed domestic abuse during her initial contact with PLT, however the response by PLT was not in line with CNTW policy. Celia was not asked about the abuse, and a DASH was not completed with her.

9.9.2. Neither the PLT nor the Crisis Team followed up on the referrals that were made for Celia, this is contrary to CNTW policy.

9.9.3. Despite the PLT and the Crisis Team both being aware of the issues around Celia's alcohol use, and being aware of her role within NCIC, there was no safeguarding advice sought in relation to the impact of alcohol on Celia's ability to undertake her Health Care Assistant role.

9.9.4. Since Celia's death, the CNTW Safeguarding Team have undertaken a targeted educational session with the PLT, regarding managing concerns relating to staff who work in a position of trust and have also delivered an awareness sessions across all staff which focused on identifying and responding to domestic abuse.

9.9.5. There should have been a referral for Celia into the Persistent Physical Symptoms Service prior to Celia being discharged from the Crisis Team. This did not happen, and Celia was discharged from the Crisis Team with no other services or support in place.

9.9.6. Despite Celia's daughter being assured that she would have input into Celia's care from the Crisis Team, they did not explore the decision to discharge Celia from the Crisis Team with Celia's daughter – who would have raised a concern that Celia was still drinking and was not emotionally stable.

9.9.7. The Crisis Team now conduct a weekly case note review with any outstanding actions tasked to an allocated practitioner. This is then followed up at the next MDT to ensure completion. The team also undertake monthly audits of care plans and quality care plan reviews to ensure this paperwork is completed and to a high quality.

9.9.8. Despite Celia agreeing to a referral into substance misuse services, this was not completed at the point of Celia's discharge from the Mental Health Unit. The referral into substance misuse services, which was made by The Crisis Team, was not followed up, and therefore Celia was not contacted by substance misuse services. The Mental Health Unit have reviewed their discharge processes, which now include the requirement for onward referrals to be detailed to the community teams.

10. Recommendations

10.1. Multi Agency Recommendations

10.1.1. The panel recommend a thematic review be undertaken, of this and two other recent reviews pertaining to the death by suicide of healthcare workers in Cumberland, where domestic abuse was a factor. Learning from the thematic will be fed into the local Suicide Prevention Plan, and also shared with healthcare provider to assist their understanding of the risks of suicide faced by their workforce.

10.1.2. The panel recommend that Cumberland Public Health's Suicide Prevention Team are represented on the panel of all statutory reviews involving death by suicide, from the inception of the review through to completion.

10.1.3. All agencies involved in the review will provide assurance that they have an Employee Domestic Abuse Policy in place which is up to date and fit for purpose. A template policy will be made available for all agencies to adopt where required.

10.1.4. A learning tool will be developed for multiagency training and awareness, which will share Celia's story and highlight the following specific areas of learning:

a. Awareness of risk indicators of suicide, including domestic abuse and bereavement.
b. Awareness of the private MARAC process.
c. Understanding of the Five Critical Questions, and resources to include these within agencies' policies.

10.2. Cumbria Constabulary

10.2.1. Refresher training to be delivered to officers and supervisors - using this review as a case study, to remind all officers of the processes that should be followed when dealing with domestic abuse incidents.

10.3. GP Practice A

10.3.1. GP's will be reminded about the Persistent Physical Symptom Service, which would be suitable for a patient like Celia who was suffering from long term chronic pain.

10.4. NCIC

10.4.1. Audit of the implementation of the 'How Safe do you Feel Campaign' across the organisation to evidence the output of the training delivered.

10.4.2. An enhanced training package for Leaders and Occupational Health colleagues on 'Managing Difficult Conversations' will be developed. The package will include the importance of applying professional curiosity and trauma informed practice to policy and procedures.

10.4.3. A programme of awareness raising will be delivered to increase the uptake of Safeguarding Supervision across the Emergency Department.

10.4.4. Occupational Health staff within the Trust will receive mandatory DASH Risk Assessment training.