Domestic Abuse Related Death Review
Celia/December 2022
Overview Report

Author: Dr Liza Thompson

Commissioned by:
Cumberland Community Safety Partnership

Review completed: July 2024

The Cumberland Community Safety Partnership, the review panel, and the Independent Chair extend their condolences to Celia's family and friends. It is clear from the information shared with the Chair by Celia's friends that she was a big personality, whose presence will undoubtedly be missed by all who knew her.

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1. Introduction

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 on 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 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.

1.4 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]

1.5 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;
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

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

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. Confidentiality

2.1. The findings of this DARDR are confidential. Information is available only to participating officers/professionals and their line managers, until after the DARDR has been approved by the Home Office Quality Assurance Panel and published.

2.2. Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved.

2.3. Details of the deceased and alleged perpetrator:

Name (Pseudonym)	Gender	Age at time of death	Relationship to deceased	Ethnicity
Celia	Female	Late fifties	*Deceased*	White British
Jim	Male	Late fifties	*Partner*	White British

3. Methodology

3.1. 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.

3.2. 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.

3.3. 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.

3.4. 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

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

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.

4. Timescales

4.1. This review began In April 2023 and was concluded in July 2024.

4.2. There was some delay in the NCIC IMR being produced due to an external agency requesting information and organising interviews with staff, Human Resources and speaking to friends/colleagues of Celia.

4.3. Following this delay, IMRs were all returned and reviewed in December 2023, and the first draft of the overview report was completed in March 2024.

4.4. The panel met on a further two occasions to agree recommendations and formulate the action plan, ahead of the report being submitted to the Home Office in December 2024.

5. Terms of Reference

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. Involvement of Family Members and Friends

6.1. At the commencement of the review a letter was sent to Jim to inform him as next of kin, of the review and to ask if he would like to be involved with the review. To date, there has been no contact from Jim.

6.2. In June 2023 a letter was also sent to Celia's daughter, advising her of the review, and requesting her involvement in the process. To date there has been no contact from Celia's daughter.

6.3. In the absence of family involvement in the review, and in an attempt to gain an insight into Celia's life, the Independent Chair met with one of Celia's friends from work. The Chair also had contact via text message with another friend who provided an insight into the relationship between Celia and Jim.

7. Contributing Organisations

Agency/ Contributor	**Service/criteria/definitions**		**Source of information**
Cumbria Constabulary	Community Policing – response officers **Pathways –** Cumbria's out of court disposal framework now incorporates an offender management programme called Pathways, this offers reparation for the victim and rehabilitation for the offender. Pathways has a dedicated team of support workers, who identify the root cause of offending, refer to prescriptive programmes, and address underlying vulnerabilities.	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	GP Practice A	IMR	Clinical case records accessed

Cumbria Integrated Care Board (ICB) – for Primary Care	**A General Practice -** is a small to medium sized business whose services are contracted by NHS commissioners to provide generalist medical services in a geographical area.		Interviews with Celia's GP
NHS Lancashire and South Cumbria Integrated Care Board – For North Cumbria Integrated Care	**Emergency Department –** a medical treatment facility specialising in emergency medicine, and the acute care of patients who present without prior appointment.	IMR	Policies were read: • Occupational Health & Support Services Trusts Alcohol & Substance Misuse Policy. • Safeguarding Guidance for Domestic Abuse • Attendance Management Policy • Safeguarding Childrens & Adults Policy 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. Interviews were carried out with managers and senior managers, clinical leads and clinicians, and HR staff.
Cumbria, Northumberlan	**Crisis Resolution and Home Treatment Team** – experienced		Electronic records accessed.

d, Tyne and Wear NHS Foundation Trust	mental health trained nurses, social workers, psychiatrists and pharmacy staff. Offering assessment and home treatment for people over 16 experiencing a mental health crisis, as an alternative to hospital admission. **Psychiatric Liaison Team -** a team of psychiatrists, registered mental health nurses, clinical psychologists and other specialist mental health professionals, providing an assessment of mental health, and treatment of mental health problems, to people attending hospital. **First Step** – talking therapies **Mental Health Unit –** this is a high risk needs-led acute psychiatric ward, providing assessment, care and treatment by a multi-disciplinary team.		Interviewed clinicians and manager of services engaged with Celia.
North West Ambulance Service	**NHS 111 –** non-emergency service available twenty four hours a day **999 –** Urgent and emergency care	IMR	The following were accessed to produced the 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	Independent Victim Advocate (IVA) Service – and Turning the Spotlight – As part of an integrated service Victim Support provides IDVA, IVA and Turning the Spotlight Services. The IDVA service supports domestic abuse victims assessed as high risk of harm. The Independent Victim Advocates (IVA) work with any victim of crime including non-high domestic abuse victims. Turning the Spotlight is a 12 week healthy relationships programme for those displaying harmful/abusive behaviours and where the risk is assessed as non-high. An accompanying 7 week partner programme and 4 week parents/children programme is also offered. Perpetrators and victims are supported by different case workers.	IMR	Accessed files from NGCM Case recording system

[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.

8. Review Panel Members

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

8.2. 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.

9. Independent Chair and Author

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

9.2 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, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

9.3 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.

10. Other Reviews/Investigations

10.1. The Cumbria Coroner held an inquest hearing into Celia's death on 6th June 2023.

10.2. The coroner reached a narrative verdict, that Celia died due to suspension whilst her cognition was severely impaired by a very high blood alcohol level. The coroner was unable to reach a verdict of suicide as he was not certain that Celia had intended to take her own life due to the level of alcohol in her blood.

10.3. Following the inquest, a Prevention of Future Deaths (PFD) Report[4] was sent to Cumbria, Northumberland, Tyne and Wear Trust (CNTW) raising a concern regarding Celia's discharge from the Crisis Resolution and Home Treatment Team (Crisis Team) two days before Celia's death.

10.4. The main concerns raised by the coroner were that Celia's discharged from the Crisis Team had no planned follow up. Celia's family were not involved in the discharge process despite being advised they would be involved, the GP did not

[4] Also known as a "regulation 28" report, this happens where a Coroner has heard evidence that further avoidable deaths could happen if preventative action is not taken. The report is sent to the person or authority who have the power to make changes that are suggested. Brenda-Shields-Prevention-of-future-deaths-report-2023-0191_Published.pdf (judiciary.uk)

receive discharge notification from the Mental Health Unit, and referrals to drug/alcohol services and Persistent Physical Symptoms Service were not made upon discharge from the Unit, or from the Crisis Team.

10.5. The PFD Report also stated that inadequate weight seemed to have been given to Celia's alcohol problems and her assurance that all was well was taken on face value despite her recent history.

10.6. CNTW responded to the PFD, citing that Jim had been involved in the discharge from hospital but accepting that no family members were involved with the discharge from the Crisis Team. They also made reference to findings of the Serious Incident Investigation[5] (SII) which had taken place following Celia's death.

10.7. The CNTW SII had identified gaps in referrals to other services, most notably addiction services, upon discharge from the Mental Health Unit; a lack of family involvement in discharge planning, including a lack of exploration of Celia's daughter's concerns about her mother being discharged home from the Unit; and a lack of involving other services in discharge planning.

10.8. The CNTW SII culminated in a series of recommendations. These were as follows:

- Discharge processes to be reviewed by Mental Health Unit to ensure onward referrals are communicated with receiving teams.

- The senior leads who attend MDTs along with clinical staff will now capture onwards referrals and the acceptance of these referrals as evidence on the MDT proforma on Rio."

- For the team to continue monitoring the inclusion of care givers in safety planning and discharge planning.

- An audit will be undertaken to understand compliance as well as continued carer awareness training to be offered to all staff.

- An audit will be completed to monitor compliance with discussion and documentation of physical health within MDTs

11. Publication

11.1. This overview report will be published on the websites of Cumbria Community Safety Partnerships.

[5] This is an internal investigation undertaken by a health provider following a patient's death. The purpose of the procedure is to enable the identification of Serious Incidents and to report, record and investigate them appropriately in order to identify lessons.

11.2. Family members will be provided with the website addresses and also offered hard copies of the report.

11.3. Further dissemination will include:

a. The DHR Steering Group, the membership of which includes Police, Integrated Care Board and the Office of the Police and Crime Commissioner amongst others.
b. The Cumbria Safeguarding Adults Board.
c. The Cumbria Safeguarding Children Multi-agency partnership.
d. The Office of the Police and Crime Commissioner
e. Additional agencies and professionals identified who would benefit from having the learning shared with them.

12. Background Information

12.1. Celia was a woman in her late fifties, with a longstanding history of low mood and anxiety. She was married with three adult children, one of her children remained living at home with Celia and Jim.

12.2. Celia had worked for NCIC as a Health Care Assistant since 2010, initially within the Rapid Response Team, moving to the District Nurse Team around 2018, and finally working within the Emergency Department at Hospital A. Celia had a lot of friends across the Trust and was well known.

12.3. The Chair spoke to a friend Ms A, who had met Celia two years before. She said they had immediately got on very well. Ms A told the Chair that Celia got on with everyone, she was always happy, cheery and loud, she described Celia as a “chatterbox”. Ms A said that Celia was a good worker, she was always drawn to supporting people who were presenting with mental health issues, she was kind and good at her job.

12.4. Ms A was unaware of Celia’s struggles with her mental health, until Celia was brought into the Emergency Department following an overdose. Ms A visited Celia during this episode of care.

12.5. Celia had disclosed issues with Jim to Ms A, and Ms A felt that the overdose was due to Jim’s behaviour. Ms A said that Celia opened up a little about the domestic abuse to the nurse who was on duty at the time, and the nurse had tried to safeguarding Celia in terms of the domestic abuse. However, when the Psychiatric Liaison Team spoke to Celia, she shut it down and stated the overdose was nothing to do with Jim.

12.6. Celia had told Ms A that Jim had thrown her down the stairs on occasions, and Celia blamed his behaviours on a historic brain injury. However, Celia would not get into the conversation about abuse, and would change the subject. Ms A

told Celia for months before her death that she should leave Jim, but Celia said, “what would people say”.

12.7. The Chair also had contact with a friend Mr B, who had known Celia since before she was married with children. They had made contact via social media around ten years’ previously, and during the last few years before Celia passed away, they had met occasionally at work, and she confided in him about her life.

12.8. Mr B told the Chair that in May 2022, they had been on a night out, and Celia had confided in Mr B’s friend about Jim. She had told Mr B’s friend “what a nasty man” Jim was, despite Celia never meeting Mr B’s friend before. Mr B said that Jim wanted to know where Celia was all of the time, and that Celia made excuses for Jim’s behaviour due to a brain injury.

12.9. Ms A said that Celia would “give little insights into her life but said nothing specific.” Celia would speak about her children a lot, but never spoke about the whole family unit. Mr B said that Celia would only mention things about Jim briefly but was never very open about the relationship.

12.10. Celia’s GP stated that Celia was adamant that despite reporting an assault by Jim, that she did not want additional support, and that they were working through things.

12.11. Ms A stated that she believed Jim “had a lot to play in Celia’s death”. Mr B told the Chair “if (Celia) wasn’t married to (Jim) she would still be here.”

12.12. Celia never spoke to Ms A about drinking. Ms A thought this might be because she did not drink herself, and therefore Celia wanted to hide it from her. Ms A said she could see Celia was a drinker, but Celia never disclosed having a problem with alcohol.

12.13. Celia’s line manager reported that Celia would often put herself forward to cover extra night shifts, however these would often be cancelled at very short notice. It was also feedback that often when Celia cancelled shifts she appeared “very drunk”, however this didn’t prompt any further queries or actions from management; but this appeared to have been known across the nursing leadership team within the department.

12.14. Ms A said that many nurses and Health Care Assistants had mental health issues. She did not feel there was much help for them from their employers around mental health.

12.15. Celia’s GP stated that Celia had a strong sense of pride in her work, but that she felt shame when she presented at ED as a patient.

12.16. Celia had reported to her GP that the chronic pain was the main trigger for her mental health difficulties.

13. Equality and Diversity

13.1. The panel addressed the nine protected characteristics of, age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, ethnicity, religion and belief, ethnicity, sex and sexual orientation - as prescribed in the Equalities Act 2010 duties, and considered if they were relevant to any aspect of this review. The review considers whether access to services or the delivery of services were impacted upon by such issues.

13.2. The panel identified that Celia's protected characteristics could be recognised as sex (gender) and disability. Celia was a female, and a mother, who was affected by male violence, and was living with mental and physical ill health.

13.3. Gender is the term used to refer to the socially constructed cluster of characteristics,[6] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[7]

13.4. Celia told people about Jim's violent behaviour within the home. A raft of research has identified that one of the most dangerous places for a woman is in her own home.[8] Women take the fear of male violence for granted; they structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[9] Jennifer Nedelsky argues that a culture of male violence is a constitutive force which shapes women's and men's lives.[10]

13.5. The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation, and shame, exists on a deeper level.

13.6. As will be explored within this review, it was recorded within case files that Jim was violent due to Celia's use of alcohol. The Coroner's conclusion also includes the following:

> *"(Celia) had for some time been alcohol dependent with binge sessions which often caused domestic friction with her husband, there was an incident of domestic violence requiring police involvement."*

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[6] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56

[7] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265

[8] Home, the most dangerous place for women, with majority of female homicide victims worldwide killed by partners or family, UNODC study says; GSH18_Gender-related_killing_of_women_and_girls.pdf (unodc.org)

[9] Stanko, above n 7 p.70

[10] *Ibid* p.204

13.7. This sentence indicates that the assaults upon Celia were deserved due to her "binge drinking". Elizabeth Stanko argues that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should behave.[11]

13.8. Celia was living with chronic pain, and she in 2021 she was diagnosed with Cauda Equina Syndrome. This is a condition where there is pressure on the nerves at the bottom of the spinal cord. It is a rare disorder, which causes lower back pain, and problems with bowel and bladder function. Although this condition did not lead to Celia being registered as disabled, her life was shaped by constant pain, and it is thought she self-medicated with alcohol.

13.9. Alongside the chronic pain, and alcohol misuse, Celia had been affected by poor mental health for many years. Celia had episodes of anxiety in 2005 and 2007, depression in 2016 and suicidal ideation in 2018. Although her poor mental health did not constitute a disability, this would have shaped her life, alongside – and compounded by - her other difficulties.

13.10. Nursing is a physically and emotionally demanding profession, there are high role expectations and difficult working conditions, and nursing staff can be at risk of burnout and stress related illness.[12] The mental health and wellbeing of healthcare workers is a global public health priority.[13] Celia's work as a urgent care health Care Assistant would have been stressful, however within the context of the COVID-19 pandemic the role may have also caused her additional stress. Although Celia is recorded as loving her job, the impact of her feelings of shame of accessing the emergency department as a patient due to alcohol use, the Mental Health Unit when she was in crisis and suicidal, and also being sent home when it was suspected that she was intoxicated at work - all would have further shaped her experiences leading up to her death.

14. Chronological Overview

14.1. From review of Celia' sickness and absence records, it appears that she had a high recorded sickness level – with over thirty period of sickness, sometimes being signed off work for weeks at a time. During late 2011 Celia had time off work with stress and anxiety which she cited as being due to family problems. There was a lack of curiosity about these issues from her employers, she was not asked about domestic abuse. There was also a lack of support offered to Celia regarding these series of absences, with short periods of return

[11] Stanko, above n 7 p.72

[12] Brennan, EJ "Towards Resilience and Wellbeing in Nurses" *British Journal of Nursing* (26) (1) (2017)

[13] Sovold, L et al "Prioritising the Mental Health and Wellbeing of Healthcare Workers: An Urgent Global Public Health Priority" *Frontiers Public Health* (9) (2021) Frontiers | Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority (frontiersin.org)

to work between each absence. There was no follow up with Celia about her welfare.

14.2. During this period in late 2011, Celia saw her GP and reported separation from Jim, she had been for around eight weeks and was the cause of her anxiety. She stated Jim had been threatening suicide following the separation, and she was caring for her fourteen-year-old twins. She was unable to sleep or eat. When she returned the following week, she stated that Jim had become abusive. She was prescribed medication for her mental health issues, however there was no exploration about the domestic abuse.

14.3. During 2011 and 2012, Celia was referred to First Step and also had occupational health assessments through work. No references to, questions about, or offers of support for domestic abuse are recorded by either GP Practice A, or by Celia's employers.

14.4. During 2013, Celia continued to take time off sick, and referenced "family reasons", however there was no enquiry into domestic abuse or any potential referrals or signposting for further support. Celia was also seen by GP Practice A for menopause symptoms, including low mood and flushes. During this consultation she mentioned splitting from her partner eighteen months previously.

14.5. During 2015, Celia was referred to First Step following a consultation with the GP where she disclosed a breakdown at work. She stated her father had passed away the year before, her partner had suffered a heart attacked which she said he put strain on their relationship, and she was going through the menopause. During 2015, it was an expectation for GPs to ask about domestic abuse, and there was no record that Celia was asked about this during the consultation.

14.6. At this point Celia was working for a community rapid response team[14] and had been working in that team for six years. Celia stated that she needed some breathing space from work and she was given a one month medical certificate.

14.7. In July 2015, Celia lost her brother, and in October 2015 she had a stage two sickness monitoring meeting, where she discussed issues surrounding stress and anxiety, gastric issues and flu. She stated that she had struggled since her father's death. Again, there was no exploration with Celia about her relationships, or discussions about domestic abuse.

14.8. During 2016, Celia was again referred to First Step. She had consultations with her GP regarding stress related problems; recorded in one consultation was the following:

[14] This team has the remit of reducing admissions to hospital. If a person is identified as having urgent needs that are not life threatening, the local community rapid response team can be called to assess if support can be given at home. The team is made up of district nurses, physiotherapists, occupational therapists and clinical practitioners.

"few issues at home; was victim of domestic violence; seen occupational health who suggested stay off work". The following GP consultation states: "says home situation has been sorted somehow; not very open about it."

14.9. In September 2016, there is a record in Celia's HR file that she had a significant number of absences from work over the past couple of months. There were repeated issues recorded which should have been cause for concern surrounding potential domestic abuse, however this was not picked up by employers and she was not asked whether she was safe at home in line with the Trust's policy.

14.10. In November 2016, Celia was taken into ED as she was found slumped in a bar, vomiting, intoxicated and experiencing abdominal pain. It is recorded that her partner attended ED with her. It is recorded that the abdominal pain had been ongoing for several months, Celia had been too afraid to discuss this with her GP, and the excessive alcohol intake had been due to her father's death two years previously. She also disclosed self-harm, however stated that her partner did not know as she was too scared to tell him. There is no evidence that she was offered advice around self-harm, or support with bereavement, and there was no professional curiosity around her fear of telling her partner about the self-harm. Consideration should be given as to whether the lack of curiosity was due to Celia being an employee of NCIC, although at this time she was working for the Rapid Response Team within the community, and not in the ED.

14.11. Celia had an Occupational Health meeting at work following this admission, the report of the meeting stated an increase in medication, however there is no evidence that mental health, substance misuse or domestic abuse were discussed as part of the meeting. In mid-December 2016, Celia had a stage one Sickness Monitoring meeting, due to absences because of depression, migraine, and medication change. Again, it was unclear if Celia was asked about her mental health, substance misuse, or domestic abuse during this meeting, and no onward referrals were made. Celia was signposted to Crus[15] for bereavement counselling, although here is no indication that she followed this up.

14.12. In June 2017, there is a record of Celia injuring her back, and this appears to be the beginning of the chronic pain which continued until her death. There is no record in the GP notes as to the cause of the back injury, where stress was involved, or whether it was linked to her job. In July 2017, Celia had a Stage Two Sickness Monitoring Meeting, following time off due to a fall, depression, and vomiting episodes. Celia's shift pattern was amended to assist with her work/life/balance. There is no evidence of professional curiosity regarding domestic abuse during this interaction, despite this being a requirement of the Trust domestic abuse guidance at that time.

[15] Home - Cruse Bereavement Support

14.13. During late 2017, and into 2018, Celia had numerous periods of sickness, due to vomiting, irritable bowel symptoms and following a period of sickness due to a chest infection. in January 2018 a Stage Three Sickness Monitoring Meeting was held. There are records of discussions with Celia around her physical health, however no professional curiosity regarding her home life and domestic abuse, despite this being a requirement of the Trust domestic abuse guidance at that time.

14.14. In March 2018, Celia attended ED due to a fall during a night out. A scan was undertaken, and no injuries were identified. Despite Trust guidance requiring exploration of possible domestic abuse, Celia was not asked about domestic abuse.

14.15. In August 2018, Celia saw her GP due to anxiety following her father-in-law passing away, and Jim had fallen down the stairs, sustaining a significant head injury. The GP also called Celia for a telephone consultation regarding acid reflux, two weeks later, she took the call whilst at work and described issues with her bowel movements. The GP advised attending ED due to possible gastrointestinal bleed. There is no documentation to indicate Celia did attend ED.

14.16. Celia attended an appointment with the out of hours GP (CHOC) in October 2018, due to suicidal ideation. There is a record that states: "Celia says she felt so low/stressed/anxious about her bowels/death of father that today she considered hanging herself. Quite clear about the way she would - on stairs". She attended CHOC with Jim and stated that he was very supportive. There was a plan made for the Crisis Team to be informed. There is no record on the HR files about the outcome of the Crisis Team referral, indicating that possibly Celia had not disclosed her involved with the Crisis Team to her employer. The GP records indicate that Crisis Team advised a referral to First Step and attendance to her GP to have a medication review. This period of sickness triggered Stage Four Sickness Monitoring Meeting, where Celia raised her concern about her job being at risk, as her partner had been off sick for eight months and they had financial difficulties.

14.17. Celia continued to be absent from work in November 2018, and when she saw her GP at the end of November 2018 her medication was increased. She had seen Occupational Health, who were going to review her again in December 2018. Celia was again referred to First Step. During this time, her role within NCIC was a Heath Care Assistant working with the District Nursing Team.

14.18. Celia was discharged from First Step in January due to lack of engagement with the service, and in late January 2019 she attended a Stage Three Sickness Monitoring Meeting, where it was agreed that Stage Two would be extended for a further twelve months.

14.19. In April 2019, Celia had time off due to a close family member passing away. In June 2019, Celia was seen by her GP due to chest pain and described feeling stressed with her mood having dipped. She had stopped the medication

herself but wanted to restart this. Celia had time off work in June 2019 due to migraine and described to her GP feeling "fatigued and out of sorts". However, there was no documented discussion about her mental health during this appointment, or any recognition of the link between her mental health and her physical symptoms; there was just a comment on her notes that BS was "alert and chatty".

14.20. August 2019, Celia resigned from her role with the District Nursing Team. The review was unable to access information from NCIC Human Resources department to enable clarification of Celia's resignations and applications across the Trust.

14.21. In March 2020, the National COVID-19 restrictions were introduced[16] which limited the movement of the general public, and greatly affected health service delivery.[17] The hospital environments changed, with areas used for triage, and streaming of patients into COVID and non-COVID pathways, this led to confusion, crowding and impacted on the ability to social distance, which all impacted on flow, and caused delays. During this time, patients were being held in ambulances, either waiting treatment, or until a place on a ward could be found. There was also an impact on staffing levels, due to sickness and absence linked to the pandemic, the need for self-isolation, staff we needed to shield, and also absence due to stress and anxiety.[18]

14.22. Celia had a review of her medication via telephone – due to COVID restrictions - in July 2020. During the review she stated no suicidal thoughts or thoughts of self-harm. There was no other contact with her GP until April 2021, when she had a telephone consultation. Celia advised her GP that she had a new job in ED, which she had started six week before, she was complaining of increasing lower back pain with some left leg symptoms. She is documented as working long shifts but wanting to continue working. She was offered a face to face meeting the same day, which was good practice. She had a scan of her back booked in, and a blood test arranged.

14.23. On 5th May 2021, the blood tests had indicated an abnormal Liver Function Test, which was linked to excessive alcohol use. She had indicated drinking thirty units per week[19] and stated she would work towards reducing this to the recommended government amount. She told the GP that her intake had increased due to the Covid-19 restrictions. Celia did not attend her repeat Liver Function Test on 10th June 2021, however had a phone consultation with her GP on 14th July 2021 where she reported pin and needles in her feet. Celia was seen

[16] Timeline of UK government coronavirus lockdowns and restrictions | Institute for Government

[17] COVID-19 Insight 9: The impact of the pandemic on urgent and emergency services - Care Quality Commission (cqc.org.uk)

[18] Gilleen, J et al "Impact of the COVID_19 Pandemic on the Mental Health and Well-Being of UK Healthcare Workers" *British Journal of Psychiatry* (April 2021)

[19] Recommended weekly consumption is 14 units

on 22nd July 2021 for her issues and was referred immediately to orthopaedics for possible Cauda Equina.

14.24. On 5th November 2021, Celia was signed off work for six weeks following bilateral decompression surgery.[20]

14.25. Celia had a telephone consultation with GP Practice A on 8th November 2021, and raised a concern that the medication provided following the surgery was not sufficient, she was therefore given further morphine and naproxen. This medication was reviewed one month later, Celia requested no more morphine, and instead amitriptyline was increased. Celia had a further four-week absence from work from 21st December 2021.

14.26. On 23rd December 2021 Celia's daughter called police, following an incident in the home. She stated that her parents were "arguing" and although this had happened before, this was the worst she had heard. Celia also called police to report an assault by Jim. 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[21] was carried out and graded as standard risk – with every question answered as a "no". It is unclear whether this was due to Celia stating no to each question, or officers completed it as no due to her declining to answer the questions. House to house enquiries were carried out. The case had a No Further Action[22] decision. The Body Worn Video[23] of Celia's initial account[24] could not be located to be reviewed for this DARDR, however the Body Worn Video of Jim's first account, showed that he was dismissive of Celia and stated that she was always drunk; yet this did not factor into the DASH RIC completed. The police report was not shared with Celia's GP, this may have been due to data protection, however this incident could have been viewed as a safeguarding issue, which permits information sharing without consent.

14.27. On 12th January 2022, Celia's GP saw her and advised a possible phased return to work. The GP received the Occupational Health report from Celia's employer on 27th January 2022, and the GP recommended adjustments following Celia's surgery. There is no record that mental health, alcohol use, or domestic abuse were considered as part of the Occupational Health assessment/recommendations.

14.28. During May 2022, Celia reported ongoing back pain, made a request for codeine which was declined, and reported issues with incontinence to her GP. She

[20] This is a surgery used to treat compressed nerves in the lower spine, it aims to improve symptoms such as persistent pain and numbness.
[21] See table at s.7
[22] This is when police take no further actions, usually due to lack of evidence. However this can be reopened if further evidence comes to light.
[23] This is the use of cameras to record police-public encounters, with the aim to provide enhanced evidence capture, and improve accountability and transparency
[24] Introduction to initial accounts | College of Policing

also contacted and was triaged by NHS 111 on 30th May 2022, where it was assessed that she required conveying to ED, however Jim took her in to ED as they lived nearby. When at ED she received an MRI scan.

14.29. 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.

14.30. Jim admitted to slapping Celia. An Evidence Review Officer[25] was used to review the investigation and decided that rather than a No Further Action decision, the Pathways[26] out of court disposal route, on a deferred caution[27] would be taken. Celia was consulted regarding this decision.

14.31. 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[28] 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.

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

14.33. 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.

14.34. 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

[25] 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.
[26] 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.
[27] 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
[28] Restorative Justice | Remedi (remediuk.org)

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.

14.35. On 20th October 2022, Celia was visiting a friend who lived out of area, when she started to have chest pains, abdominal and groin pains, her friend called an ambulance and taken to the hospital local to her friend. Following the administering of pain relief, Celia felt better and was able to leave the hospital with her friend.

14.36. 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.

14.37. Also on 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[29] 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.

14.38. On 26th October 2022, 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 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.

[29] 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.

14.39. 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.

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

14.41. 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. There was no evidence of actions or discussions following this disclosure. 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).

14.42. 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.

14.43. 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 for two weeks.

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

14.45. 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.

14.46. 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.

14.47. 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.

14.48. 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.

14.49. 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.

14.50. 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.

14.51. 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.

14.52. 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.

14.53. 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.

14.54. 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.

14.55. 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[30] which was completed the same day.

14.56. 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.

14.57. 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.

14.58. 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.

14.59. 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.

14.60. 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.

14.61. 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.

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

14.62. 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.

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

14.64. 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.

14.65. 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.

14.66. 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.

15. Analysis

15.1. Cumbria Constabulary

15.1.1. The following sections will analyse each of the three contacts Celia and/or Jim had with police.

23rd December 2021

15.1.2. Based on the information provided, the incident was correctly risk assessed by the control room staff, using the THRIVE process.[31]

15.1.3. Following officers attending the scene, Jim was arrested for common assault, and taken to the local police station, and was later interviewed at 3.45am. the interview lasted for six minutes. It is questionable whether it was appropriate to interview a person at that time of

[31] This is the risk assessment process used by control staff – T = Threat, H = Harm, R = Risk. I = Investigation, V = Vulnerability, E = Engagement.

the night/morning, also considering Jim's intoxication, this could have waited until a more reasonable time. The length of the interview is also of concern and does not indicate a comprehensive interview, exploring relationship dynamics.

15.1.4. The Domestic Abuse Evidence Review Officer (ERO) then reviewed the evidence of the case and considered a Domestic Violence Protection Order (DVPO)[32] which was discounted due to a lack of reported domestic abuse history between the couple, and the fact that the incident was classed as minor, resulting in no injuries. The ERO highlighted a lack of statement from Celia, that Jim had admitted the assault, but had cited self-defence, and that Celia's daughter's statement undermined Celia's account.

15.1.5. Consideration was given to Evidence Led Prosecution[33] (ELP) however this was discounted because the ERO deemed that the requirements to facilitate an ELP were not available, for example, hearsay evidence[34] would not be utilised as the requirement to open the "fear gateway" for admission of hearsay was not met. This means that the ERO did not feel that Celia would be unlikely to give evidence due to fear of Jim. The case was therefore no further action (NFA) and Jim was released from custody at 4am to return home with no restrictions.

15.1.6. The NFA decision was made very quickly and was not in keeping with best practice. For domestic abuse incidents, guidance states that sufficient time should be given for the victim to have time to assess the situation and consider the position regarding providing an evidential account. Celia was spoken to when officers attended the initial incident, where she said she didn't want to provide an evidential account. However, she was intoxicated, and was in emotional distress following the incident, and a very stressful situation for her to be in. Celia should have been afforded time to rest, recover from her intoxication, and then approached again after she had time to make an informed decision regarding whether she wanted to provide a statement.

2nd October 2022

15.1.7. Officers arrived at the scene within eight minutes of the call being made, and Celia immediately disclosed that Jim had slapped her face – she had visible reddening to her face. Jim was promptly arrested and removed from the property, whilst an officer remained with Celia.

[32] Domestic Violence Protection Notices (DVPNs) and Domestic Violence Protection Orders (DVPOs) guidance - GOV.UK (www.gov.uk)

[33] A case which does not rely on the victim's statement

[34] A statement not made in oral evidence that is evidence of any matter stated – this is inadmissible in criminal proceedings except where there is some statutory provision which renders it admissible.

15.1.8. Body Worn Video footage of Jim arrest show him being derogatory to Celia when he was arrested, however there was no mention of this behaviour in the safeguarding report.[35]

15.1.9. An account was taken from Celia by the officer who remained with Celia. This was recorded on the Body Worn Video and shows the officer remaining standing whilst recording he account, and little effort was made to build a rapport with Celia. Throughout, Celia was seen to be apologising for bothering the police, however there was no mention of these behaviours in the SAF[36] report, despite these being clear indicators around Celia's mental state and Jim's attitude towards her.

15.1.10. The officer did not ask Celia any questions about her mental health, or suicidality. The SAF report was reviewed in the safeguarding hub but was not referred to MARAC or an IDVA as the risk was assessed as medium. The officer in the case was sent safeguarding planning, however there is no evidence that safeguarding discussions took place with Celia, and whether anything was implemented to protect or support her.

15.1.11. The crime investigation was thorough, and although Celia did not provide an evidential account, an alternative to prosecution was utilised, to try to obtain a positive outcome for all involved. A Pathways referral was made, which resulted in a deferred caution, and sought to address Jim's behaviours. Jim is recorded as engaging well with the process, however there is no evidence that Celia was involved in the process, or even if she was aware of it.

10th November 2022

15.1.12. Celia had been on a call to her GP, and indicated she was by a river and was going to throw herself in. She had returned to work, on the first day of a phased return following an overdose, and her colleague had smelt alcohol on her and sent her home.

15.1.13. The call handler dealt with the call very promptly, identifying the Celia had been known previously to police. Officers were dispatched to the scene, and the control room staff also identified the possible requirement for the Street Triage Team (STT) which at the start of this review was a pilot, consisting of a mental health nurse, and a police officer attending calls for service involving possible mental health need. This project is now embedded into practice. On this occasion, once it was established that Celia had consumed alcohol and taken an overdose, the STT was stood down as not appropriate.

15.1.14. The ambulance wait was estimated as four hours, so officer conveyed Celia to hospital. This is against normal protocol however the officer obtained permission, and it is considered this was the most empathetic way to resolve the situation at the time.

[35] Cumbria Constabulary have three types of safeguarding report – domestic abuse, vulnerable adult, and vulnerable child. The domestic abuse safeguarding report includes the DASH assessment.

[36] Safeguarding Domestic Abuse Report – completed by police when responding to an incident involving domestic abuse

15.1.15. The officers took care to speak to staff in charge of her care discretely, and Celia was left in the care of the hospital.

15.1.16. The SAF VA report was discussed at the daily triage meeting, the following day. This meeting is attended by an adult social care team manager (ASC TM) and a representative from the police safeguarding hub team. ASC did not identify a role for them, and CNTW identified that Celia was supported by her GP and had been taken into hospital where PLT would be involved with her. whilst this is deemed as standard practice, there was a missed opportunity for a Persons in a Position of Trust[37] (PiPOT) referral.

15.2. GP Practice A

15.2.1. Practice A is relatively small, but keen to deliver excellent patient care. The practice serves a population of 16,000 patients.

15.2.2. Every patient has a designated "usual GP" although they can see any clinician. For the purposes of letters/information coming into the practice, these are forwarded to the usual GP. In their absence, there is a buddy system, meaning that information is usually brought to the attention of just one or two named GPs, as well as being filed into the patient records for any clinician to access when appropriate.

15.2.3. The practice has had a wellbeing and safeguarding lead since January 2022. The most recent CQC inspection took place in December 2022 and the practice was awarded a 'Good' rating. The practice also had a CQC review in July 2023, and this did not change the rating previously awarded.

15.2.4. The practice adopted the Domestic Abuse policy written by the ICB in 2022. All staff members have access to domestic abuse training via an online learning portal and have to complete this as part of mandatory training. They have also been offered domestic abuse training by Victim Support, and the practice is in the process of identifying a Domestic Abuse Champion.[38]

15.2.5. Staff have been trained in suicide awareness following previous case reviews at the surgery, the most relevant in this case being in January 2022.

15.2.6. On 25th October 2022, Celia called the practice and spoke with her GP to report significant issues with pain. Celia disclosed to her GP problematic alcohol use, to help alleviate her pain, and her GP immediately made her a face-to-face appointment. This was the start of excellent continuity and follow up plans between Celia and her GP.

[37] Persons in a Position of Trust (PiPoT) are individuals whose job or voluntary role involves close contact and authority over children or vulnerable adults. These roles often place them in situations where they can influence or have an impact on an individual's life, well-being or development. Where a concern is raised that a PiPoT has behaved in a way which could harm, this should be flagged with the local authority using a PiPoT form.

[38] Domestic and Sexual Abuse Champions Network : Cumbria County Council (cumbriasafeguardingchildren.co.uk)

15.2.7. Following an overdose the following day, Celia's GP placed Celia on weekly prescriptions to reduce the opportunity for future overdoses.

15.2.8. Celia's GP booked her into a face-to-face consultation following this overdose, where Celia opened up about her main issues, these were pain, recent overdose, fear of losing her job, and family situation – she mentioned the assault on her by Jim the previous month. There is very good documentation of an action plan, including clear follow up plans, which were actioned.

15.2.9. Celia's GP told the author of the IMR that Celia had been very open with her about her issues with Jim, and she felt they had a good rapport, and Celia would have told her if she was struggling. Celia was always adamant when she spoke to her GP that her mood was not related to any issues with Jim. She put her mental health issues primarily down to chronic pain, and then the shame of the situation at work when she was accused of drinking, even though she had not been drinking that morning.

15.2.10. During the phone call on 10th November 2022, when Celia told her GP that she was intending to jump in the river, Celia was kept as calm as possible by her GP, who was able to keep Celia talking while simultaneously messaging the GP Practice reception team to call police. This was excellent practice by Celia's GP, for which she should be commended.

15.3. NCIC

15.3.1. Celia had worked in Hospital A ED since July 2021, and as has been detailed within this report she was also provided with urgent care treatment within the ED.

15.3.2. There is evidence from Celia's employee files dating back to 2011 which indicated that Celia was a victim of domestic abuse. NCIC has appropriate policies and procedures in place for accessing services to help staff identify domestic abuse, and also an expectation to practice professional curiosity. However, these policies were inconsistently followed, and staff speaking to the IMR author stated they did not feel confident approaching the topic of domestic abuse with a colleague.

15.3.3. Staff also told the IMR author that clinical supervision was not available, and there was no safeguarding supervision undertaken. Some staff voices a culture of "getting into trouble" if things went wrong and described a "reactive approach". This review highlights the need for a robust supervision process for ED staff, which would provide staff with the opportunity to address challenges and issues in a more proactive and positive manner.

15.3.4. Throughout the course of Celia's employment with NCIC, she had thirty-three periods of sickness from work. She also had seven attendances to ED, four of which should have presented a reason for staff attending to her to consider asking about domestic abuse. There also did not appear to be any consideration of Celia's suicide risk.

15.3.5. Applying professional curiosity to these sickness periods would have been in line with the Trust's policy.[39] This policy details a list of potential indicators of domestic abuse, which should prompt selective enquiry into reasons for absences. The causes of sickness which Celia was giving fit into the categories within the policy.

15.3.6. During the attendances to ED in October and November 2022, Celia disclosed that home was a trigger to her current mental health state. There are records that nursing staff who initially cared for her asked about domestic abuse, and Celia's friend told the Independent Chair that nursing staff tried to start the process of a DASH being completed. However, it was recognised at this time that resus was not the best place for the completion of a DASH. Following Celia's hand over to care to PLT, there appears to have been a gap in communication between the two teams, and subsequently the plan for a DASH completion seemed to have been forgotten.

15.3.7. These two episodes of care raise several learning points which require attention to ensure preventative and protective safeguarding arrangements are strengthened in the future, particularly for those individuals who work within the organisation.

15.3.8. The IMR author conducted numerous interviews with NCIC staff members, and their reflections indicated that when approached regarding concerns relating to domestic abuse Celia "played down" incidents, stating this was due to her husbands acquired brain injury and that police were already involved, also that the alleged perpetrator was seeking support. It was also reported that Celia didn't directly want to speak to colleagues surrounding the disclosures. Staff felt this made it challenging to provide further support to Celia to safely manage the ongoing situation.

15.3.9. NCIC Domestic Abuse Policy requires that individual staff do not take lone responsibility for dealing with such situations, and the review has raised the need for the introduction of mechanisms and processes to assist with situations such as these. For example, staff should be encouraged to access the NCIC Safeguarding Team, or ask for support from HR; rather than perceiving that asking for help will lead to a punitive response.

15.3.10. Hospital A also has a dedicated Independent Domestic Abuse Advocate, who would have been available to provide specialist and enhanced support to the staff caring for Celia, or to Celia herself. This review has raised a clear need for awareness raising, training and guidance for management, to assist with supporting their employees where there is suspected or disclosed domestic abuse.

15.3.11. Also, the majority of the referrals into the Trust's Occupational Health services lacked information about disclosures and concerns of domestic abuse, mental or substance use. The Occupational Health referrals concentrated on Celia's physical health and did not take into account Celia as a "whole person".

15.3.12. The IMR author spoke with the Occupational Health practitioner, who reflected that the Occupational Health role was perfectly positioned to be upskilled, with

[39] Safeguarding Guidance: Domestic Abuse – July 2020

dedicated training around domestic abuse, including the ability to complete a DASH. This will form a recommendation from this review.

15.3.13. Celia did not access the NCIC Staff Psychological Services. Access to these is via either self-referral or referral from a staff member's line manager. It is unclear whether Celia was given the option to self-refer.

15.3.14. At the time of Celia's death, she had recently commenced on the NCIC alcohol pathway. Celia had stated that her use of alcohol was as pain relief from the chronic pain she was experiencing. The pain, and the subsequent alcohol use, were directly impacting her ability to carry out her duties at work.

15.3.15. There was a sense when speaking to Celia's colleagues and managers that staff had been aware of Celia's struggles with alcohol for many years. Celia was known to cancel shifts at short notice and was identified as sounding intoxicated when she called to cancel. This never prompted any form of intervention or discussion by her employers. Had the Alcohol & Substance Misue Policy been utilised as a proactive preventative tool as intended, then there would have been potential for informal discussions to have been initiated. This may have led to earlier intervention and support being wrapped around Celia in a trauma informed way, compromising of a supportive risk assessment and reasonable adjustments which may have enhanced her capability to work in the form of an Alcohol or Substance Misuse Agreement being drawn up.

15.3.16. During the IMR author's interviews with Occupational Health staff, the contents of the Substance Misuse Policy were discussed. It was reflected how in parts, the policy could appear to be negative, rather as supportive and trauma informed. The policy has recently been reviewed to ensure a trauma informed approach.

15.3.17. There was no disciplinary action taken from the incident where Celia attended work potentially under the influence of alcohol. She was simply sent home, which raises the concerns for whether she was left to drive herself home, or if alternative arrangements had been considered in line with the Trusts policy. Due process should have been followed, including consideration of the Persons in Position of Trust Policy.

15.3.18. However, following this incident, an urgent face to face appointment was booked for Celia to see the Occupational Health doctor. During this appointment was the first time that Celia was asked about domestic abuse, as an employee. Celia disclosed the abuse, however she normalised this, referencing Jim's acquired brain injury. The notes refer to "complex domestic stresses" and also possible caring responsibilities for Celia in terms of Jim's care, although this informal caring was not acknowledged as potentially an additional stressor or placing her in a vulnerable position regarding domestic abuse. There is no indication within the notes that Celia was offered a carer's assessment.

15.3.19. During this appointment an agreement was made regarding reasonable adjustments to be implemented to enable Celia to return to work on a phased return, and several wellbeing resources were provided to her at this point.

15.3.20. With a long-term chronic pain condition, a partner who was violent and required her to care for him, a problematic alcohol issue and long-term mental health issues, Celia may have had feeling is hopelessness. She was known to be proud of her job and had told professionals that she did not want to lose this role. There is no indication that Celia's managers, the Occupational Health team, or anyone else linked to NCIC identified that this may place Celia at a risk of harm from herself. The Trust requires more advice and support for their staff with long term conditions.

15.3.21. There was also little consideration given to the possible shame felt by Celia, attending her place of work as a patient. She is recorded as leaving the mental health ward due to this stigma. Stigma and shame can be associated with delays in seeking treatment, avoiding clinical encounters, poor adherence to treatment, mental distress, mental ill health and an increased risk of the recurrence of health problems. What this means is that while an illness or health condition can cause physical discomfort, suffering and possibly even impairment, the stigma one experiences alongside the condition or illness can bring a whole host of additional social, psychological and health burdens.

15.4. CNTW

15.4.1. CNTW is a mental health and disability Trust, serving a population of approximately 1.7 million. The Trust works from over 70 sites across Cumbria, Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland. The Trust also has a number of regional and national specialist services.

15.4.2. CNTW Trust has a Domestic Abuse policy for staff to follow. The policy clearly explains what actions need to be undertaken when domestic abuse is suspected or disclosed. Staff are expected to complete DASH, make appropriate referrals to the MARAC, referring to Independent Domestic Abuse services and other agencies as appropriate.

15.4.3. Advice, support and supervision can be obtained from the Trust Safeguarding and Public Protection (SAPP) team as required.

15.4.4. All clinical staff have mandatory Safeguarding training level 3 including recognising domestic abuse and the actions that should be taken. There is additional learning available via, team briefs, management cascade, local induction training, awareness sessions, a staff handbook, face to face training, and e-learning.

15.4.5. During assessment by PLT on 26th October 2022 Celia disclosed experiencing domestic abuse from her husband, who she stated had suffered a brain injury which had changed his behaviour. There were several attempts made by the Crisis Team to further explore this with Celia, she was reluctant to discuss further, but stated it was a one-off incident.

15.4.6. There had been a plan following Celia being discharged from the Mental Health Unit that referrals would be made to the local drug and alcohol service and the persistent physical symptoms service. These referrals were not made.

15.4.7. Celia disclosed to CNTW staff that she used alcohol to cope with her pain, however also denied that alcohol was a problem for her. She would on occasion agree for a referral to the local drug and alcohol service but on other occasions declined referrals saying that she was not dependent on alcohol that she could stop if she wished. There was a note in Celia's records that a referral had been made the alcohol services, however it appears this was not completed until the day Celia was discharged from the Crisis Team – this was the day before she passed away.

15.4.8. CNTW were not aware of the information held about domestic abuse by any other agencies and were only aware of what Celia told them; this being that there had been one incident of violence from Jim and that this was due to his brain injury.

15.5. NWAS

15.5.1. NWAS covers five geographical areas across the North of England. Suicide has become a prominent theme within DHR information requests across all of the areas within the Trust. In response to multi-agency learning across completed DHRs, NWAS has heavily promoted professional curiosity as part of any assessment and in particular with patients in mental health crisis, to identify patients who are suffering abuse.

15.5.2. Safeguarding information is shared with partners in various ways within NWAS. All concerns identified or disclosed are expected to be documented on the patient report form which is a predominantly medical form detailing the patient demographics, medical history, clinical observations, social circumstances and agreed plan for care. During clinical handover at hospital the information is shared verbally, and a copy of the patient report form is available for hospital records.

15.5.3. In circumstances where the patient does not require hospital treatment, concerns and disclosures are shared via verbal referral with partner agencies such as GP or mental health teams.

15.5.4. Safeguarding concerns within NWAS are raised electronically via a dedicated support centre who input the information provided by clinical staff. The system which was in place during the majority of the review timeframe was ERISS (2.4) and utilizes the postcode of the patient's home address to identify the responsible Local Authority to receive the concern. This system has now been replaced by CLERIC which operates in the same way as ERISS in terms of appropriate service and an Early Help referral pathway has been further developed to compliment the Safeguarding procedures.

15.5.5. All patient facing staff and those involved with clinical triage of patients are identified and profiled for level 3 safeguarding training. The content is written by the Safeguarding Team in line with the intercollegiate document. The training package is updated annually and includes scenarios to encourage discussions and is delivered by the learning and development team. Safeguarding training is a yearly mandatory training offer.

15.5.6. Educating staff around the wider context of Domestic Abuse and the emotional and psychological effects that control and coercive behaviours have on victims has been a focus for the Safeguarding Team.

15.5.7. The aim is to ensure staff utilise professional curiosity with every patient and especially when faced with a patient who maybe in mental health crisis to explore the reasoning behind the presentation and provide a safe and supportive environment to ease any disclosures that the patient is willing to make. Often patients feel safe enough to disclose any abuse they are suffering during transport to hospital as it is predominantly one to one and away from the home environment, relatives, or partners.
15.5.8. It is expected practice that patient facing staff are open and honest with patients who disclose that there is a duty of care to share the information with appropriate partners to ensure support beyond the NWAS contact.

15.5.9. NWAS had six contacts with Celia during the scoping period. These were for a mixture of medical issues and latterly mental health crisis and took the form of face-to - face assessments and telephone triage/referral outcomes.

15.5.10. Celia was seen face-face on two occasions prior to her death and clinical assessments were completed at her home address except for one incident where she was visiting a friend in Preston.

15.5.11. Contact began with Celia due to her suffering issues with back pain. Her mental health appears to have deteriorated significantly in October 2022. A 999 call was made by Celia's daughter on 22nd October 2022, and the appropriate response was provided, with Celia's situation being re-triaged when new information was provided. When crew arrived at the scene, Celia declined to attend ED due to being employed in the department; her capacity was assessed as lacking in terms of decision making about attending ED, and she was conveyed in her best interests. This was correct practice.

15.5.12. On arrival at ED a paramedic crew member spoke with the ED consultant about Celia's concerns and the consultant gave assurances that Celia would only be spoken to when she was in a more stable condition.

15.5.13. NWAS staff were not aware that Celia had been subjected to domestic abuse, and she did not disclose this to crew. NWAS frontline clinicians do not have caseloads and will normally only attend a patient once. Therefore, each incident is viewed through fresh eyes. During the scoping period, patient facing clinicians did not have access to medical records, and were therefore reliant upon the patient, or those at the scene to share information. Since September 2023, NWAS frontline clinician now have access to the National Care Records Service, and are able to now deliver more personalised care, with the awareness of a patient's medical history.

15.6. Victim Support

15.6.1. Victim Support offer support to victim/survivors of domestic abuse, and also to alleged perpetrators of domestic abuse. Both Celia and Jim were referred into Victim Support by police following the second incident involving police.

15.6.2. At the time of the referrals into Victim Support, the Independent Victim Advocacy Service had a high number of vacancies and were utilising agency staff to ensure business continuity.

15.6.3. Victim Support employ both Independent Domestic Violence Advocates (IDVAs), who support high risk victim/survivors and are trained to a national Safe Lives accredited standard; and Independent Victim Advocates (IVAs) who support victims with lower-level risks.

15.6.4. Celia was referred to an IVA on 3rd October 2022, four attempts were made to Celia to offer support, however the IVA was unable to speak with Celia and her case was closed.

15.6.5. A referral was made to Turning the Spotlight for Jim on 25th October 2022. This referral was made by the Remedi Pathways worker. At the time Jim was undergoing Pathways as a deferred caution following the incident on 3rd October 2022. Following a call to Jim, he declined engagement with Turning the Spotlight, stating he wanted to concentrate on the Pathways work. The case was subsequently closed.

15.6.6. There was a delay in the IVA attempting initial contact with Celia following receipt of the referral, this was initially due to a delay in a telephone number being provided by police. When the IVA made the call to Celia using this number, Jim answered. And finally, a further number was provided to the IVA, however three attempts to call Celia were unsuccessful, and the case was closed.

16. Conclusions

16.1. Celia was working in a high-pressure role, whilst living 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.

16.2. 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.

16.3. 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.

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

16.5. 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.

16.6. 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.

16.7. 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.

16.8. 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.

17. Lessons to be Learnt

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

17.2. 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."[40] As has been discussed above, Celia was not identified as a suicide risk throughout her engagement with health and social care agencies.

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

17.4. 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

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

treated by her colleagues when intoxicated and suicidal. These elements would have exacerbated her risk of suicide.

17.5. 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.

17.1. Cumbria Constabulary

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

17.1.2. 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.

17.1.3. 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.

17.1.4. 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.

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

17.2 GP Practice A

17.2.1. 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.

17.2.2. 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.

17.3. NCIC

17.3.1. 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.

17.3.2. 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.

17.3.3. 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.

17.3.4. 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.

17.4. CNTW

17.4.1. 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.

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

17.4.3. 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.

17.4.4. 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.

17.4.5. 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.

17.4.6. 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.

17.4.7. 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.

17.4.8. 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.

18. Recommendations

18.1. Multi Agency Recommendations

18.1.1. 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.

18.1.2. 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.

18.1.3. 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.

18.1.4. 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.

18.2. Cumbria Constabulary

18.2.1. 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.

18.3. GP Practice A

18.3.1. 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.

18.4. NCIC

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

18.4.2. 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.

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

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

19.1 The Review Panel makes the following recommendations from this DARDR:

	Paragraph	Recommendation	Organisation
1.	18.1.1	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.	
2.	18.1.2	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.	
3.	18.1.3	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.	
4.	18.1.4	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.	
5.	18.2.1	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.	Cumbria Constabulary

6.	18.3.1	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.	GP Practice A
7.	18.4.1	Audit of the implementation of the 'How Safe do you Feel Campaign' across the organisation to evidence the output of the training delivered.	NCIC
8.	18.4.2	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.	NCIC
9.	18.4.3	A programme of awareness raising will be delivered to increase the uptake of Safeguarding Supervision across the Emergency Department.	NCIC
10.	18.4.5	Occupational Health staff within the Trust will receive mandatory DASH Risk Assessment training.	NCIC

18. Action Plan

	Recommendation	Scope	Action To Be Taken	Lead Agency/ Accountable Professional	Key Milestones	Target Completion Date	Outcome and Date of Completion
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.						
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.						

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

5	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.	Cumbria Constabulary					
6	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.	GP Practice A					
7	Audit of the implementation of the 'How Safe do you Feel Campaign' across the organisation to evidence the output of the training delivered.	NCIC					
8	An enhanced training package for Leaders and Occupational Health colleagues on 'Managing Difficult Conversations' will be developed. The package will include the	NCIC					

	importance of applying professional curiosity and trauma informed practice to policy and procedures.						
9	A programme of awareness raising will be delivered to increase the uptake of Safeguarding Supervision across the Emergency Department.	NCIC					
10	Occupational Health staff within the Trust will receive mandatory DASH Risk Assessment training.	NCIC					