SWINDON
COMMUNITY SAFETY
PARTNERSHIP

DARDR 7

Executive Summary of the death of Mitchell in November 2022

Parminder Sahota

DATE REPORT COMPLETED: APRIL 2025

Preface

To ensure confidentiality, only the authors' and review panel's names have been disclosed; all other names are pseudonyms, as accepted by the family.

The independent author and review panel send their deepest condolences to all those impacted by Mitchell's untimely passing and thank them for their involvement and support in this process. The primary objective of a Domestic Abuse Related Death (DARDR) is to permit the learning of lessons from the death of a person in a relationship where domestic abuse was known to have occurred. Professionals must understand what transpired in each instance for these lessons to be thoroughly and effectively assimilated and what must be altered most to reduce the likelihood of such tragedies.

The author thanks the panel and persons who submitted chronologies and materials for their time and cooperation.

"Mitchell was the life of the party, bubbly, outgoing, energetic, loved travelling and was loving."

Katie (sister)

"Mitchell always wanted to help people; he was kind-hearted and would do anything for anyone; he would go without to help others.

Brianna (Mum)

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Section One: The Review Process

1.1.1 This summary outlines the process undertaken by the Keeping Swindon Safe Partnership domestic homicide review panel in reviewing the death of Mitchell, who was a resident in the area.

1.1.2 The following pseudonyms have been used in this review for the victim and partner to protect their identities:

- The victim: Mitchell
- The Mother: Brianna
- The Sister: Katie
- The Friend: Jack
- The Partner: Abe

1.1.3 Mitchell was 25 years old at the time of his death; he was born in Swindon and had two siblings. His parents separated when he was five, and his father and brother lived abroad. His family reported he had a 'rocky' relationship with his father and lacked a male role model growing up.

1.1.4 Mitchell received mental health services; he was diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) and prescribed pharmacological treatment; however, the prescription was discontinued due to his history of overdosing on ADHD medication.

1.1.5 Mitchell had been in a relationship with Abe for four to five years. Both had a history of self-harm and suicidal ideation.

1.1.6 The police's first report of a domestic abuse incident was in November 2018. Further domestic abuse reports suggest they were both recorded as victims and perpetrators.

1.1.7 Mitchell had overdosed on prescribed medication; he was reported missing to the police by his Abe. Mitchell was involved in a fatal traffic collision.

1.1.8 The process began with the Keeping Swindon Safe Partnership meeting on 12 May 2023, when the decision to hold a domestic homicide review was agreed upon. All agencies that potentially had contact with Mitchell and Abe before the point of death were contacted and asked to confirm whether they had been involved with them.

1.1.9 Eight agencies confirmed contact with Mitchell and/or Abe and were asked to secure their files.

1.1.9 The medical cause of death was:

1a Multiple Head and Body Injuries due to

1b Road Traffic Collision.

Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

Agency and Profile	Contribution-Chronology/IMR/Summary/Other
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) Provides inpatient and community-based mental health care to 1.6 million people across our region.	Chronology and IMR
Avon and Wiltshire Mental Health Partnership NHS Trust Improving Access to Talking Therapies It provides help to manage a range of common mental health problems, including anxiety, stress, depression, and low mood. Matching the difficulties experienced with evidence-based treatments.	Chronology and IMR included contact with talking therapies.
GP - Mitchell	Chronology and IMR
GP – Abe	Chronology
Great Western Hospital NHS Foundation Trust (GWH) General Hospital	Chronology and IMR
Nelson Trust - Abe The Nelson Trust's Residential Rehabilitation Treatment and Women's Community Services span Gloucestershire, Wiltshire, Somerset, Bristol, and Wales. Services are trauma-informed and gender-responsive and provide holistic support for those affected by addiction and their families.	Chronology and Summary Report
South Western Ambulance Service NHS Foundation Trust (SWASFT)	Chronology
Wiltshire Police	Chronology and IMR

2.1.2 The chronologies and reports were authored by professionals independent of the case management or service delivery.

Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

Name	Role	Organisation
[redacted]	[redacted]	Nelson Trust
[redacted]	[redacted]	Avon and Wiltshire Mental Health Partnership

		Swindon Community Safety Partnership
		Avon and Wiltshire Mental Health Partnership
		Wiltshire Police
		Swindon Women's Aid (Swindon Domestic Abuse Support Services)
		Swindon Borough Council Adult Social Care
		Community Safety Partnership
		Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board
		Swindon Borough Council Housing
		Great Western Hospital

3.1.2 The ManKind initiative and Public Health reviewed the final report.

3.1.3 The panel met a total of four times.

Section Four: Author of the Overview Report

4.1.1 Parminder Sahota is an independent author with over ten years of experience in domestic abuse and safeguarding. Advocacy After Fatal Domestic Abuse provided the DHR Chair training in 2021. She has worked as a mental health nurse in the NHS for over twenty years and is a Director of Safeguarding, Prevent, and Domestic Abuse Lead for an NHS Trust.

4.1.2 Parminder is independent of all agencies involved and had no prior contact with family members or the Keeping Swindon Safe Partnership.

Section Five: Terms of Reference for the Review

5.1.1 The statutory guidance sets out the purpose of domestic homicide reviews to:

- Establish the facts that led to the death in November and whether any lessons can be learned from the case about how local professionals and agencies worked together to safeguard Mitchell.
- Establish what lessons will be learned from the death regarding how local professionals and organisations work individually and together to safeguard victims.

- Identify these lessons, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change.
- Apply these lessons to service responses, including changes to inform appropriate national and local policies and procedures.
- Prevent domestic violence and related deaths and improve service responses for all domestic violence and abuse victims by developing a coordinated multi-agency approach to identify and respond to domestic abuse at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic abuse.
- Highlight good practice.
- Ensure that Mitchell's voice is heard regarding her experiences and the impact of the domestic abuse. Allowing her journey to be told and identifying the lessons that may be learnt.
- Ensure that Mitchell's voice is heard regarding her experiences and the impact of domestic abuse. Allowing his journey to be told and identifying the lessons that may be learnt.

5.1.2 The review's time frame was from July 2019 to November 2022. The selected chronology resulted from November 2018, which was the first report of domestic abuse to the police.

5.1.3 The panel set fifteen terms of reference. The terms of reference were forwarded to Brianna, who accepted them and emphasised that agencies had overlooked Mitchell, a male victim of domestic abuse.

Section Six: Summary Chronology

November 2018

6.1.1 The relationship was established between Mitchel and Abe.

6.1.2 The first domestic incident reported between the couple was Abe's report to the police that Mitchel had taken out a loan in her name. The police were subsequently informed that the money had been refunded, and she no longer wished to file a complaint.

July 2019

6.1.3 A third party reported Mitchell and Abe to the police following a verbal argument.

October 2019

6.1.4 The police contacted the ambulance service following reports of injured female domestic abuse victims. Abe informed the police that she and Mitchell were as bad as each other.

December 2019 – March 2020

6.1.5 Five reports of domestic disputes between the couple surfaced, the majority of which involved verbal altercations. Abe, who once struck and kicked Mitchell, was arrested, questioned, and given a caution. Ongoing calls to the police regarding domestic incidents involving the couple contain allegations of assault (e.g., pushing and hitting). However, upon the arrival of the police, neither assault nor any mention of assault was present, and the couple claimed they had merely been engaged in an argument. Officers did not observe any injuries on each occasion.

6.1.6 This was the initial instance in which Abe was issued a caution after her assault on Mitchell.

6.1.7 Public Protection Notice[1] (PPN) and a Domestic Abuse, Stalking, and "Honour"-Based Violence[2] (DASH) assessment was completed on the following occasions:

- Dec 2019 – PPN, which includes DASH, was completed with Abe listed as the victim. This was graded as standard risk.
- January 2020 – PPN, which includes DASH, was completed with Mitchel listed as the victim. This was graded as standard risk.
- February 2020 – PPN, which includes DASH, was completed with Mitchel listed as the victim. This was graded as standard risk.
- 6th March 2020 – PPN, which includes DASH, was completed with Mitchel listed as the victim. This was graded as medium risk. This was the incident in which Abe was cautioned.
- 26th March 2020 – PPN, which includes DASH, was completed with Abe listed as the victim. This was graded standard risk

February 2020

6.1.8 Abe and Mitchell exchanged text messages in which Abe requested that Mitchell return home and informed him that she had no one. Mitchell requested that she vacate the residence at noon on 14 February 2020. He wrote, *"I will no longer put up with the violence and controlling behaviour you cause. I'm sorry it's come to this"*

6.1.9 Abe responded by stating: he sounded like his mum, and *"…you're not sorry you never cared about me! You're not perfect. You're a gambler and will always be one! I've already gone,"*

April 2020

6.1.10 Mitchell's mother reported him missing; she had received text messages from him expressing suicidal ideation and a desire to be a "burden no longer." Since Mitchell was

[1] https://hmicfrs.justiceinspectorates.gov.uk/glossary/public-protection-notice/
[2] https://safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf

considered a high-risk missing person, officers searched for him. Mitchel, who had overdosed on his ADHD medication, had returned home; an ambulance had since transported him to GWH.

6.1.11 Mitchell was promptly located by the police, who ensured that he received the necessary care and treatment following the overdose.

6.1.12 Mitchell and the landlord exchanged text messages. Mitchell reported that the police had attended the address and believed it was unjust to the other residents. He requested that the codes for the safe be modified. *"… She let herself in yesterday, which caused more issues."*

6.1.13 The landlord reported receiving complaints from the other residents, who had reported loud arguing and fighting, and the police and ambulance coming to the address. Mitchell was requested to vacate the property.

6.1.14 Mitchell texted the landlord to inform them he had been admitted to the hospital and stated: "I'll be getting the help I need, but unfortunately, *the domestic abuse went too far. I will be out ASAP, I'm currently on a cardiac ward as I am in a bit of a position"*

6.1.15 Micthell was admitted to the GWH with an overdose of oral medication. The risk was assessed as 'amber' on the risk assessment matrix. Reports suggest Mitchell advised the practitioner he was depressed and the overdose was intentional. ADHD diagnosis was noted.

6.1.16 He was referred to and seen by the AWP Mental Health Liaison Team (MHLT), and that service gave specialist support and advice. AWP mental health risk assessments did not highlight alcohol as an identified concern. AWP have access to ED notes.

6.1.17 Mitchell was admitted to a cardiology ward for further monitoring due to palpitations.

6.1.18 The ADHD Service took appropriate action in halting further prescriptions, and a plan was put in place to review Mitchell again in 3 months should Mitchell request this.

May 2021

6.1.19 Michell called the ambulance following an overdose of his ADHD-prescribed medication. He reported experiencing stress, and he had lost his job and fallen out with family and friends. He regretted the overdose.

6.1.20 Mitchell was taken to GWH by ambulance and seen by AWP. He was reviewed and assessed as low-risk and discharged two days later.

October 2021

6.1.21 Abe contacted the police to report that Mitchel had assaulted her twice between September and October. After photographs of the injuries were taken, Mitchel was arrested. He asserted that he was acting in self-defence and denied the assault. No further action was taken. Attending officers have consistently completed and submitted PPNs to the Multi-Agency Safeguarding Hub (MASH) in response to domestic abuse incidents. The officers concluded the process of safeguarding.

November 2021

6.1.22 Mitchel reported Abe's assault to Thames Valley Police while in Reading; Abe was arrested, and no further action was taken against her.

March 2022

6.1.23 Mitchell was provided with a telephone review of his treatment by the ADHD team. Following the May 2021 incident, he had not taken his medication. At the time, he was reportedly in a difficult situation, living with his mother and stepfather, and family disputes were occurring. He had been unemployed and was grappling with a gambling addiction. He had joined a gambling support group, begun an apprenticeship, and moved in with Abe. He wished to restart his ADHD medication. Due to his history of overdosing on the medication, it was decided that this should be discussed with the Multi-Disciplinary Team (MDT).

April 2022

6.1.24 Abe contacted the police because she was concerned for Mitchell's safety. After an altercation, Mitchell declared that he wanted space and left the premises. He did not reply to attempts to contact him. He was located at a friend's house.

6.1.25 A PPN and a risk assessment for Domestic Abuse, Stalking, and 'Honour'-Based Violence (DASH) were conducted for Abe as the victim and Mitchell as the suspect and shared with the Police Multi-Agency Safeguarding Hub.

May 2022

6.1.26 Mitchell sought treatment at the Emergency Department (ED) for a head injury. He recounted being low and having a "psychotic episode" before self-injuring by hitting his head against a wall.

6.1.27 Mitchell had overdosed on a combination of Paracetamol X16, Ibuprofen X16, and Omeprazole X 12. Mitchell had taken the overdose and then fallen out with Abe. He walked

to the park with his cousin and consumed an undetermined alcohol. No low mood, life pressures, suicide ideation, or physical symptoms were reported by Mitchell.

6.1.28 The ADHD MDT discussion. Due to the three overdoses, the team deemed the risk of overdose to be considerable, and hence, no ADHD medication was prescribed. Mitchell was offered an appointment.

June 2022

6.1.29 Mitchell did not attend the appointment for ADHD. Following two previous overdoses of his ADHD medication, he was discharged from the ADHD service. The team felt that prescribing this medicine would represent a significant risk, and Mitchell would need to contact his GP for mental health support.

July 2022

6.1.30 Mitchell flagged down police officers and reported that he and Abe had a verbal altercation. Abe refused to leave the vehicle after a dispute over a shared mobile phone. Mitchell spent the night with friends, while Abe stayed with her family. The police MASH received a PPN containing a standard-rated DASH.

September 2022

6.1.31 Mitchell acknowledged receipt of the discharge letter from the ADHD service and, although understanding the risks of an overdose, he proposed a seven-day prescription because he suffered significantly more without it. He had lost his job. However, due to the risk, the discharge remained.

October 2022

6.1.32 Mitchell had been hitting his head against a wall and had acquired injuries as a result. The Police conveyed him to GWH while intoxicated. Mitchell reported to the police that Abe had assaulted him and scratched his neck. Due to his intoxication, a full account could not be taken.

6.1.33 Mitchell informed the officer after hospitalisation that he was not filing a complaint and had lied to the police. He said Abe's attempt to stop him from doing drugs resulted in a scratch on his neck. He indicated that he and Abe were receiving support and did not perceive themselves in an abusive relationship.

6.1.34 Information regarding domestic abuse services was provided to Mitchell. A standard operating procedure was placed at his home to ensure that officers were aware of the history of domestic abuse, and a PPN was submitted to the Police MASH.

6.1.35 GWK referred Mitchel to the Mental Health Liaison Team (MHLT). He reported to MHLT that he was drinking excessively to regulate his emotions. The team observed signs of self-neglect; his mood was low, and he could not afford meals. He expressed his desire to end his life by suicide. Concerning his prior unsuccessful efforts, he indicated that he had a concrete plan that involved jumping off a bridge after leaving the hospital. He was referred to the Swindon Intensive Support (SIS).

6.1.36 The GWH notes recorded by AWP stated that he experienced a recent bereavement and ended a four-year relationship last night. He was currently experiencing a crisis and could not return to his ex-girlfriend's home. The hospital notes recorded 'domestic abuse'. Mitchell left GWH with his girlfriend. It was uncertain whether the GWH staff had read the notes by AWP, which stated: "domestic abuse." Furthermore, it should be noted that AWP did not provide a verbal handover of the disclosure, and the record lacked explicit definitions of abuse and victim status for Mitchell.

6.1.37 Mitchell was assessed by SIS, who agreed to provide him with home treatment (intensive support at home to provide an alternative to hospital admission) and contacted the ADHD team to reinstate Mitchell's medication.

6.1.38 Mitchell revealed periodic binge drinking and described the stresses of living in a shared residence due to his diagnosis of ADHD and prior trauma. As a result of his financial issues, he was forced to sell his phone to purchase food. He indicated that he would like to return to work, but his unstable mental health prevented him from doing so. As Mitchell continued to have suicidal thoughts, SIS highlighted the risk of suicide.

6.1.39 SIS agreed to write a letter that he could provide housing to support a move to appropriate accommodation and to discuss with the specialist ADHD team regarding medication and a re-referral.

6.1.40 Abe informed SIS that Mitchell had not slept well, was experiencing pain, and could not attend the appointment.

6.1.41 SIS sent an email request to the ADHD team to discuss medication for Mitchell.

6.1.42 Mitchell attended SIS, where they explored the effects of alcohol and narcotics on his mental health. Mitchell disclosed that he was a social drinker and had experimented with cannabis but did not presently use it. He had used cocaine, which had a calming effect on him, but he said he no longer used it due to negative experiences.

6.1.43 SIS and the ADHD team manager discussed it; the ADHD service agreed to assess Mitchell in a month and consider restarting his medication, as it was acknowledged that he had responded well.

6.1.44 SIS visited Mitchell's home: Mitchell was not at home. SIS gave Abe an opt-in letter requesting that Mitchell make contact.

6.1.45 Abe called an ambulance (999 call) because she was frightened that Mitchell was experiencing a seizure since he repeatedly hit his head against the wall. Mitchell was transported to GWH.

6.1.46 Mitchell was brought to the hospital by ambulance after he was discovered hitting his head against a wall. According to the police, Mitchell had been out drinking, became stressed, and then began banging his head against the wall. There was speculation that he had suffered a seizure. He was discharged home and left with his girlfriend.

6.1.47 Mitchell called SIS to report that he had been attempting to get in touch after receiving the opt-in letter. He was informed that he was discharged. Mitchell said he was experiencing mental health issues and lacked a phone. The SIS told him he could use his partner's phone, but the news of his discharge was disappointing. SIS sent Mitchell's GP a discharge summary.

November 2022

6.1.48 Mitchell was admitted to the ED owing to excessive intoxication. Alcohol intoxication was diagnosed in the context of depression and suicidal ideation. There was no documentation to report the referral or consideration of alcohol services. Mitchell reported feeling depressed and had suicidal thoughts and drank to "feel numb." He stated he was scheduled to see his GP but had no phone.

6.1.49 Mitchell was seen by AWP and indicated that his mother was on holiday abroad, that his brother lived abroad, that he is separated from his sister, and that he does not get along with his stepfather. He indicated that his mental health prevented him from maintaining employment and that he had been abusing alcohol. He was referred to the SIS.

6.1.50 SIS contacted Mitchell, but he did not respond. SIS contacted Abe, and Mitchell acknowledged that this was the best number to reach him.

6.1.51 Mitchell and Brianna met with SIS, and Mitchell explained that he had stopped engaging with SIS because he found it upsetting to examine his triggers. When he received the opt-in letter, he reported having a rough day and would have benefited from SIS support. He asserted that he did not overdose and believed that his drink was spiked. He wished to resume taking his ADHD medication. Brianna stated she would gladly administer Mitchell's prescription to lessen the possibility of an overdose. Mitchell highlighted housing as an

issue that affected all facets of his life. He was given a letter to support his housing application.

6.1.52 Brianna disclosed to SIS that she had given Mitchell thousands of pounds over the past few years in response to his demands. She reported that he threatened suicide if she did not pay him money. She had to re-mortgage her home and was trying to care for him, considering herself his carer. She was given a carer's leaflet and invited to join the SIS carers' support group.

6.1.53 Brianna called SIS to express concern for Mitchell's safety and to report that he was experiencing a "meltdown" because she refused to give him additional money. According to Brianna, Mitchell had emotionally abused her and had taken out loans and remortgaged her home.

6.1.54 During an unannounced visit by SIS, Mitchell disclosed that he had purchased a plane ticket to visit his aunt in another country. Mitchell mentioned that his friend was waiting for him in a car park and needed a prescription. He believed it would be beneficial to leave Swindon. He agreed to contact the team when he returned. Mitchell was given medication for seven days, which he indicated he would give to his aunt upon his arrival.

6.1.55 SIS called Mitchell to confirm that he had handed his prescription to his aunt, who confirmed that he had. According to the documentation, he sounded upbeat and engaged well.

6.1.56 Mitchell called SIS to let them know he was boarding the airline and to request an appointment. According to his medical records, he was optimistic, had not taken his prescription, and indicated he would explain this during tomorrow's visit

Section Seven: Key Issues Arising from the Review/Lessons Learned

7.1.1 **Male Victims**

7.1.2 Mitchell, who was male, informed AWP and the police about domestic abuse. He confided in his mother that he would not be believed due to his gender; the DASH's findings and the absence of a response from Health may have reinforced his belief.

7.1.3 The majority of the research refers to domestic abuse as a gendered crime. While women are more vulnerable than men, this may have an impact on men coming forward as victims, as well as society's recognition of men as victims.

7.1.4 The absence of a positive male role model can increase a young man's vulnerability to domestic abuse by limiting their understanding of healthy relationships and reducing emotional resilience. This can make it harder to recognise abuse, particularly non-physical forms like coercive control. These factors can also lead to silence and delayed help-

seeking because of stigma or low self-esteem. Services should consider these factors and ensure that support for male victims is accessible, sensitive, and free from gender bias

7.1.5 The following is in place within Wiltshire Police:

- Wiltshire Police rolled out Domestic Abuse Matters training to all frontline officers and staff within the last year, which contained a clear emphasis on the fact that domestic abuse does not discriminate and victims can be from any background/gender. The domestic abuse policy and other training programmes related to investigating incidents of domestic abuse also make it apparent that victims can be of any gender.
- Communication campaigns—The corporate communications department is planning an International Men's Day campaign that will include information about male victims of domestic abuse. The Domestic Abuse, 16 Days of Action, follows very closely after International Men's Day, which gives another opportunity to discuss male victims of domestic abuse alongside other key messages that will be covered as part of that campaign.
- Domestic abuse services are available to men on the website and to the public. The intranet has clear information regarding domestic abuse services, including Mankind and Men's Advice Line. This information is passed on to male victims who are identified through leaflets, passing on contact details, or making referrals on behalf of male victims.

7.1.6 **Coercion and Control**

7.1.7 The offence of controlling or coercive behaviour, where the perpetrator and victim are personally connected, is defined under Section 76 of the Serious Crime Act 2015.

7.1.8 According to the Domestic Abuse Act 2021, domestic abuse isn't necessarily physical. Coercive control is an assault, threat, humiliation, intimidation, or abuse designed to damage, punish, or intimidate the victim. This controlling behaviour is intended to make a person reliant by isolating them from assistance, exploiting them, robbing them of independence, and dictating their daily behaviour.

7.1.9 The following is in place within Wiltshire Police:

- This is covered in the Domestic Abuse Matters training and is also included in other key training programmes which cover domestic abuse and the investigative process alongside key questions being asked in the DASH to assist in identifying coercion and control. Relevant training is delivered to all required officers and staff, including supervisors, on conducting domestic abuse-related investigations and completing the DASH.

7.1.10 **Response to Disclosures of Domestic Abuse**

7.1.11 In April 2022, the Department of Health and Social Care published guidance to further strengthen the response to domestic abuse.

'Domestic abuse is a serious health and criminal issue. Practitioners are in a key position to identify and help interrupt domestic abuse.'

'Health professionals have a responsibility to address the health impacts on people directly or indirectly affected by domestic abuse. They also must ensure that other agencies are engaged to address the social, environmental, and broader impacts. People experiencing domestic abuse may choose to disclose it to health professionals, including GPs.

7.1.12 The following is in place within Wiltshire Police:

- *Pathways and resources for domestic abuse survivors are incorporated into policies and training and covered in Domestic Abuse Matters training and other key training programmes, which include domestic abuse; all officers are aware of signposting agencies and completing necessary safeguarding at the scene or referring to MARAC based on DASH risk grading. Officers can also complete referrals to support agencies on the survivor's behalf*

7.1.13 **Self-Harm, Suicide and Domestic Abuse**

7.1.14 As a means of coping with psychological turmoil, some people resort to self-harm. Self-harm is associated with domestic abuse.

7.1.15 A study, which was conducted in collaboration with Refuge and the University of Warwick, presents comprehensive, original, and detailed evidence regarding the incidence of suicide ideation and attempts among domestically abused individuals in the United Kingdom. This finding provides support for prior research that indicates a substantial correlation between domestic abuse and adverse psychological consequences. Furthermore, it emphasises the need for professionals who work with individuals who have experienced domestic abuse to be more aware of and attuned to their suicidal tendencies.

7.1.16 Wilshire Police will be liaising with the mental health lead in force and speaking to other police forces to understand if Wiltshire Police can implement a routine enquiry for all individuals presenting with self-harm and or suicide

7.1.17 **Professional Curiosity**

7.1.18 Professional curiosity is being interested in the individual and listening to their story without judgment or assumptions.

7.1.19 **Routine Enquiry and Domestic Abuse**

7.1.20 As a result of their regular interactions with victims, healthcare practitioners are appropriately placed to identify and spot domestic abuse.

7.1.21 To aid professionals in facilitating enquiries, a report revealed the subsequent research findings:

- Interpersonal relations – Listening skills, Trust, Empathy
- Safety – Privacy and confidentiality, home visits
- Validation

Section Eight: Conclusion

8.1.1 Mitchell was diagnosed with ADHD; however, the medication was discontinued in June 2021, as Mitchell had overdosed on the medications; he was discharged from the ADHD service in June 2022.

8.1.2 Mitchell had several contacts at the GWH, and they implemented an HIU strategy to support and better understand attendance. However, this was not completed due to Mitchell's death.

8.1.3 Mitchell was referred to AWP following some of the attendances at GWH and received interventions from SIS. Mitchell disclosed to AWP that he was a victim of domestic abuse.

8.1.4 The disclosure was sent to GWH through their clinical records, and both GWH and AWP informed Mitchell's GP practice about the attendance and disclosure.

8.1.5 Mitchell contacted the police to report Abe's domestic abuse towards him.

8.1.6 The review emphasised the numerous publications and guidelines that support Health's response to domestic abuse. Furthermore, Brianna stated that Mitchell, as a male, would not be believed, and the review found that professional curiosity was not employed.

8.1.7 Additionally, the ManKind Initiative asserts that, in their experience, a lack of professional curiosity might result from the public and professional community's failure to recognise and understand male victims. In 2021, the University of Cumbria conducted a study in which it examined 22 domestic homicide reviews in which male victims were involved. According to this study, opportunities were missed due to outmoded assumptions that men could not be victims.

8.1.8 The police provided Mitchell with a directory of domestic abuse services he could access.

8.1.9 According to the "Mapping of Domestic Abuse Services across England & Wales" report by the Domestic Abuse Commissioner, more than two-thirds of male survivors and more

than half of non-binary survivors reported finding it "quite difficult" or "very difficult" to obtain assistance, compared to only one-third of female survivors.

Section Nine: Recommendations from the Review

9.1.1 Recommendation One: Male Victims:

All Participating Agencies

1.1a Swindon Community Partnership to be assured of the availability of resources and staff training in this area from the participating agencies.

1.1b Swindon Community Partnership should consider specific local communications campaigns to encourage the local community-based service/police to come forward around events such as International Men's Day. (This recommendation would also support recommendations two and three.)

1.1c Swindon Community Partnership will collaborate with the Schools Project, Safer Streets, and Young People's Participation in the Safeguarding Children Partnership, ongoing initiatives designed to increase young people's awareness of healthy relationships.

1.1d Ensure that the organisations participating in the Swindon Community Safety Partnership are explicit that domestic abuse services are accessible to all men and women on their websites and in materials readily available to staff, patients, and the general public. (This recommendation would also support recommendations two and three.)

9.1.2 Recommendation Two: Coercion and Control

All Participating Agencies

2.1a All agencies are to ensure that their staff consider coercion, control, and unconscious bias through clinical supervision.

9.1.3 Recommendation Three: Response to Disclosures of Domestic Abuse

All Participating Agencies

GP Practice

3.1.a GPs are to be provided with guidance on recording identifiers on patient records to support the recognition of domestic abuse.

Swindon Domestic Abuse Service

3.1.b Swindon Domestic Abuse service to gather the "lived experiences" of male domestic abuse survivors to have a better understanding of how they perceive the response of agencies when they disclose such abuse.

9.1.4 Recommendation Four: Self-Harm, Suicide and Domestic Abuse

All Participating Agencies

4.1a All individuals who present to services with suicidal ideation must be asked about domestic abuse.

4.1b For public health to include the risk of suicide for victims of domestic abuse in the suicide strategy.

4.1c When self-harm/suicidal thoughts are found in the context of domestic abuse, services must have clear pathways in place to support the disclosure and provide appropriate assistance to the victim/survivor. This could involve assisting the victim/survivor in submitting a referral or referring on their behalf. In addition, consider reporting victims/survivors to MARAC and seeking help for those who do not consent.

National

4.1d The development of supplementary guidance to the DASH risk assessment for risks associated with suicide.

9.1.5 Recommendation Five: Professional Curiosity & Routine Enquiry of Domestic Abuse

All Participating Agencies

5.1a The partnership will provide bespoke Professional Curiosity training to its partners and undertake evaluations three and six months later.