



SWINDON

**COMMUNITY SAFETY
PARTNERSHIP**

Domestic Abuse Related
Death Review DARDR 7

Overview Report into the death of Mitchell in November 2022

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Independent Chair and Author
Date Completed: April 2025



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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 the review panel send their deepest condolences to all those affected by Mitchell's untimely passing and thank them for their involvement and support throughout 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 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)*

1.1 Introduction

- 1.1.1 The report was written after Mitchell, aged twenty-five, died in November 2022. Avon and Wiltshire Partnership NHS Trust (AWP) referred Mitchell to the Swindon Community Safety Partnership (CSP) on 12 May 2023.
- 1.1.2 The case was discussed at a partnership meeting on 10 October 2023. The partnership panel unanimously found that the domestic homicide review (DHR) criteria, in line with the [Domestic Violence, Crime and Victims Act 2004](#), had been satisfied.
- 1.1.3 Additionally, the [Victims and Prisoners Act 2024](#) defines a “domestic abuse-related death review” as a review of the circumstances surrounding a person’s death, conducted— (a) where the death has, or appears to have, resulted from domestic abuse directed at the individual, within the meaning of the Domestic Abuse Act 2021; and (b) for the purpose of identifying lessons to be learned from the death.
- 1.1.4 Although the new term for this review is used, the [Home Office's Multi-Agency Statutory Guidance for Domestic Homicide Reviews \(December 2016\)](#) still governs the review.
- 1.1.5 Mitchell resided in Swindon before his death in November 2022. This review examines the agency's responses and support for Mitchell.
- 1.1.6 In addition to considering agency involvement, the review will appraise the last years of Mitchell’s life (**November 2018 – November 2022**) to determine any relevant background or history of abuse before his death, whether community support was obtained and whether there were barriers to seeking community support.
- 1.1.7 November 2018 was the beginning of Mitchell’s relationship with Abe.
- 1.1.8 This review does not replace criminal or coroner's courts or resemble a disciplinary proceeding.
- 1.1.9 Mitchell had overdosed on medication, and Abe reported him missing to the police. Mitchell was involved in a fatal traffic collision.
- 1.1.10 The toxicology revealed high levels of both over-the-counter and prescription medication, as well as traces of illicit drugs.
- 1.1.11 The medical cause of death was: *1a Multiple Head and Body Injuries due to 1b Road Traffic Collision.*

1.2 Case Summary

- 1.2.1 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.
- 1.2.2 Mitchell had been in a relationship with Abe for four to five years. Both had a history of self-harm and suicidal ideation.
- 1.2.3 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.
- 1.2.4 Between December 2019 and March 2020, police received five reports of domestic abuse between Mitchell and Abe. These included verbal disputes and a report that Abe had once kicked and hit Mitchell. She was arrested and issued a caution.
- 1.2.5 In March 2022, Mitchell and Abe moved into a house of multiple occupancies and lived in separate rooms. Mental health professionals provided him with a housing letter after he stated that housing was a problem.
- 1.2.6 Mitchell struggled to maintain employment and experienced financial difficulties. He asked his mother, Brianna, for £5,000 for a county court judgment, which she later learned was for a holiday for Mitchell and Abe. Brianna added that Mitchell frequently asked her for money, which she discovered was for Abe.
- 1.2.7 Mitchell disclosed binge drinking on occasion, and Abe reported he had a gambling addiction.
- 1.2.8 Following Mitchell's death, Brianna advised AWP that Mitchell was in a "controlling relationship." Abe would make Mitchell's life miserable if he went anywhere without her. Brianna said Abe would wait around the corner whenever Mitchell visited her home. Due to Abe's influence and the family's concerns, Mitchell was requested not to bring Abe to his brother's wedding overseas. Abe, therefore, stopped Mitchell from attending.
- 1.2.9 Brianna reported that Abe had attacked Mitchell and cut his head open. Brianna felt that because Mitchell was six feet tall, no one would assume his girlfriend was assaulting him or would believe him.
- 1.2.10 Mitchell had argued with Abe the night he was reported missing. The police were called regarding a body on the road. Mitchell was identified and suspected of having jumped from a bridge.

1.3 Background Information about Mitchell

- 1.3.1 Mitchell was 25 years old at the time of his death. He was born in Swindon and had two siblings. When he was five, his parents separated, and his father was stated to be living abroad. His family stated that he was not close to his father. Their relationship was described as 'rocky', and he lacked a male role model while growing up.
- 1.3.2 Brianna supported Mitchell financially while he resided with Abe in a shared house.
- 1.3.3 Mitchell disclosed to AWP that he had engaged in self-harm throughout emotional and familial turmoil spanning from 16 to 18 years of age. Two of his overdoses during this period necessitated overnight hospitalisation.
- 1.3.4 A family history of ADHD was also identified during the assessment conducted by the specialised ADHD service in 2018, which resulted in his diagnosis of ADHD.
- 1.3.5 Additional background information can be found in the family/friend's section of the review.

1.4 Timescales

- 1.4.1 The Keeping Swindon Safe Partnership commissioned this Review following the decision on 9 August 2023 to proceed with a DHR; the panel subsequently determined that it should continue as a DARDR, as the death was not classified as a homicide.
- 1.4.2 The DHR Statutory Guidance specifies the requirements for review Chairs and Authors in sections 36 through 39. In this review, the responsibilities of the Chair and Author were merged.
- 1.4.3 The independent author for this review was commissioned on 8 September 2023.
- 1.4.4 The first panel meeting was held on 10 October 2023, at which agencies' detailed chronologies were reviewed, the terms of reference were agreed, and it was determined that six reports would be required.
- 1.4.5 The family received the report in July 2024. The author subsequently met with the family to discuss the report. Advocacy support, initially offered in October 2023, was later accessed in January 2025. This enabled further scrutiny and provided additional time for review, ensuring the family had a full opportunity to engage with the process.
- 1.4.6 This extended period of consideration contributed to the overall timeframe of the Review and supported a thorough and inclusive approach.

1.4.7 The CSP approved the finalised report on 26 June 2025. Brianna requested further amendments on 30 June 2025; these were duly considered, accepted, and incorporated into this report.

1.5 Confidentiality

1.5.1 The review is confidential until the Home Office Quality Assurance Board approves the release of the overview report. Only contributing officers/professionals and line managers have access to confidential information.

1.5.2 The review has been appropriately anonymised following the DHR Statutory Guidance. The family has agreed to the pseudonyms; only the independent author and review panel are identified. Additionally, the date of death has been removed to protect anonymity.

1.5.3 The following terms have been anonymised throughout this report to preserve the identities of the victim, family, friends, and partner.

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

1.6 Terms of Reference

1.6.1 This review intends to identify the lessons learned from Mitchell's tragic death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.

1.6.2 The terms of reference are found in section 3.2. Brianna was emailed the terms of reference on 6 November 2023. While she agreed with these, she emphasised the importance of domestic abuse agencies maintaining an awareness of male victims. As a result, at the panel meeting on 5 December 2023, it was agreed to solicit Mankind's support in reviewing the final draft report.

1.7 Methodology

1.7.1 The DHR Statutory Guidance outlines the procedure for undertaking a review.

1.7.2 Mitchell was a resident of Swindon at his death; hence, the review panel consisted of agencies from this area.

1.7.3 At the first review panel meeting on 10 October 2023, panellists shared their agency engagements for Mitchell.

- 1.7.4 The review's approach was to request that agencies submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or summary report.
- 1.7.5 The chronologies, reports, and contact with family and friends influenced this review's recommendations.
- 1.7.6 The panel met a total of four times.

1.8 Involvement of Family and Friends

- 1.8.1 The review author and the review panel acknowledged the vital role that Mitchell's family and friends could have in the review.
- 1.8.2 On **22 September 2023**, the author sent Brianna a letter describing the purpose of the review and providing information on an advocacy service: Advocacy After Fatal Domestic Abuse and the Home Office information concerning DHRs.

On 27 October 2023, the author contacted Brianna.

- 1.8.3 Brianna reported that Mitchell and Abe had been in a relationship for approximately four to five years. She further stated that Abe was not in employment, contrary to her own claims, and that she subjected Mitchell to financial and emotional abuse. This included telling him that nobody loved him. Brianna also reported that Abe was physically violent towards Mitchell.
- 1.8.4 Brianna recalled an incident in which the paramedic had been called as Abe had hit Mitchell over the head and caused an injury. She also reported that Abe had caused Mitchell's eye to bruise and swell.
- 1.8.5 Mitchell frequently climbed out of the bedroom window to escape Abe. However, Abe followed Mitchell, who often went to Brianna, and Abe waited for him outside.
- 1.8.6 Mitchell's friends had told him to leave Abe, with some friends distancing themselves from him as they did not like Abe. Abe threatened to self-harm or end her life if Mitchell left her.
- 1.8.7 Brianna had taken Mitchell abroad, and Abe had threatened to kill herself as a result.
- 1.8.8 Brianna felt Mitchell would not go to the police, as he would not be believed, as he was a male and over six feet tall.
- 1.8.9 Brianna found a message (undated) on Mitchell's phone after his death. He wrote:

"It's a situation rather not to be in. Things were good, but I can't afford to be in an abusive relationship. It's hard being a male because you're always seen as the dominant type. However, things were never good, even in my safe space. Just felt vulnerable and don't mind losing the money as long as I'm out. At least everything's paid anyway."

- 1.8.10 Brianna discovered after Mitchell's death that her daughter, Katie, frequently met him at night, carrying a first aid bag to bandage him. Neither Mitchell nor Katie disclosed this information to Brianna since they knew she would report the incidents to the police.
- 1.8.11 Brianna was abroad attending to her late father's affairs on the day Mitchell died, and she believed Abe and Mitchell had a dispute when she was away. She felt Abe knew he would have nowhere to go after the argument.
- 1.8.12 Brianna stated Mitchell had told the mental health service he was in an abusive relationship; however, he withdrew this. Brianna felt she was not allowed to speak with mental health services about Mitchell's mental health or her concerns about Mitchell's relationship with Abe.

On 11 November 2023, Katie initiated communication.

- 1.8.13 The author agreed on a date to talk with Katie. She responded by email that she could not participate, and the author encouraged her to contact her later when she felt more able.

On 17 November 2023, Mitchell's best friend, Jack, emailed the author:

"I was Mitchell's best friend. I saw Mitchell at his best and his worst. I will list the good and bad parts of Mitchell's life.

Good parts

Mitchell was always a happy chap when he was around his friends.

He loved long drives with me and exploring new places.

He loved going abroad, especially to Spain.

Mitchell always thought of others before himself.

Knew how to throw a great party.

He loved his walks, so he avoided everything when he needed space.

Bad parts

His relationship with Abe started in 2018/2019.

At the start, it was good, but as time went on, things got worse and worse, such as mental abuse and picking arguments over anything.

There was gambling; when he wanted his own space, blackmailing, she would say If you don't come back, I'll self-harm, which she had done multiple times.

Abe smashed a glass chest of drawers because she didn't get her way.

She also refused to get on with Mitchell's family.

It then turned into physical abuse.

Every time I saw Mitchell, he had a new bruise.

My thing is, I don't know why she's done this because Mitchell was amazing to her and paid for everything, a loving boyfriend to her, but I honestly think the pain and abuse from her got too much and that he thought he didn't have another way out. However, we told him time and time again to finish things because it's affecting your mental health and well-being, and he tried so many times, but it was always the same old story. I'll get a job; I'll sort my life and mental health out, but 4 years down the line, nothing has changed. The day he passed, I picked him up from the airport, and we even saw my parents. He wanted me to drop him off at his cousins' house with Abe, and then there was a big argument with them. Abe wouldn't let him have his space as usual, putting him over the edge.

Sometimes, I feel it wouldn't have happened if I had never left Mitchell that night. Mitchell will always be my best friend, and forever in my heart, you will stay till we meet again my brother ❤️"

On 28 November 2023, the author contacted Katie.

- 1.8.14 Katie confirmed that she would visit Mitchell after midnight, as Abe had harmed him, and he wanted to get away from her. Although he was concerned that no one would believe him, he disclosed his fear of Abe to mental health services, and Katie felt that mental health had done nothing in response to this.
- 1.8.15 This review confirmed that mental health did not respond to the disclosure.
- 1.8.16 Abe, according to Katie, would self-harm when Mitchell left, and Abe would put Mitchell down. Abe, being aware of Mitchell's gambling addiction, encouraged him to engage in gambling activities and stopped him from socialising with his friends. Katie said that she believed Mitchell should not have been discharged from the hospital following his report of abuse by Abe and subsequent mental health assessment, as she believed he posed a risk to himself and was at risk of abuse from Abe.

Brianna, Katie and a family friend met with the panel on 17 January 2024.

- 1.8.17 At Brianna's request, the police were asked about the possibility of initiating criminal proceedings related to the abuse, not the death. The police panellist consented to arrange a meeting with Brianna to discuss this matter further and address any further enquiries she may have for the police.
- 1.8.18 In response to Brianna's questions, the family liaison officer spoke with Brianna and confirmed that there would be no criminal investigation. A criminal investigation was not undertaken due to the location of certain marks on the overbridge railings. These marks were assessed as two hand /palm marks set aside, and a larger cleaning mark appeared from someone's bottom. These marks were on the roadside railing

and showed that someone (believed to be Mitchell) had climbed over it, sat on top, and then lowered themselves to the edge of the bridge. These marks were directly above the point where the investigation unit stated that the person fell to the carriageway, consistent with a witness's account.

- 1.8.19 During the investigation, consideration was given to establishing Mitchell's route to the final location. According to the Police Lead Investigator who ran the investigation, Mitchell's route to the bridge could never be fully determined, as he could have taken multiple paths. The investigators also considered searching for CCTV, but this was not a reasonable line of enquiry without a defined path.
- 1.8.20 Brianna believed the CCTV should have been further investigated, as it is in various locations, including the pub, post office, and residences. She asserted that there is only one route to the bridge.
- 1.8.21 Brianna maintained that there were unresolved enquiries regarding the investigation. The police panellist responded, advising Brianna to consider filing a formal complaint if her concerns about the standard of the investigation persisted. Brianna stated that she did not intend to submit a complaint.
- 1.8.22 Brianna, Katie, and the family friend raised the issue of AWP's absence of a safeguarding enquiry throughout their assessment with Mitchell. Brianna was provided with AWP's Patient Safety Report, and the DARDR panellist for AWP discussed the ensuing measures. The AWP panellist stated that the absence is addressed through continuous case reviews and audits.
- 1.8.23 Brianna reported that the family felt Mitchell was not believed because of the 'inadequate' response. AWP received Brianna's feedback.
- 1.8.24 Brianna spoke of Mitchell, a six-foot-tall male who had concerns regarding the credibility of his disclosures of domestic abuse. Mitchell was emotionally drained because of the abuse. He was unable to leave the relationship due to Abe's threats to end her life, as stated by Brianna and Katie. Abe was physically and emotionally violent towards Mitchell.
- 1.8.25 The panel emphasised that males must be informed of the available support options and that family members and friends helping the victim/survivor should also have access to the same information.

The author and the panel considered paragraph 57 of the DHR Statutory Guidance on approaching the alleged perpetrator's family.

- 1.8.26 The information regarding Abe and her grandparents was disclosed to the author. The panel confirmed they were not involved in working with Abe or the grandparents. The panel examined whether it was suitable to communicate with the grandparents. The panel lacked knowledge regarding the grandparents' awareness

of the review and their needs. To mitigate potential harm from contact with the grandparents, no communication was established.

1.8.27 Though the author attempted to communicate with Abe, the provided contact information was inaccurate.

1.8.28 Brianna believed Abe's mother should have been contacted. The panel did not have the mother's information and would require Brianna to provide it. Additionally, Mitchell's family had reported that Abe's relationship with her mother was fraught. As a result, the panel agreed that it would be unwise to communicate with Abe's mother.

In July 2024, the author sent Brianna and Katie the draft report.

1.8.29 Brianna and Katie were kept informed of the Review's progress. They were provided with the report for their consideration as key stakeholders, to ensure it addressed the agreed terms of reference and appropriately reflected Mitchell's voice throughout.

In October 2024, the author discussed the report with Briana and Katie.

1.8.30 Mitchell's family and friends wished for the following to be emphasised:

1. *Avon and Wiltshire Mental Health Partnership NHS Trust's (AWP) absence of a safeguarding enquiry during Mitchell's emergency department assessment.*
2. *Mitchell was discharged from the hospital and subsequently left with Abe. This was following his disclosure of domestic abuse perpetrated by Abe.*
3. *Mitchell agreed that the AWP should share his information with Abe. Mitchell had disclosed domestic abuse to AWP before this; consequently, it was not in Mitchell's best interest for Abe to possess this information, as it could potentially grant Abe additional control over Mitchell.*
4. *Mitchell had presented to the hospital three times in May 2022 with a mental health crisis, including thoughts of suicide and overdoses. She enquired why AWP did not escalate the situation to develop a safety plan for Mitchell.*
5. *AWP encountered difficulties contacting Mitchell and submitted a letter to Abe requesting that Mitchell establish communication. Brianna believed this was unsuitable, given the abuse Mitchell had reported by Abe, and that it should have prompted AWP to reevaluate their efforts to establish contact with Mitchell.*
6. *Mitchell's family and friends believe that the response to Mitchell's status as a victim of domestic abuse was predicated on his gender. They believe that if a female had reported domestic abuse, they would have received a more proactive response.*

1.8.31 Katie also believed that it was crucial to emphasise Mitchell's relationship with their stepfather and Mitchell's biological father.

1.8.32 To ensure that the points above were addressed, the report was revised and resubmitted to Brianna and Katie in October 2024 for additional feedback.

On 8 November 2024, the author met with Brianna and Katie to review the report.

In January 2025, the family accessed Advocacy.

1.8.33 Brianna and Katie requested the advocates' assistance, believing the report needed strengthening in two areas.

1. Concerning Mitchell and Katie's stepfather:

1.8.34 Katie reported that their stepfather was physically violent, humiliating, and intimidating to Mitchell. Katie reported that Mitchell's departure from the family home was primarily due to his fear of "this monster." Nevertheless, Katie asserted that Mitchell jumped from "one monster to another."

1.8.35 Katie recalled an incident in February 2016 in which Mitchell was required to contact the police after the stepfather had reportedly strangled Katie and hit Mitchell. Katie believed this had diminished Mitchell's confidence in the police.

1.8.36 The police confirmed attendance at this call. They reported that although Mitchell was observed to have slight bleeding from his nose, he declined medical assistance and refused to allow police to photograph the injury. A [Public Protection Notice](#) (PPN) was shared with Swindon Children's Services and Child Health, as Katie was a minor.

1.8.37 Neither Mitchell nor Katie wished to make a statement. Due to insufficient evidence and the absence of medical reports, no further action was taken.

2. Safeguarding Enquiry

1.8.38 The second area addressed the lack of a safeguarding query during Mitchell's emergency department (ED) visit and subsequent mental health assessment by the Avon and Wiltshire Partnership NHS Trust. Although the trust has implemented a recommendation, the family feels this was a missed opportunity to address Mitchell's concerns, particularly regarding Abe's representation during reviews, despite Mitchell disclosing Abe's abuse. The trust has made a recommendation to address this issue.

1.8.39 The family believes it is crucial to be informed of these actions to ensure the lessons have been acquired. The family's advocate agreed to assist with this matter.

On 25 April 2025, the author, Katie and the advocate scheduled a video call.

- 1.8.40 The purpose was to finalise the report and ensure it highlighted Mitchell's absence of a male role model.
- 1.8.41 Brianna, through the advocate, requested a further meeting with the author, which was arranged for 30 June 2025.
- 1.8.42 During the meeting, Brianna expressed that a significant factor that might have helped Mitchell was better recognition by services, particularly the police, of the need for support for victims of domestic abuse during interviews. She emphasised that victims often require the presence of supportive individuals, such as family members or friends, and that police should ensure this support is provided by allowing them to attend interviews.

1.9 Contributors to the Review

1.9.1 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

1.10 The Review Panel Members

1.10.1 The independent members of this review's panel were the following:

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

1.10.2 ManKind Initiative and Swindon Public Health reviewed the final report; no changes were requested.

1.10.3 Public Health confirmed that a priority area outlined in the suicide prevention action plan is addressing population-level risk factors associated with suicide through early intervention and individualised support. The following are:

- Physical illness
- Gambling
- Financial difficulty and economic adversity
- Alcohol and drug misuse
- Social isolation and loneliness
- Domestic abuse

1.10.4 Public Health is in the process of developing a suicide prevention training programme for professionals; however, it will not include a distinct emphasis on domestic abuse.

- 1.10.5 The Domestic Abuse Local Partnership will be leading on any specific support to practitioners in understanding the connection between domestic abuse and suicide.
- 1.10.6 Swindon CSP is conducting an audit of its domestic abuse training; they have identified the link between suicide and domestic abuse as a gap and will investigate how to implement training in the near future.

1.11 Chair and Author of the Overview Report

- 1.11.1 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for over ten years and obtained DHR Chair training in 2021 and 2024 from Advocacy After Fatal Domestic Abuse. She has worked in the NHS for over 20 years as a Mental Health Nurse with a particular focus on crisis work and working with persons diagnosed with a personality disorder. She was previously employed as the Director of Safeguarding, Prevent, and the Domestic Abuse Lead for an NHS Trust.
- 1.11.2 Before this review, Parminder had no contact with Mitchell's family or friends. She conducted a Safeguarding Adult Review for the Swindon Safeguarding Adult Partnership. She is independent of the agencies involved in the DARDR.

1.12 Parallel Reviews

- 1.12.1 The coroner's conclusion was:

"Mitchell had a complex neuropsychiatric history with a diagnosis of ADHD, which led to impulsiveness and depression. Mitchell had attempted to take his own life on several occasions but sought help.

In the period before his death, Mitchell was actively engaging with the mental health team and had made an appointment to see them the day after he died. On the night of the X of November 2022, Mitchell received some personal information, after which he consumed a quantity of medication and left his home. In the early hours of November 2022, a passing motorist saw a male clinging to the overbridge on the northern side of the southbound carriageway. Other motorists reported to the police that they had seen something lying in the southbound carriageway. Subsequently, the body was identified as Mitchell's.

The toxicology revealed high levels of both over-the-counter and prescription medication, as well as traces of illicit drugs, the combined effect of which was difficult to assess.

On the evidence, it has not been possible to ascertain how Mitchell came to be in the carriageway, whether that resulted from a deliberate act on his part, and if so, with what intent."

1.12.2 Brianne suggested that the “*personal information*”, according to a mutual friend, said that Abe was having an affair, but she is unsure how true this was.

1.13 Equality and Diversity

1.13.1 During the review process, the review author and panel reviewed all protected characteristics under the Equality Act 2010.

1.13.2 Mitchell was of white British heritage and was 25 at his death.

1.13.3 The characteristics relevant to this review are sex, age and disability.

1.13.4 Mitchell reported self-harm between the ages of 16 and 18 owing to emotional and familial challenges. During this time frame, he had taken four overdoses, two of which necessitated overnight hospitalisation. Following six additional overdoses between 2015 and 2022, the Mental Health Liaison Team (MHLT) at Great Western Hospital NHS Foundation Trust (GWH) assessed him.

1.13.5 Although self-harm is not a mental disorder, it is linked to mental distress ([Rethink](#)). In addition, domestic abuse significantly influences mental health and can result in depression, anxiety, self-harm, substance abuse, and suicide ([Advance](#)). Mitchell had disclosed that his prior instances of self-harm were precipitated by stress. Consequently, the panel concluded that this may have been a coping mechanism that Mitchell employed to alleviate stress.

1.13.6 Mitchell was diagnosed with ADHD in February 2018. ADHD is characterised by hyperactivity, impulsivity, and concentration issues ([ADHD UK](#)). ADHD is a neurodevelopmental disorder and typically presents in childhood and lasts into adulthood. It causes problems with focus, behaviour, and movement ([NHS England](#)).

1.13.7 People with ADHD may experience relationship challenges, including anger because of stress and anxiety, which may be unrelated to the relationship. Adults with ADHD likely experience anxiety, depression, bipolar disorder, or other pre-existing psychiatric disorders ([Royal College of Psychiatrists](#)).

1.13.8 Mitchell had a history of self-harm and was reportedly addicted to gambling, resulting in financial issues. He also reported binge drinking alcohol on occasion. The [Gateway Foundation](#) explored ADHD with early-in-life consumption of alcohol and a higher risk of binge drinking.

1.13.9 Alcohol abuse or illicit drug use increases the risk of psychological intimate partner abuse perpetration and victimisation, regardless of ADHD symptoms ([ADHD and Intimate Partner Violence](#)).

1.13.10 Given Mitchell's history of suicidal ideation and overdoses, the panel believed that ADHD, alcohol, and drugs were critical issues that required further investigation.

- 1.13.11 [Suicide statistics in England and Wales](#) indicate that men are three times more likely to take their own lives than women. The rate in the UK is thirteen men per day who die by suicide, and this is 5,000 men per year ([Tackling Male Suicide](#)).
- 1.13.12 An [All-Party Parliamentary Group](#) on Issues Affecting Men and Boys identified three intertwined issues that impact male suicidality:
- Stressors, such as relationship breakdown (including domestic abuse), employment concerns, financial concerns, bereavement, and isolation
 - Universal issues, social integration, loss of meaning and purpose, gap in available and signposted male-friendly services, place, occupation, and lack of professional curiosity
 - Life transitions, family, relationship loss, sexuality, bereavement, Veterans, students
- 1.13.13 According to the report, males do not perceive suicide as a matter of mental health or clinical concern. They consider it a "rational" reaction to issues they have attempted to resolve without success. Suicide is therefore perceived as the sole remaining option by them. Mitchell's family and friends stated that Mitchell believed that agencies would not accept his report of domestic abuse. In the past, when he and Abe had arguments, Mitchell would visit Brianna. Brianna was attending to her father's affairs abroad. The day Mitchell and Abe had argued. Consequently, Mitchell's support was unavailable.
- 1.13.14 The [Office for National Statistics](#) report 751,000 men (3.2%) and 1.38 million women (5.7%) experienced domestic abuse in the year ending March 2023. One in seven men (13.9%) and one in four women (27%) will be a victim of domestic abuse in their lifetime.
- 1.13.15 The [Royal College of Psychiatry](#) highlight that persons with Autism may be more likely to succeed in their first suicide attempt, use more lethal means, and be less connected to support services than other at-risk groups.
- 1.13.16 Mitchell died as a result of a road traffic collision. According to data from the [Department of Transport](#), in 2023, there were 1,645 fatalities, and 29,643 individuals were killed or seriously injured. According to the [RAC](#), 75% of fatalities were male, and 24% of the fatalities were between the ages of 17 and 29.
- 1.13.17 The [Office for National Statistics](#) estimates that 1.6 million women and 712,000 men reported abuse in the year ending March 2024. The [ManKind Initiative](#) emphasises the challenges for male victims of domestic abuse, which includes that provision is unevenly distributed and limited, with a median of five spaces per organisation, presenting a particular challenge for male victims seeking safe accommodation provisions for male refuges.

- 1.13.18 As of 1 February 2024, there were 410 refuge or secure accommodation spaces across 57 organisations in the UK, including 108 for men. This is further compounded by underreporting, as 21% of male victims do not disclose partner abuse, meaning the true level of need is likely higher than recorded.
- 1.13.19 [Bristol University](#) identified reasons why males in abusive relationships might not seek assistance. According to the findings, specialised training is necessary to address the unique needs of men and build more robust levels of trust.
- 1.13.20 Brianna reported that Mitchell told her that, as a male and six feet tall, services would not believe he was a victim of domestic abuse.
- 1.13.21 The absence of a positive male role model can significantly affect a young man's development, particularly in emotional regulation, identity, and understanding of healthy relationships. Without such guidance, young men may struggle with setting boundaries, managing emotions, or recognising abusive behaviour, making them more vulnerable to manipulation and domestic abuse ([The Importance of Positive Male Role Models](#)).
- 1.13.22 Role models help teach key safeguarding behaviours such as assertiveness, emotional literacy, and conflict resolution. In their absence, boys may internalise harmful stereotypes or seek belonging in unsafe environments. This can leave them ill-equipped to identify coercive control or to protect themselves from harm ([NSPCC](#)).
- 1.13.23 The [University of Warwick and Refuge](#) study presented extensive and substantial evidence on the incidence of suicidal ideation among victims of domestic abuse. They emphasised risk factors such as depression, psychological distress, despair, hopelessness, difficulties with drugs or alcohol, childlessness, and cumulative experiences of abuse, particularly sexual abuse.
- 1.13.24 The [National Suicide Prevention Strategy 2023-2028](#) was published in 2023, and it highlights that domestic abuse is an additional risk factor for all victims.
- 1.13.25 According to an [analysis of domestic homicides](#), mental health issues were recorded in 94% of the reviews, and in almost half of the reviews, there was evidence of self-harm. In addition, 40% of the victims were aged 25–34.
- 1.13.26 Mitchell's absence of a male role model combined with a history of self-harm and domestic abuse significantly influences mental health and can result in depression, anxiety, self-harm, substance abuse, and suicide ([Rethink](#)).

1.14 Dissemination

1.14.1 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Members of the Swindon Community Safety Partnership
- Swindon Community Safety Partnership
- Agencies represented
- Safeguarding Adult Board
- Safeguarding Children Partnership
- Domestic Abuse Commissioner
- local Police and Crime Commissioner
- A copy of the Summary report will also be published on the Keeping Swindon Safe Partnership Website.

2.1 The Facts

- 2.1.1 Mitchell had been to visit his aunt in another part of the UK one week before he died.
- 2.1.2 Mitchell contacted the Swindon Intensive Service (SIS) before boarding his homebound flight. He had scheduled a meeting with the service for the following afternoon. He confirmed over the phone that he had not taken any medication and would discuss this at the next day's appointment.
- 2.1.3 Abe called the police in the early hours of the day Mitchell was found deceased to report that Mitchell had not returned following a thirty-minute walk. Mitchell's cousin's girlfriend had spoken to Abe. Abe stated that Mitchell had overdosed on Paracetamol x 10, Diazepam x 7, Zopiclone x 7, Ibuprofen x 9 and Co-codamol x 8, and no one knew where he was.
- 2.1.4 Mitchell was categorised as a high-risk missing person. The police did not obtain a statement from the cousin's girlfriend, as their details were not provided. A statement was also not obtained from Mitchell's cousin, as he did not engage with the investigative process, and there was no evidence that he was involved in any way other than receiving some messages from Mitchell. However, numerous statements were obtained from other key witnesses for the coroner's file.
- 2.1.5 According to AWP records, the police contacted AWP to provide them with the information from Abe. Abe called the police in the early hours of the day Mitchell was found deceased to report that Mitchell had not returned following a thirty-minute walk. Mitchell's cousin's girlfriend spoke to Abe.
- 2.1.6 A police log noted that an AWP staff member had reported seeing Mitchell standing among trees an hour after the call.

2.1.7 A few hours later, a fatal traffic collision was reported; the deceased was named Mitchell.

2.2 Key Events from November 2018 to January 2023

Date	Contact	Agency
Nov 2018	<p>Mitchell and Abe established a relationship.</p> <p>The first domestic incident between the couple was reported to the police. Abe told the police that Mitchell had taken out a loan in her name. Subsequently, the police were informed that the money had been refunded, and she no longer wished to file a complaint.</p> <p>The police did not speak to Mitchell, as the incident was resolved after Abe's subsequent communication.</p>	Police
July 2019	<p>According to a third-party account, Mitchell and Abe were arguing.</p> <p>No offences were determined, and the case was closed. A PNN was submitted for Mitchell and Abe, and both were listed as 'subjects'; neither was identified as a victim or perpetrator.</p>	Police
Oct 2019	<p>The police were contacted by an ambulance regarding an injured female domestic abuse victim. Abe informed the police that she and Mitchell were just as bad as each other.</p> <p>The case was closed upon the determination that no further action was required. The PPN was completed for Abe, the victim, and graded as standard. The inspector reviewed the full case before closure, which is in line with the domestic abuse policy, as the suspect was not interviewed. The case was closed because the victim did not support any further action, and due to evidential challenges.</p>	Police
Dec 2019 - March 2020	<p>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 had not observed any injuries on each occasion.</p> <p>This was the initial instance in which Abe was issued a caution after her assault on Mitchell.</p>	Police

	<p>PPNS and Domestic Abuse, Stalking, and "Honour"-Based Violence (DASH) Assessment was completed on the following occasions:</p> <ul style="list-style-type: none"> • 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 	
Feb 2020	<p>Text Messages between Mitchell and Abe</p> <p>Abe sent the following string of messages to Mitchell:</p> <ul style="list-style-type: none"> • <i>"Please come home"</i> • <i>"I need you"</i> • <i>"You haven't gone that far, I don't want you b****ing to Jack or whoever's house that you're going to"</i> • <i>"You hung up on me, and I was talking"</i> • <i>You know I have no one"</i> • <i>"Just please come home"</i> • <i>"Who have I got? No one"</i> • <i>"I'm going now"</i> <p>Mitchell responded: <i>"Just to confirm, I want you out by 12:00 on Friday, 14th February 2020. I will no longer put up with the violence and controlling behaviour you cause. I'm sorry it's come to this."</i></p> <p>Abe's response: <i>"Sounding like your mum with my stuff now, 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."</i></p>	Family
April 2020	<p>Brianna reported Mitchell missing; she had received text messages from him expressing suicidal ideation and a wish to no longer be a "Burden." Mitchell was considered a high-risk missing person, and officers searched for him. Mitchell had overdosed on his ADHD medication and had returned home; an ambulance transported him to GWH.</p>	Police

<p>Mitchell was promptly located by the police, who ensured that he received the necessary care and treatment following the overdose.</p>	
<p>Text messages between Mitchell and the landlord</p> <p>Mitchell sent the following: <i>“Unfortunately, we had the police out last night again, and it's not something I can keep going through, and it's not fair on the other residents. I have had to put the spare keys in the safe, but is it possible we can get those codes changed on the locks she let herself in yesterday, which caused more issues? Hopefully, we can get things back on track.”</i></p> <p>Landlords' response:</p> <ul style="list-style-type: none"> • <i>“Hi yes unfortunately we have had a lot of issues as discussed previously complaints from all 3 previous tenants who have lived in room 3 and tenants in room 1 only room 2 have not complained as they are further from the room. Multiple times we have had police and ambulances, and continued loud arguing and fighting caused neighbours to contact me also”</i> • <i>“Now the time has come where it would be best to leave”</i> • <i>“I can issue a formal notice or we can come to an agreement on dates but it is a final decision”</i> • <i>“Please call me to discuss”</i> 	Family
<p>Text messages between Mitchell and the landlord</p> <p>Message from the Landlord: <i>“Yeh have a look speak to friends/family etc and then get back to me, but you won't be able to stay at X – I've had all sorts of complaints coming from local residents and neighbours, but I'm still willing to help work to a date that works for you. Thanks”</i></p> <p>Mitchell's response: <i>“Just to make you aware I'm being rushed into hospital so Abe will be staying at the property tonight”</i></p> <p>Landlord's response: <i>“stay safe”</i></p> <p>Mitchell's response: <i>“Just to let you know I had the police and ambulance out today as I was a vulnerable position they found me and took me and took me to resuss 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”</i></p> <p>Landlord's response: <i>“Ok il let you deal with your private matters hope you feel better; I would appreciate a quick resolution to you vacating the property. Thanks”</i></p>	

19.04.20	<p>Mitchell was admitted with an overdose of oral medication. The risk was evaluated as 'amber' on the risk assessment matrix. The report suggested that Mitchell advised the practitioner that he was depressed and the overdose was intentional. He was also noted to have a diagnosis of ADHD.</p> <p>Mitchell was referred to and seen by the AWP MHL team, which provided him with specialist support and advice. The AWP mental health risk assessment did not highlight alcohol as an identified concern. AWP have access to ED notes.</p> <p>Due to palpitations, Mitchell was admitted to a cardiology ward for further monitoring.</p> <p>For all AWP MHLT referral records, the Trust bleeps AWP MHLT to make the referral. A simple referral form also passes through to them (but can be delayed, hence the bleep). Either of these causes AWP to review their notes for further information.</p> <p>Mitchell's risk assessment did not include alcohol, which resulted in a lack of consideration for the potential risk to himself. Consequently, the risk was not thoroughly investigated, as it is well-established that alcohol can exacerbate self-harm and increase the risk of suicide (UCL).</p>	GWH (ED)
April 2020	<p>The ADHD Service took appropriate action to stop further prescriptions, and a plan was put in place to review Mitchell again in three months should Mitchell request this.</p> <p>However, the author proposes that Mitchell's capacity to function without the medication was not documented, as well as the potential implementation of additional protective measures to mitigate the risk of overdose. Nevertheless, the author agreed that in the absence of the above, the medication needed to be stopped to prevent a further overdose.</p>	AWP (ADHD)
29.05.21	<p>Mitchell contacted the ambulance (999 call) to report that he had overdosed on his ADHD medication.</p> <p>He reported feeling a great deal of pressure /stress. Mitchell had lost his job and fallen out with his family and friends; he expressed regret for the overdose and said he had attempted to walk to the hospital; however, he felt too unwell.</p> <p>He was transported by ambulance to GWH.</p>	SWASFT
	<p>Mitchell was admitted to GWH after he overdosed and disclosed that the overdose was a suicide attempt.</p>	GWH (ED)

	<p>He informed staff that familial issues caused the overdose. No domestic abuse enquiries were made.</p> <p>He stated his partner was at home, unaware he had overdosed, and he later regretted taking the overdose.</p> <p>Mitchell was admitted to the assessment area; however, he self-discharged two days later.</p> <p>Mental Health attempted to assess Mitchell but could not do so due to the medication's effects. They determined that Mitchell was at low risk and would review him in a few days.</p> <p>The author emphasised that this demonstrated that GWH had considered a mental health review and had engaged in a conversation with Mental Health. Nevertheless, the author recommended that a review should have been prioritised to ensure Mitchell's safety and to examine the circumstances that led to his regret of the overdose.</p>	
<p>October 2021</p>	<p>Abe contacted the police to report that Mitchell had assaulted her twice between September and October. After photographs of the injuries were taken, Mitchell was arrested. He asserted that he was acting in self-defence and denied the assault. No further action was taken.</p> <p>Attending officers completed and submitted a PPN to the Police Multi-Agency Safeguarding Hub in response to domestic abuse incidents. The on-site officers concluded the safeguarding process.</p> <p>The MASH agencies include:</p> <ul style="list-style-type: none"> • Social Care • Health • Local Authority Designated Officer • Child and Adolescent Mental Health Service • Housing • Domestic Abuse <p>The list is not exhaustive.</p>	<p>Police</p>
	<p>Mitchell's family and friends reported that Mitchell had informed them that Abe would inflict injuries on herself and subsequently blame Mitchell.</p>	<p>Mitchell's family and friends</p>

Nov 2021	Mitchell reported Abe's assault to Thames Valley Police while in Reading; Abe was arrested, and no further action was taken against her.	Police
01.02.22	Mitchell did not attend his ADHD review appointment. There was no documentation to indicate whether the service attempted to contact Mitchell.	AWP (ADHD)
18.02.22	Mitchell did not attend his ADHD review; instead, he emailed to say he could not locate the video link and requested a rescheduling for a phone conversation. A telephone appointment was arranged.	AWP (ADHD)
01.03.22	Mitchell sent an email over the weekend stating he could not attend his review as he had started a new job. An alternative appointment was arranged.	AWP (ADHD)
10.03.22	Telephone ADHD treatment review. Since overdosing on the ADHD medication in May 2021, Mitchell said he had not been taking the medication. He indicated that he had been in a bad place, as he was living with Brianna and his stepfather amid family disputes. He was unemployed and battling a gambling addiction and had taken an impulsive overdose. He had moved in with Abe, started an apprenticeship, and joined a gambling support group. His workplace was aware of his ADHD and mental health issues, and they sought to establish a mental health team to assist him. He wanted to resume his medication since he felt it was beneficial. However, since he had previously overdosed on the medication, it was agreed to address this with the Multi-Disciplinary Team (MDT). Considering Mitchel's previous overdose on his prescribed medication, the author emphasised that the MDT discussion was positive in promoting a safety plan for him.	AWP (ADHD)
02.04.22	Abe contacted the police because she was concerned for Mitchell's safety. After an altercation, Mitchell declared he wanted space and left the residence. He did not reply to attempts to contact him. Police located Mitchell at a friend's house.	Police

	<p>A PPN and a DASH were conducted for Abe, the victim, and Mitchell, the suspect, and were shared with the Police MASH.</p> <p>Abe reported Mitchell missing to the police; therefore, mental health services were contacted, and the police enquired into Mitchell's whereabouts.</p> <p>The police called back to say that Mitchell's safety had been established.</p> <p>The author would recommend that AWP contact Mitchell to discuss his mental health, as they are aware of his history of suicidal ideation and self-harm.</p>	AWP (Mental Health Control Room)
05.05.22	<p>Mitchell sought treatment at the ED for a head injury. He recounted being low and having a "psychotic episode" before self-injuring by hitting his head against a wall. The management of self-reported "psychotic episodes" was the primary concern. The reason for the absence of a referral to MHLT remained unclear.</p> <p>GWH reported that no domestic abuse enquiry was made.</p> <p>A referral to mental health would be expected, given the cause for Mitchell's presentation.</p>	GWH (ED)
07.05.22	<p>Mitchell had overdosed on a combination of Paracetamol X16, Ibuprofen X16, and Omeprazole X12. Mitchell was reported to have taken the overdose and then fallen out with Abe. He walked to the park with his cousin and consumed an undetermined amount of alcohol.</p> <p>Mitchell was conveyed to GWH by ambulance.</p> <p>Mitchell was brought to the ED by ambulance after taking an overdose and informing his cousin, who then contacted emergency services.</p> <p>No low mood, life pressures, suicide ideation, or physical symptoms were reported by Mitchell.</p> <p>The mental health service was content for Mitchell to be discharged, and they agreed to email the ADHD clinic to provide an update and enquire about the outcome of the MDT discussion on restarting the ADHD medication. AWP advised that the ADHD team contact Mitchell.</p>	SWASFT
		GWH (ED)

	Due to this being the second presentation of self-harm within two days, it would be reasonable for the mental health service to conduct a review.	
08.05.22	<p>Mitchell was brought to the hospital by ambulance following an overdose of Paracetamol X 16, Ibuprofen X16, Omeprazole X12, and excessive alcohol. According to the AWP record, the medics did not consider Mitchell required a mental health assessment.</p> <p>GWH refuted this, stating they discussed it with the mental health team on 07.05.22.</p>	AWP (ADHD)
24.05.22	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.	AWP (ADHD)
May 2022	The repeated episodes of ED were emphasised by Mitchell's family and friends, who believe it should have prompted an immediate response from AWP to address Mitchell's mental health needs.	Family and friends.
16.06.22	<p>Mitchell did not attend the ADHD appointment. Following two previous overdoses of his ADHD medication, he was discharged from the ADHD service.</p> <p>The team felt that prescribing this medicine would represent a significant risk, and Mitchell would need to contact his GP for mental health support.</p> <p>Mitchell received a discharge letter advising him to contact the crisis team for support, with the possibility of re-referral when the risk is reduced.</p> <p>Considering the previous episodes of self-harm, the author would recommend that AWP request a further mental health assessment to ensure that he has access to services and to specify the safety measures in place to mitigate the risk of self-harm and support him with his suicidal ideation.</p>	AWP (ADHD)
29.06.22	<p>The police were called to investigate the welfare of a two-year-old child at an address where the mother was reportedly taking drugs with her friends.</p> <p>Mitchell and Abe were present when the police arrived.</p> <p>A PPN was submitted for the child and shared with Children's Social Care. The infant was not related to Mitchell or Abe.</p>	Police

25.07.22	<p>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.</p> <p>Mitchell spent the night with friends, while Abe stayed with her family.</p> <p>The police MASH received a PPN containing a standard-rated DASH.</p> <p>Immediate safeguarding was completed at the scene, with parties separated to prevent further arguments. Officers gave safeguarding advice to both parties.</p>	Police
03.08.22	<p>According to an intelligence report (unable to identify the reporter), Mitchell uses psychedelic drugs.</p>	Police
15.09.22	<p>Mitchell acknowledged receipt of the discharge letter 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.</p> <p>The author postulates that Mitchell tried to reduce the risks associated with the overdose by requesting a limited prescription. Nevertheless, he was informed that he had been discharged. The team did not provide additional input, even though he had lost his job and was experiencing difficulty.</p>	AWP (ADHD)
27.09.22	<p>Mitchell witnessed another female assault Abe by spitting on her and throwing an aftershave bottle at her.</p> <p>The female was arrested and issued a caution.</p>	Police
15.10.22	<p>Mitchell had been hitting his head against a wall and had acquired injuries as a result. The Police conveyed him to GWH while intoxicated.</p> <p>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.</p> <p>After hospitalisation, Mitchell informed the officer that he was not filing a complaint and that he 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 himself in an abusive relationship.</p>	Police

	<p>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.</p>	
	<p>Mitchell was brought to the ED by three police officers after he was seen in town expressing a wish to self-harm. He was observed repeatedly beating his head against the wall while intoxicated and stating, "It's hopeless."</p> <p>He was admitted to the observation ward of the ED along with a Registered Mental Health Nurse to sustain observation.</p> <p>He was referred to the SIS. The notes from the MHLT recorded 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, but did not state whether he was the victim or the alleged perpetrator.</p> <p>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.</p> <p>GWH were unable to establish whether a verbal handover had taken place. As a result, Mitchell left the ED with the individual whom he had reported abusing. Additionally, there was no safety plan or offer of domestic abuse services.</p>	<p>GWH (ED)</p>
	<p>Mitchell was brought to GWH by police after reporting suicidal thoughts, head banging, intoxication, and assault suspicions. MHLT was recommended for him.</p> <p>He reported 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.</p> <p>He expressed his wish to end his life by suicide. Regarding his prior unsuccessful efforts, he indicated he had a concrete plan to jump off a bridge after leaving the hospital. He expressed feeling like a burden on his family. He was experiencing difficulties with his social situation, including housing and a recent relationship breakdown with their ex-girlfriend, who allegedly assaulted him yesterday and was abusive in the relationship. The recent loss of an uncle followed the loss of his grandfather.</p>	<p>AWP (MHLT)</p>

	<p>Mitchell was referred to the intensive team for a gatekeeping assessment due to their inability to discharge safely. Due to the risk of absconding and the ongoing intention to end his life, Mitchell received 1:1 support in the ED.</p>	
17.10.22	<p>Mitchell was assessed by SIS, who agreed to provide Mitchell with home treatment (intensive support at home to provide an alternative to hospital admission) and contacted the ADHD team to reinstate Mitchell's medication.</p> <p>Mitchell revealed periodic binge drinking and described the stresses of living in a shared residence due to his diagnosis of ADHD and prior trauma. Due to his financial issues, he was forced to sell his phone to buy 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.</p> <p>SIS agreed to write a letter that he could provide housing to support a move to an appropriate accommodation and to discuss with the specialist ADHD team regarding medication and a re-referral.</p> <p>No additional enquiries regarding domestic abuse or the offer to provide Mitchell with food, such as a food bank or financial assistance, were documented.</p>	AWP (SIS)
18.10.22	<p>Abe informed SIS that Mitchell had not slept well, was experiencing pain, and could not attend the appointment.</p> <p>SIS sent an email request to the ADHD team to discuss medication for Mitchell.</p> <p>The record did not indicate Abe's reported risk to Mitchell. The author stated that additional discussions should have been held to ensure the team could communicate directly with Mitchell and that his voice was not conveyed through Abe.</p>	AWP (SIS)
19.10.22	<p>Mitchell attended SIS, where they explored the effects of alcohol and drugs 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.</p> <p>The disclosure of domestic abuse and the subsequent follow-up of the self-neglect concerns were not addressed.</p>	AWP (SIS)

21.10.22	SIS and the ADHD team manager held a discussion; the ADHD service agreed to assess Mitchell in a month and consider restarting medication, as it was acknowledged he had responded well to it.	AWP SIS & ADHD)
22.10.22	SIS had booked a taxi to take Mitchell to his appointment, but he and Abe did not answer calls.	AWP (SIS)
25.10.22	Visit to Mitchell's home: Mitchell was not at home. SIS gave Abe an opt-in letter requesting that Mitchell make contact. Mitchell's family and friends emphasised that this was inappropriate, as Mitchell had reported that Abe was abusing him.	AWP (SIS)
29.10.22	Abe called an ambulance (999 call) because she was frightened that Mitchell was experiencing a seizure, as he had repeatedly hit his head against the wall. Mitchell was transported by ambulance to GWH.	SWASFT
	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. To review Mitchell's mental state, the author recommends that he be referred to MHLT. Furthermore, there was no domestic abuse enquiry. On 15.10.22, domestic abuse was reported. Nevertheless, GWH reported that neither the victim nor the perpetrator was identified, making the situation ambiguous.	GWH (ED)
31.10.22	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. He expressed his disappointment; however, the discharge remained. SIS sent Mitchell's GP a discharge summary. The author stated SIS had not considered the domestic abuse Mitchell had reported to AWP, and as a result, it was inappropriate to provide Abe with a letter and suggest that he use Abe's phone to contact them. It is recommended that a mental health assessment be conducted during this contact.	AWP (SIS)

12 days before Mitchell's death	<p>A 999 Call: Mitchell was intoxicated and unresponsive and was immediately transported to the ED Resuscitation room.</p>	SWASFT
	<p>Mitchell was admitted to the ED owing to excessive intoxication. Alcohol intoxication was diagnosed in the context of depression and suicidal ideation.</p> <p>There was no documentation to report the referral or consideration of alcohol services.</p> <p>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.</p> <p>According to the records, he was assessed by a mental health professional.</p> <p>According to the IMR author, there was no indication that ED was cited in the domestic situation.</p>	GWH
	<p>Referral by ED: Mitchell attempted suicide by overdosing on Mirtazapine X14 and Quetiapine X70.</p> <p>Mitchell indicated that Brianna was attending to her late father's affairs abroad, that his brother lived abroad, that he had an estranged relationship with his sister, and that he did not have a good relationship with his stepfather. He indicated that his mental health prevented him from maintaining employment, that he was not entitled to a personal independence allowance as he did not meet the criteria and that he had been abusing alcohol. He was referred to the SIS.</p> <p>MHLT documented that Mitchell should continue to engage with Turning Point (Alcohol and Drug Service). The panel confirmed Mitchell was receiving support from Turning Point. MHLT further documented that Mitchell's GP was required to review him. They indicated that Mitchell was receiving psychological care (although the panel did not receive any confirmation that he was receiving psychological interventions).</p> <p>MHLT discussed Samaritans with Mitchell. However, he reported having had a negative experience with them. He was advised to contact SIS if his mental health deteriorated, and his GP was instructed to contact the local Primary Care Liaison service if necessary.</p>	AWP (MHLT)

	<p>The following factors that may increase the risk of self-harm or suicide were identified by the IMR author: An accidental suicide may be the consequence of Mitchell's unpredictable behaviour, alcohol misuse, being a male and lack of a consistent job.</p> <p>Furthermore, the author observed that Mitchell's support network was absent at this time, and MHLT did not discuss domestic abuse.</p> <p>It is unclear why they were unaware that he was not receiving the psychology service, as it is under the AWP. Furthermore, it would be more appropriate for mental health services to evaluate his mental state and provide referrals to mental health services rather than the general practitioner.</p>	
11 days before Mitchell's death	<p>SIS contacted Mitchell, but he did not respond.</p> <p>SIS contacted Abe, and Mitchell acknowledged that this was the best number to reach him.</p>	AWP (SIS)
9 days before Mitchell's death	<p>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.</p> <p>When he received the opt-in letter, he reported that he had had a rough day and would have benefited from SIS support. He asserted that he did not overdose and believed that his drink was spiked.</p> <p>He wished to resume taking his ADHD medication. Brianna stated she would gladly administer Mitchell's prescription to lessen the possibility of an overdose.</p> <p>Mitchell highlighted housing as an issue that affected all facets of his life. He was given a letter to support his housing application.</p> <p>He was advised to seek support from Citizens' Advice on his benefits.</p> <p>Due to his ADHD, which rendered him unable to concentrate for extended periods, he sought a written summary of the session.</p> <p>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,</p>	AWP (SIS)

	<p>considering herself his carer. She was given a carer's leaflet and invited to join the SIS carers' support group.</p> <p>The author suggests that Brianna should have been offered a carer's assessment (Section 10: Care Act 2014) and should have been provided with support in caring for Mitchell, particularly when he threatened suicide if she did not give him money.</p>	
7 days before Mitchell's death	<p>Brianna called 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.</p> <p>The author proposed that safeguarding should have been considered for Brianna, who stated that Mitchell had emotionally abused her.</p>	AWP
	<p>During an unannounced visit, Mitchell disclosed that he had purchased a plane ticket to visit his aunt in another part of the UK. Mitchell mentioned that his friend was waiting for him in a car park, and he needed a prescription. He believed it would be beneficial to leave Swindon. He agreed to contact the team when he returned.</p> <p>Mitchell was given medication for seven days, which he indicated he would give to his aunt upon his arrival.</p>	AWP (SIS)
	<p>According to Mitchell's family and friends, he had informed AWP that he was travelling independently. AWP had advised Mitchell to take a break from Abe. Nevertheless, Abe had accompanied Mitchell to visit his aunt, unbeknownst to AWP.</p>	Mitchell's Family and Friends
6 days before Mitchell's death	<p>SIS had arranged a taxi to collect Mitchell, but when the team called him, he informed them he was still out of the country.</p> <p>SIS called Mitchell to confirm that he had handed his prescription to his aunt, who confirmed that he had.</p> <p>According to the documentation, he sounded upbeat and engaged well.</p> <p>The author proposed that the team should have asked to speak to Mitchell's aunt to confirm the medication arrangement.</p>	AWP (SIS)
1 day before Mitchell died	<p>Mitchell called SIS to let them know he was boarding the airline and to request an appointment. According to AWP records, he was optimistic; however, he had not taken his prescription and indicated he would explain this during tomorrow's visit. He was informed that the visit would occur at 5 p.m.</p>	AWP (SIS)

The day Mitchell died.	The police were notified that Abe had received a call from Mitchell's cousin's girlfriend to report that he had overdosed, and she was unaware of his whereabouts. He was classified as a high-risk missing person by the police.	AWP Mental Health Control Room)
	Abe reported she sent him a message saying she loved him, which she noted he had read, but he never responded.	AWP (SIS)

3.1 Analysis of Agency Involvement

3.1.1 This section explores the agencies' involvement with Mitchell.

Mitchell had contact with the following Agencies:

1. Avon and Wiltshire Mental Health Partnership NHS Trust
2. GP – Mitchell
3. GP – Abe
4. Great Western Hospital NHS Trust
5. Nelson Trust – Abe
6. Wiltshire Police

Avon and Wiltshire Mental Health Partnership NHS Trust

3.1.2 Mitchell's initial contact with AWP was in September 2015, after an assessment conducted by the MHLT based at GWH.

3.1.3 In February 2018, Mitchell received a diagnosis of ADHD following an assessment conducted by the Specialised ADHD Service at AWP.

3.1.4 Mitchell was provided medication by the ADHD service to treat his ADHD diagnosis; however, the prescription was discontinued in April 2020 and June 2021 due to his overdoses of the prescribed medications.

3.1.5 Mitchell had taken an overdose of his ADHD medication in May 2021; he did not attend two appointments for an ADHD review in February 2022. He received a telephone review from the ADHD team in March 2022. At this review, he requested reinstatement of medication and was offered a follow-up consultation; the service discovered that he had overdosed before this appointment. As a result, Mitchell was discharged from the ADHD service in June 2022.

3.1.6 Mitchell was written to by the ADHD service, which provided an overview of the potential risks associated with ADHD medication overdoses, suggested alternative support systems such as his GP and mental health services, and advised that a period

of stability without overdose would be required before a re-referral for the resumption of ADHD medication.

- 3.1.7 The author would recommend that the ADHD service refer Mitchell to the mental health service, as it is within their Trust and would be more logical than the GP doing so.
- 3.1.8 The MHLT at AWP assessed Mitchell following six overdoses between 2015 and 2022; his most recent overdose occurred in November 2022.
- 3.1.9 AWP considered the legislative framework specification of the Mental Health Act for the least restrictive treatment alternatives for individuals with mental illness. On 19 October 2022, this was used, with Mitchell's consent, to refer to the SIS team in place of hospitalisation. Crisis, contingency and relapse planning were incorporated into his SIS care. This planning process involved identifying triggers and engaging in actions that would decrease the probability of future episodes of suicidal ideation and self-harming behaviours.
- 3.1.10 The implementation of safety planning is endorsed by the [National Institute for Health and Care Excellence](#) (NICE) as a recommended approach to managing suicide. Furthermore, recent findings published in the [British Journal of Psychiatry](#) indicate that safety planning may effectively mitigate the risk of suicidal ideation by 43% among patients who have undergone this intervention.
- 3.1.11 Mitchell did not attend the follow-up appointment. [NICE](#) recommends: "People aged fourteen and over with severe mental illness and substance misuse are contacted if they miss any appointment, rather than being automatically discharged from the service. The service should work with them to arrange appointments at suitable times and places to help them avoid missing appointments in the future."
- 3.1.12 According to [research](#), issues of utility may cause disengagement (people feel the treatment is ineffective), attitude (people feel mistrustful or coerced), or practical considerations (treatment may be challenging to access or complex to schedule). Engagement occurs in the context of an individual's unique personality, social and life circumstances, and symptom burden; there is no universal approach. Consequently, the care plan should be customised to the individual to incorporate engagement.
- 3.1.13 [NHS England](#) placed significant importance on reducing the frequency of missed outpatient appointments. They highlighted the significance of identifying the underlying causes of absenteeism so that appropriate support systems, such as text reminders, can be implemented and attendance rates reduced.
- 3.1.14 The following attempts to engage Mitchell were made:

- First appointment 01/02/22 – Did not attend – offer for further appointment given
- Second appointment 18/02/2022 Did not attend- emailed later to advise, could not find the link
- Third appointment 01/03/2022 – contacted to advise starting a new job – rearranged
- Fourth appointment 10/03/2022 – Assessment attended

3.1.15 During October 2022, following a presentation of suicidal ideation and head banging, Mitchell disclosed a recent breakdown with his girlfriend, whom he characterised as "abusive". Furthermore, the day before, he reported having been assaulted. The Trust did not explore this further with Mitchell, contrary to their procedure, whereby a DASH should have been completed, signposted, or referred to domestic abuse services for men.

3.1.16 The [ManKind Initiative](#) asserts that a lack of professional curiosity can result from the public and professional community's failure to recognise and comprehend male victims, thus erecting further obstacles. The [University of Cumbria](#) conducted a study in 2021 in which it examined twenty-two domestic homicide reviews in which male victims were involved. According to the study, opportunities were missed due to outmoded assumptions that men could not be victims.

3.1.17 According to the [Centre for Social Justice](#), domestic abuse is commonly depicted as a crime that is gendered, with men committing the abuse against women. The hostile and suspicious reception that men face when they disclose domestic abuse to the police effectively silences them. In addition, they found that support services frequently neglect situations involving female abusers and fail to identify the abuse of men.

3.1.18 Despite Mitchell's disclosure, this was not considered throughout his engagement with AWP. An SIS worker advised Mitchell to use his partner's phone to contact services because his phone was not functioning, and an opt-in letter was provided to Mitchell's girlfriend, further emphasising that they had not considered his disclosure of domestic abuse perpetrated by his girlfriend.

3.1.19 In November 2022, Mitchell was readmitted to SIS; Mitchell's prior engagement was considered, and this episode was regarded as a continuation of treatment rather than an isolated incident. However, this did not include either consideration of the disclosure of domestic abuse or an enquiry into domestic abuse.

3.1.20 Professionals and service users recognise continuity of care as a critical component of high-quality health care. Nonetheless, the extent to which this is defined depends on the accessibility of information and the rapport between the healthcare practitioner and the service user ([NHS England](#)). In this case, the information was shared with all the healthcare practitioners who met with Mitchell. Nevertheless, the

review uncovered deficiencies. MHLT had indicated that Mitchell was working with Turning Point and Psychology, but this was not the case. Additionally, the disclosure of domestic abuse was not addressed.

- 3.1.21 The [Royal College of Psychiatrists](#) reported that reduced continuity of care is related to poorer clinical outcomes, and greater therapeutic relationships are predictive of better outcomes for a variety of mental health problems. Therefore, it was positive that Mitchell's re-referral was viewed as ongoing rather than a new referral in isolation.
- 3.1.22 The SIS team does not assign individual practitioners to service users. It is an emergency assessment and intervention service designed to assist those undergoing a mental health crisis. Therefore, establishing a therapeutic relationship with a single practitioner would be difficult.
- 3.1.23 Brianna had discussed her engagement with services with the Trust, and while AWP had encouraged engagement, Brianna was unaware that she could offer information beyond SIS appointments.
- 3.1.24 Families are vital in the treatment of mental illness. Families may be required to provide care for service users with poor mental health. Family participation in individuals with poor mental health may improve service user outcomes, including reduced medication and treatment plan adherence, longer intervals between relapses, fewer hospital admissions, and shorter inpatient stays ([Family Engagement](#)).
- 3.1.25 The [Royal College of Psychiatrists](#) highlighted the need to include families in risk assessment and soliciting their viewpoints. Additionally, the family must be permitted to discuss and appreciate the potential threats their loved one's condition may pose to themselves or others.
- 3.1.26 Brianna was provided with information and invited to participate in a carer support group. However, under [Section 10 of the Care Act 2014](#), anyone over eighteen who provides care for a disabled, old, or ill adult is entitled to a carer's assessment. The assessment should assess the carers' mental and physical health, capacity, willingness to provide care, and interpersonal relationships. Brianna was not referred to a carer's assessment.
- 3.1.27 Brianna revealed that Mitchell had asked for money from her, forcing her to re-mortgage the property. When she refused to give him money in the past, Mitchell threatened to end his life. The team did not discuss this with Brianna or review her care, support needs, and potential safeguarding concerns.
- 3.1.28 The [Care Act 2014](#) specifies the duty to raise safeguarding concerns; the Trust safeguarding team was not approached for advice/support.

- 3.1.29 Brianna highlighted in Mitchell's care notes that Abe was identified as his next of kin four days after she assaulted Mitchell. In addition, she attended an appointment with him.
- 3.1.30 AWP responded to Brianna and stated that on 20 April 2020, following assessment by the MHLT at GWH, Mitchell reported the next of kin as Brianna, with the telephone number provided. When Mitchell next presented to the ED and was seen by the MHLT on 1 June 2021, it was noted that he had contacted his family but did not want them visiting, as they would worry; he signed a consent form to share information, but only with the ADHD service.
- 3.1.31 When Mitchell presented to the ED in October 2022, following an assessment by the MHLT on 15 October 2022, Mitchell consented to share information with X, noted as a cousin on the records (Brianna clarified that it was not his cousin; it was his friend). But no phone number was given.
- 3.1.32 Following this attendance in the ED, Mitchell was followed up by SIS. When he met with them on 17 October 2022, the records noted that Abe (partner) was present for the second half of the appointment. Mitchell was seen again by SIS on 19 October 2022; Abe was present at this appointment. A consent-to-share form was completed at this appointment, and Mitchell consented to share information with Brianna, Abe, and his cousin.
- 3.1.33 Brianna emphasised that the consent to share information with Abe was inappropriate as Mitchell had disclosed she had abused him. The author agreed that this allowed Abe to exert more control over Mitchell.
- 3.1.34 When Mitchell was seen in GWH by the MHLT twelve days before Mitchell died, on the consent to share form, he only gave consent for information to be shared with Abe.
- 3.1.35 On review of the notes, there is an entry nine days before Mitchell died stating that Brianna is his carer and that all appointments are to be made through Brianna. Brianna's number was recorded.
- 3.1.36 It is anticipated that the presence of alleged abusers at appointments will restrict the individual's ability to communicate freely and may also indicate controlling and coercive behaviour from the alleged abuser.

3.1.37 The Trust made five recommendations.

GP - Mitchell

3.1.38 The GP practice supported Mitchell with the following: mental health, seizures, stomach issues, minor injuries, and medicine prescriptions.

- 3.1.39 Mitchell did not routinely attend his scheduled sessions; the practice called him, left messages, and sent him letters to assist with his engagement. This is consistent with NHS England's instruction (as above) to decrease non-attendances.
- 3.1.40 Upon reviewing the discharge report, the author of the IMR observed that support in the form of a home visit might have been recommended. The author also noted that Mitchell had been hospitalised after an intentional overdose.
- 3.1.41 The IMR author also remarked that professional curiosity was not used during Mitchell's appointments to understand his well-being and relationship with his partner and refer him to appropriate resources.
- 3.1.42 Mitchell frequently reported to the GP that he could not recollect the circumstances behind the minor injuries, and he did not disclose domestic abuse. Notwithstanding this, GWH notified the GP practice that Mitchell had disclosed domestic abuse. No further action was taken with this information. The GP uses 'codes' on their clinical recording system. However, this was not entered for Mitchell.
- 3.1.43 [Safe Lives](#) has issued guidance to assist GPs in addressing domestic abuse. The guidance emphasises the importance of understanding local domestic abuse services, establishing access routes to these resources, and providing staff training.
- 3.1.44 As stated by the [General Medical Council](#) (GMC), patients should be provided with information to aid in decision-making, such as establishing communication with support agencies that support individuals enduring domestic abuse.
- 3.1.45 Additionally, the [GMC](#) states:
- "But in very exceptional circumstances, you may be able to justify disclosing information without consent, where:*
It is necessary to prevent a serious crime such as murder, manslaughter or serious assault
There is clear evidence of an imminent risk of serious harm to the individual and no alternative (and less intrusive) methods of preventing that harm."
- 3.1.46 To combat domestic abuse, the [House of Commons](#) issued twenty-three recommendations, many of which were particular to NHS practices. Two such recommendations are as follows:
1. *All NHS staff should have and apply a clear understanding of the risk factors for violence and abuse and the consequences for the health and well-being of violence and abuse when interacting with patients...*
 2. *Every NHS organisation should have a single designated person to advise on appropriate services, care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk.*

3.1.47 The Royal College of Nursing (RCN) also offered recommendations in this domain:

“Make every contact count; health services can be the first, and only, point of contact for victims. GPs, in particular, are trusted professionals, trained to listen actively to patient stories and pick up on hidden cues.”

3.1.48 Save Lives, GMC, RCN and House of Commons recommendations apply equally to male victims of domestic abuse or wider harms.

GP Practice – Abe

3.1.49 Only those aspects that are relevant to the review are addressed.

3.1.50 According to a safeguarding alert issued by SWASFT, Mitchell had assaulted Abe. The practice wrote to Abe, offering her an appointment. However, Abe reported that she was staying with Mitchell.

3.1.51 Abe moved to another practice, and the information above was not disclosed to the new practice.

3.1.52 [Safe Lives](#) issued guidance and the UK Caldicott Guardian Council, highlighting the importance of information sharing to minimise the risk of further domestic abuse.

3.1.53 A segment of DHR Statutory Guidance is devoted to safe and effective information sharing. It emphasises the need for agencies to know potential risks to facilitate their work with victims/survivors and perpetrators.

Great Western Hospital NHS Foundation Trust

3.1.54 During the period under review, Mitchell visited the hospital on eleven separate occasions. Ten of these were attendances in the ED, and one was a referral to neurology, where Mitchell was discharged from the clinic with no concerns identified with the fainting episodes.

3.1.55 Aside from the above, the following nine attendances were for the following:

- One explained a back injury.
- Four involved head injuries in the context of self-harm and alcohol consumption.
- Four involved self-harm with medication.
- The police brought in Mitchell on two occasions; he had self-harmed by striking his head against a wall and verbally expressed suicidal thoughts.
- One for excessive alcohol use on a background of suicidal ideation.

3.1.56 Mitchell met the referral criteria for a High-Intensity User (HIU) after the last presentation, three attendances in three months or five in a year. This prompted a

review for support and management to formalise an agreed-upon safety management plan.

- 3.1.57 Mitchell was assessed by the HIU specialist nurse, who also extended an option for an alcohol liaison referral. However, he declined the referral due to the consent requirement, so no referral was made. He stated that alcohol consumption was not an issue and that he engaged in binge drinking rather than daily drinking.
- 3.1.58 The author of the IMR observed that Mitchell did not receive a domestic abuse score during triage; had he been, he would have been assigned a red triage status, which would have elevated the priority for him to obtain an HIU plan. His GP was informed of his inclusion on the HIU plan, and a review was arranged; this was cancelled due to Mitchell's death.
- 3.1.59 On 15 October 2022, Mitchell was brought by police to the ED. A Registered Mental Health Nurse was assigned to observe him to ensure his safety, and the ED referred him to the MHLT.
- 3.1.60 The MHLT recorded the following in the clinical notes: *'Recent bereavement and ended the four-year relationship last night, currently in crisis. Cannot return to the shared house where ex lives (Domestic Violence*).'*
- 3.1.61 Mitchell was discharged from the ED, accompanied by his girlfriend. The entry did not indicate whether Mitchell was the victim or the perpetrator, and it was unclear whether ED staff had seen the entry before discharge.
- 3.1.62 Having disclosed domestic abuse at the hands of his abusive girlfriend and then being discharged and leaving with her raises a question of how this made Mitchell feel and whether it made him safe. There is no evidence of whether he was offered the opportunity to contact the police and/or domestic abuse services. It also raises the question of whether the ED would have given the same response if the genders had been reversed.
- 3.1.63 According to the [Mankind Initiative](#), most males do not recognise they are victims until they have lost control of their lives and become socially isolated.
- 3.1.64 Eight of Mitchell's presentations to the ED were for self-harm; self-harm may be a result of relieving stress or a coping strategy ([Coping Style and Intentional Self-Harm](#)).
- 3.1.65 An article examining intimate partner abuse, self-harm, and suicidality was published in The [Lancet](#), which reported that the male rate is 50% of the female rate. It may well be that, given that far more men take their own lives than women, the actual volumes of female and male suicides due to intimate partner violence could be the same. There is more research needed on male victims.

- 3.1.66 Domestic abuse was not discussed throughout any of Mitchell's presentations regarding suicidal ideation and self-harm at ED, and it may be considered that the vagueness of the recording was because he was male.
- 3.1.67 The author of the IMR emphasised the MHLT notes' vagueness and speculated that this may have impacted their staff in not enquiring about domestic abuse.
- 3.1.68 Literature on male victims reveals that men's reluctance to come forward is influenced in part by the fear of being disbelieved. Unfortunately, the literature is accurate since Mitchell reported this to the MHLT while at GWH and was discharged in the company of his girlfriend. On his subsequent presentations to the ED, no additional enquiries were made.
- 3.1.69 GWH made two recommendations.

Nelson Trust

- 3.1.70 Only those aspects that are relevant are covered in the review.
- 3.1.71 Abe participated in six Nelson Trust sessions. She expressed concern during these sessions about Mitchell, whom she claimed to have a gambling addiction; she was also concerned that he would be unfaithful to her because he was associating with a female friend.
- 3.1.72 The Nelson Trust made three recommendations.

Wiltshire Police

- 3.1.73 Mitchell had prior contacts with the police before the review period, both as a victim and as a witness. None of these interactions was related to domestic abuse.
- 3.1.74 In November 2018, the police knew that Mitchell was in a relationship with Abe. They lived in separate rooms within a multi-occupancy house in Swindon, albeit at the same address.
- 3.1.75 The records indicate that Mitchell had a history of self-harm and suicidal ideation, financial issues, and was a gambler.
- 3.1.76 Thirteen incidents of domestic abuse between Mitchell and Abe were documented by the police during the review period, with both individuals being identified as the victims and perpetrators.
- 3.1.77 Abe initially reported a domestic dispute between the couple to the police in November 2018 when she complained about Mitchell obtaining a loan in her name. Police were subsequently informed that the money had been refunded and that she had decided against progressing a case.

- 3.1.78 A third party reported that a couple had been arguing in July of 2019. In October 2019, an ambulance contacted the police in response to a report of a female victim who had sustained injuries in a domestic dispute. Abe reported to the police that an altercation had occurred, during which both parties were at their worst. She further disclosed that she had suffered a cut while cleaning the mess.
- 3.1.79 From December 2019 to March 2020, the couple was the subject of five reports of domestic incidents, the majority of which involved verbal disputes. Abe, who had struck and kicked Mitchell, was arrested, questioned, and given an unconditional caution. According to the panel, five incidents during twelve months should have justified a referral to MARAC.
- 3.1.80 MARAC is a meeting that facilitates the exchange of information regarding the most severe domestic abuse cases. Representatives from the statutory or voluntary sectors, including police, health, child protection, housing, probation, and independent domestic violence advisors, attend these meetings ([Safe Lives](#)).
- 3.1.81 The MARAC would have allowed Mitchell to engage with a specialist domestic abuse service, and for all agencies to share the information they possessed to ensure an appropriate safety plan.
- 3.1.82 Ongoing calls to the police regarding domestic incidents involving the couple contained 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 engaged in an argument. The officers did not observe any injuries on either occasion.
- 3.1.83 Brianna filed a missing person's report in April 2020, detailing the receipt of text messages from Mitchell, which included suicide ideation and expressions of wanting to be relieved of the burden he had become. After determining that Mitchell was a high-risk missing person, officers initiated a search for him. Following Mitchell's return to his home after overdosing on his ADHD medication, an ambulance transported him to GWH.
- 3.1.84 Abe contacted the police in October 2021 to say that Mitchell had assaulted her twice between September and October 2021. After obtaining images of the injuries, Mitchell was arrested. Mitchell refuted the assault, attributing it to self-defence. No further action was taken.
- 3.1.85 The author believed that Mitchell's report of self-defence should have been further investigated to determine whether he was a victim of domestic abuse.
- 3.1.86 Attending officers prepared and submitted PPNs to the police MASH in response to domestic abuse incidents. The officers on the scene had concluded the safeguarding process. The outcome did not support a referral to domestic abuse services without

consent; such a referral would be possible only if the individual had received a high-risk rating.

- 3.1.87 Mitchell reported being assaulted by Abe to Thames Valley Police in Reading in November 2021; Abe was arrested, but no further action was taken.
- 3.1.88 Thames Valley Police confirmed the outcome of this contact: 'Police were called to a Hotel in Reading following a call for service from Mitchell concerning a domestic incident. On arrival, Mitchell and Abe greeted the officers. Mitchell reported being bitten by Abe on the arm, which left a mark; he pinned her down to prevent further assault, and he was punched in the face when he released her, causing a bloody nose.
- 3.1.89 Abe advised officers that Mitchell started shouting at her following a text message she had received; Mitchell had pinned her down on the floor and put his hands around her neck, and Abe had punched Mitchell in the face to get him off. Officers noted reddening on Abe's cheeks and arms, but no marks on her neck. Abe was arrested and advised not to contact Mitchell; no further action was taken later. Mitchell did not make a statement of complaint or answer the DASH on the night of the incident, nor did he do so later, when officers approached him while Abe was on bail.
- 3.1.90 Abe reported her concern for Mitchell to the police in April 2022 after an argument. Mitchell declared his need for personal space and left the area; Abe attempted to communicate with him but received no response. Officers discovered Mitchell at a friend's home. He stated he only required some space and denied any dispute. A PPN, including a DASH-standard risk assessment, was submitted to the police MASH and not further disseminated; no offences were discovered.
- 3.1.91 Mitchell contacted the police in July 2022 and reported that Abe had verbally abused him. Mitchell informed the police of the situation. A dispute arose around the use of a communal mobile phone. Upon completing initial safeguarding measures, no offences were detected; Abe returned to her family, while Mitchell spent the night with friends. PPN, including standard risk DASH, was submitted to the police MASH without further dissemination.
- 3.1.92 In October 2022, officers on patrol were flagged down by Mitchell, who was reportedly experiencing a mental health crisis. Mitchell had suffered head injuries because of banging his head against a wall.
- 3.1.93 He was transported to GWH after being intoxicated. Mitchell disclosed that his partner, Abe, had assaulted him, resulting in a minor scratch on his neck. Details were not obtainable from Mitchell at that moment owing to his level of intoxication and the necessity of medical attention. When Mitchell responded to the officer's repeated attempts to communicate, he clarified that he had no complaints and had initially misled the police.

- 3.1.94 According to Mitchell, Abe's attempt to dissuade him from using drugs caused him to sustain a scratch on the neck. Mitchell expressed his decision not to file a police report. There was no evidence to suggest he was in an abusive relationship, and he and Abe were concurrently seeking support for their mental health concerns. An investigation was conducted, and officers attempted to engage with Mitchell. However, Mitchell declined to file a complaint and did not endorse a prosecution. Consequently, the case was closed without further action.
- 3.1.95 The officer advised Mitchell on safeguarding and furnished him with a directory of domestic abuse services he might contact. The directory contained male domestic abuse services. A standard operating procedure was placed on the home address to increase the awareness of responding officers regarding the history of domestic abuse. The police MASH was provided with a PPN.
- 3.1.96 It is Force Policy that all PPNs have an automatic workflow into the MASH, where a Police decision-maker then reviews them to determine if they should be shared with wider partners. Any PPN that mentions children being present/involved is forwarded to children's services once checks have been made to confirm if the child is open to children's services. The information has been graded to determine the child's risk level. For PPNs involving adults, the MASH Police colleagues do not have access to the local authorities' adult systems to check if a person is open to adult social services. Routine checks with adult social services colleagues would only be carried out where the adult has been highlighted as vulnerable within the PPN. Depending on the results of these checks, a decision will be made on whether the PPN needs to share information with other partner agencies to support the adult further.
- 3.1.97 Officers conducted DASH risk assessments using a grading system to categorise risks as standard, medium, or high. As per force policy, the attending officer must finalise safeguarding measures with the victim in standard to medium-risk situations. A high-risk situation will be automatically sent to the MARAC.
- 3.1.98 Previously, the details of safeguarding measures used by officers were not always clearly recorded. However, a safeguarding checklist was developed in August 2022 and integrated into police processes to document safeguarding activities and ensure no safeguarding measures were overlooked. This was completed in October 2022 concerning the domestic abuse incident.
- 3.1.99 Mitchell and Abe's alleged status as both victims and perpetrators of domestic abuse suggests that bidirectional abuse may have marked the relationships.
- 3.1.100 [Elizabeth Bates](#) characterised bidirectional abuse as:

'Bidirectional or mutual abuse can be prevalent and unrelenting in big and small matters. It suggests that both partners can display aggressive behaviours during a

conflict. However, this may not be the case with each conflict episode and may not be symmetrical.'

- 3.1.101 According to [research](#) in bidirectional abuse, men were less frequently categorised as "victims" and women as "perpetrators." The study also found that men were less likely to be advised to "contact the police" in situations involving bidirectional abuse.
- 3.1.102 Among all other types of crime, victims of domestic abuse are most likely to experience a recurrence of the abuse. Repeat victims must be identified by the police immediately. Therefore, the officer's ability to recognise patterns of abuse will be enhanced. This is especially crucial when a single incident does not appear significant, but earlier incidents demonstrate a pattern of behaviour ([Police Response to Domestic Abuse](#)).
- 3.1.103 This implies that perceiving the incidents as a recurring pattern of abuse would prompt a more robust response towards Mitchell and Abe, requiring a multi-agency consultation that may include consultations with domestic abuse services to gain a more comprehensive understanding of the relationship dynamic.
- 3.1.104 Wiltshire Police made one recommendation.

3.2 Analysis of Terms of Reference

- 3.2.1 This section analyses the Terms of Reference (TOR) and draws together the key findings arising from agency involvement. It should be read alongside section 3.1, which sets out the detailed agency chronology and analysis.

TOR 1: Identify good practice where responses may have surpassed required standards

- 3.2.2 The review identified examples of positive practice across agencies. AWP involved Brianna in aspects of Mitchell's care and invited her to attend a carers group. She was also provided with information about Swindon Carers.
- 3.2.3 The SIS team demonstrated structured consideration of Mitchell's mental health presentation, including the use of mental health legislation to support decision-making and the development of crisis, contingency, and relapse planning in response to suicidal ideation.
- 3.2.4 The decision to treat Mitchell's later presentation as a continuation of care, rather than a separate and isolated episode, reflected good practice and supported continuity of care.
- 3.2.5 GWH appropriately identified Mitchell as meeting the criteria for High Intensity User support, and the referral to the HIU service was appropriate.

- 3.2.6 Police officers responded promptly to domestic abuse incidents and completed safeguarding procedures, including DASH risk assessments and PPNs. Mitchell was also provided with information about domestic abuse services, including services for male victims.

TOR 2: Were Mitchell's service responses affected by the COVID-19 pandemic?

- 3.2.7 Agencies did not identify direct operational concerns arising from COVID-19. However, the wider context of the pandemic is relevant to Mitchell's circumstances and engagement with services.
- 3.2.8 During the pandemic, many services moved to remote delivery. The GP IMR author noted that this may have affected Mitchell's ability to engage and may have reduced opportunities for professionals to create a safe environment in which he could disclose domestic abuse, trauma, or other vulnerabilities.
- 3.2.9 Research into the impact of COVID-19 ([COVID-19 and Domestic Abuse](#) and [COVID-19 Lockdowns](#)) has identified isolation, reduced face-to-face contact, and restricted movement as significant risk factors for victims of domestic abuse. These conditions could increase a victim's dependence on, or proximity to, the alleged perpetrator.
- 3.2.10 Brianna reported that Mitchell's isolation affected his ability to interact with others and left him increasingly alone with Abe. This is relevant to the review's consideration of coercive control, help-seeking, and missed opportunities for professional intervention.

TOR 3: How readily was Mitchell able to use services?

- 3.2.11 Mitchell had access to a range of services, including AWP, his GP, GWH, and the police. He also had repeated contact with emergency and mental health services in relation to self-harm, overdose, suicidal ideation, and domestic abuse incidents.
- 3.2.12 Although Mitchell could access services, the effectiveness of that access was limited by the way in which his needs were understood and responded to. His mental health presentations were recognised, but the relationship between his mental health, self-harm, domestic abuse disclosures, financial hardship, substance use, and isolation was not consistently explored.
- 3.2.13 Mitchell was not referred to domestic abuse services by health agencies, nor is there evidence that he was clearly signposted to specialist male domestic abuse support by AWP, GWH, or his GP. Police did provide information about domestic abuse services, including services for men, but the panel has not seen evidence that Mitchell engaged with them.
- 3.2.14 There was a lack of clarity regarding support following Mitchell's discharge from the ADHD service and SIS. This included uncertainty about how he was being supported

in the absence of ADHD medication and how his use of self-harm as a coping strategy was being addressed.

- 3.2.15 Financial hardship was known to agencies, and Brianna suspected financial abuse. There is no evidence that Mitchell was directed to available financial support or that financial abuse was explored as part of a wider domestic abuse assessment.
- 3.2.16 Mitchell's access to informal support was also limited. Brianna and Katie described his reduced contact with friends and family, including his non-attendance at his brother's wedding. This isolation was relevant to both domestic abuse risk and suicide risk.
- 3.2.17 Research ([Dying from Inequality](#) and [Unveiling The Hidden Crisis](#)) indicates that male victims of domestic abuse may be less likely to disclose, less likely to be recognised as victims, and less likely to access support. This was an important contextual factor in Mitchell's case.

TOR 4: How did agencies respond to information that Mitchell may have been a male victim of domestic abuse?

- 3.2.18 A central finding of the review is that Mitchell's disclosures of domestic abuse were not adequately explored, assessed, or acted upon by health agencies.
- 3.2.19 AWP acknowledged that Mitchell's disclosure should have led to completion of a DASH risk assessment. This did not happen. As a result, his level of risk and vulnerability was not formally assessed, and opportunities for safety planning, signposting, or referral were missed.
- 3.2.20 There was also insufficient professional curiosity about the impact of domestic abuse on Mitchell's mental health. His presentations involved self-harm, suicidal ideation, intoxication, relationship breakdown, and allegations of abuse, yet domestic abuse was not consistently considered as a potential driver of risk.
- 3.2.21 GWH records referred to domestic violence but did not clearly identify whether Mitchell was the victim or perpetrator. This lack of clarity may have affected subsequent enquiry, risk assessment, and discharge planning.
- 3.2.22 Mitchell was discharged from GWH in the company of Abe despite the recorded reference to domestic violence. The review considers this a significant missed opportunity to clarify risk and provide Mitchell with a private opportunity to speak.
- 3.2.23 The GP practice was notified that Mitchell had disclosed domestic abuse, but no further action was taken, and the information was not coded in his clinical record.
- 3.2.24 Police completed DASH assessments and PPNs and followed relevant policy. However, the number of domestic abuse incidents involving Mitchell and Abe should

have prompted stronger consideration of cumulative risk and potential escalation, including MARAC referral.

- 3.2.25 Mitchell's family and friends believe that gendered assumptions contributed to services not recognising him as a domestic abuse victim. The review considers this a credible concern, particularly given the limited professional curiosity shown following his disclosures.
- 3.2.26 Indicators of coercive and controlling behaviour were present. These included isolation from family and friends, concerns about the use of phones, Abe's attendance at appointments, threats of self-harm if Mitchell left, and reports that Mitchell felt responsible for Abe's safety. These indicators were not sufficiently identified or assessed by agencies.
- 3.2.27 The case demonstrates the importance of recognising that domestic abuse can affect male victims, can involve female perpetrators, and can exist within complex or bidirectional relationship dynamics. This should not reduce the seriousness of risk to either party, but it should prompt careful, evidence-based assessment.
- 3.2.28 Evidence ([Improving Outcomes for Male Victims](#)) suggests male victims are often overlooked due to gendered assumptions, potentially contributing to the lack of response in Mitchell's case.
- 3.2.29 Police completed DASH and PPNs appropriately; however, the panel considered that repeated incidents may have warranted MARAC referral. Indicators of coercive control were reported but not identified by services.
- 3.2.30 The introduction of [Domestic Abuse Risk Assessment](#) (DARA) aims to improve the identification of coercive control, though DASH remains necessary for safeguarding processes.
- 3.2.31 During the pilot phase of DARA, the proportion of police reaching the same risk assessment as a domestic abuse expert increased by 38%. Officers were better positioned to reduce or eliminate the risk and protect the victim from further harm ([College of Policing](#)).
- 3.2.32 [Safe Lives](#) emphasises that the DARA should not replace the DASH and that safeguarding officers and specialised support services should continue to use it.
- 3.2.33 The case aligns with the eight-stage [Suicide Timeline](#) suicide timeline:
1. History of abuse: Multiple police reports involving both parties.
 2. Intense relationship: Rapid progression and increasing isolation.
 3. Control: Evidence of coercive and controlling behaviour.
 4. Disclosure: Mitchell disclosed abuse, but responses were limited.

5. Help-seeking: Contact with police and health services without effective intervention.
6. Suicidal ideation: Repeated presentations with self-harm and suicidal thoughts.
7. Entrapment: Mitchell expressed feeling responsible and unable to leave.
8. Outcome: Suicide.

TOR 5: Alternatives for perpetrator disruption or victim safety planning

- 3.2.34 The review found limited evidence of safety planning in response to Mitchell's domestic abuse disclosures.
- 3.2.35 AWP had a directory of domestic abuse support services at the time of Mitchell's involvement, but this was not used with him. AWP has since developed a domestic abuse safety planning toolkit, although this was not in place when Mitchell was receiving support.
- 3.2.36 The absence of a DASH assessment meant that opportunities for structured domestic abuse intervention were missed. Had the disclosure been assessed appropriately, Mitchell could have been signposted or referred to specialist support, including services for male victims.
- 3.2.37 Police issued Abe with an unconditional caution following one incident. Police records identified both Mitchell and Abe as victims and perpetrators at different points. This complexity required careful consideration of pattern, context, control, and cumulative harm.
- 3.2.38 The review considers that repeated domestic abuse contacts should have prompted a more coordinated response, including consideration of MARAC and specialist domestic abuse input.

TOR 6: Policies, procedures, and assessment tools for domestic abuse

- 3.2.39 Agencies had relevant domestic abuse policies and procedures. The issue was not primarily the absence of policy, but inconsistent application.
- 3.2.40 AWP policy required completion of a DASH risk assessment where domestic abuse was newly disclosed or where new information about known domestic abuse emerged. This process was not followed in Mitchell's case.
- 3.2.41 GWH had domestic abuse policies and access to domestic abuse support, including IDVA provision and links with the Swindon Domestic Abuse Service. However, Mitchell was not identified as a victim and therefore did not benefit from this provision.

3.2.42 Police used PPNs and DASH risk assessments in accordance with policy. However, the review found that repeated standard-risk incidents may still reveal a pattern that warrants escalation or multi-agency discussion.

TOR 7: Was information promptly communicated to all relevant parties?

3.2.43 Communication within AWP teams was generally evident, particularly between MHLT, SIS, and ADHD services. However, domestic abuse information was not sufficiently discussed or acted upon.

3.2.44 AWP and GWH communicated with Mitchell's GP regarding presentations and assessments. However, the information that Mitchell had disclosed about domestic abuse did not lead to meaningful action by the GP practice.

3.2.45 Communication between AWP and GWH regarding domestic abuse was insufficient. The record lacked clarity, and there was no evidence of any verbal discussion to determine whether Mitchell was a victim, a perpetrator, or both.

3.2.46 Police PPNs were reviewed in MASH according to policy. The threshold for further sharing was not met. However, the review considers that the cumulative pattern of incidents should have been more clearly recognised.

3.2.47 Overall, information was shared in some respects, but it was not always interpreted, clarified, or used effectively to inform risk management.

TOR 8: Were collaborative discussions undertaken to review risk factors?

3.2.48 There was evidence of collaboration around Mitchell's mental health, particularly within AWP and through the development of the HIU plan.

3.2.49 However, there was limited evidence of collaborative discussion about the combined risks of domestic abuse, self-harm, suicidal ideation, substance use, financial difficulty, and social isolation.

3.2.50 Domestic abuse services were not involved in Mitchell's care. This limited the opportunity for specialist assessment of coercive control, victim safety, perpetrator behaviour, and barriers to disclosure.

3.2.51 [Research](#) from DHRs has identified a recurring issue of professionals lacking confidence or curiosity when asking about domestic abuse, suicide, and the relationship between the two. This theme is reflected in Mitchell's case.

3.2.52 The [University of Manchester](#) indicated that risk assessment tools alone are insufficient to predict self-harm or suicide. Professional curiosity, contextual analysis,

and multi-agency information sharing are required, particularly where domestic abuse and suicidality coexist.

TOR 9: Significant considerations and decision-making opportunities

- 3.2.53 The most significant missed opportunity was the failure to fully explore Mitchell's disclosure of domestic abuse and its relationship to his mental health and suicide risk.
- 3.2.54 AWP should have completed a DASH assessment, considered safety planning, and clearly communicated the disclosure to GWH and the GP. This would have enabled a more coordinated response.
- 3.2.55 GWH should have clarified the domestic abuse entry before discharge, particularly as Mitchell left the hospital with Abe. This was a key point at which private enquiry and safety planning could have occurred.
- 3.2.56 The GP practice had an opportunity to follow up on the domestic abuse information received from GWH/AWP and consider coding, enquiry, signposting, or safeguarding advice.
- 3.2.57 Police had repeated contact with Mitchell and Abe. Although individual incidents may not all have met high-risk thresholds, the pattern and frequency of incidents should have prompted consideration of escalation.
- 3.2.58 The review also identified incomplete safeguarding documentation within the mental health assessment. Risk to self and others is a critical part of assessment and should be consistently recorded.

TOR 10: Would anything else have been done, and would it have made a difference?

- 3.2.59 It is not possible to determine whether different actions would have prevented Mitchell's death.
- 3.2.60 However, the review identified several actions that should reasonably have been taken upon completion of a DASH assessment, private enquiry about domestic abuse, clearer information sharing, referral or signposting to specialist domestic abuse services, and consideration of cumulative risk.
- 3.2.61 These actions may have improved Mitchell's access to support, increased professional understanding of his circumstances, and enabled more effective safety planning.
- 3.2.62 The review considers that gendered assumptions, limited professional curiosity, and insufficient recognition of male victimisation may have contributed to the lack of response.

TOR 11: Capacity and resources

3.2.63 The participating agencies did not identify capacity or resource concerns that prevented them from delivering services to Mitchell, Abe, or other relevant individuals.

TOR 12: The participating agencies did not identify capacity or resource concerns that prevented them from delivering services to Mitchell, Abe, or other relevant individuals

3.2.64 AWP has undertaken significant work since Mitchell's death in relation to suicide risk profiling. This includes analysis of suicide-related deaths among service users and identification of domestic abuse as a significant risk factor.

3.2.65 Where domestic abuse is identified as a possible factor preceding suicide, AWP now undertakes further analysis of associated risk factors. The Trust has also shared learning through training events and with partner agencies.

3.2.66 AWP now recognises domestic abuse as a significant risk factor for suicide and has recommended that this be included as a prompt in safety assessments for people presenting with suicidal ideation.

3.2.67 GWH has recognised the challenges of identifying domestic abuse within the ED environment, where the primary focus is often physical health assessment and treatment. However, the Trust has strengthened safeguarding arrangements, including domestic abuse support, training, and safeguarding oversight.

3.2.68 GWH's work to improve ED pathways and information exchange provides an opportunity to ensure domestic abuse is better embedded into emergency care processes.

3.2.69 Wiltshire Police have introduced Domestic Abuse Matters training for frontline staff, with emphasis on coercive and controlling behaviour and safeguarding referral pathways.

3.2.70 Police have also introduced a safeguarding checklist to improve documentation of safeguarding actions and referrals.

3.2.71 The review identified a broader learning point about adult safeguarding information sharing. Unlike children's safeguarding, adult systems are not routinely accessible to police MASH staff, which can limit understanding of whether an adult is already known to services.

TOR 13: National or local enhancements to legal and policy frameworks

3.2.72 Further research is required into the relationship between domestic abuse and suicide, particularly for male victims. The review identified that male victimisation remains under-recognised and under-researched.

3.2.73 Local systems should ensure that domestic abuse policies, training, and risk assessment tools explicitly address male victims, coercive control, bidirectional abuse, and the relationship between domestic abuse and suicide.

TOR 15: Equality and diversity

3.2.74 Equality and diversity considerations are relevant to Mitchell's experience, particularly in relation to sex, mental health, unemployment, financial hardship, substance use, housing instability, and social isolation.

3.2.75 Mitchell's sex is a significant factor. [Research, case analysis of domestic homicide reviews](#) and family evidence suggest that male victims may be less likely to be recognised, believed, or supported. Mitchell himself expressed concern that services would not believe him.

3.2.76 Mitchell's financial difficulties and unemployment increased his vulnerability. [Shelter](#) identifies financial instability, poverty, debt, unemployment, and poor housing as factors associated with increased suicide risk.

3.2.77 Mitchell also reported housing concerns. Where domestic abuse is present, victims need clear information about their housing rights, options for remaining safely in the home, and options for leaving if necessary.

3.2.78 Substance use was also relevant. Agencies recorded alcohol misuse, and police were informed of drug use. Substance misuse can increase vulnerability and complicate assessment, but it should not prevent a domestic abuse enquiry ([Safe Lives](#)).

3.2.79 An intersectional approach is required to understand how these factors interact. Mitchell's experience cannot be understood through a single lens, such as gender or mental health ([Intersectionality](#)). His vulnerability arose from the combined effect of domestic abuse, suicidality, financial hardship, isolation, substance use, and limited support.

The review identified the following overarching findings:

- Mitchell's mental health needs were recognised, but the relationship between domestic abuse and suicide risk was not sufficiently explored.
- Domestic abuse disclosures were not consistently clarified, assessed, or acted upon.
- AWP should have completed a DASH assessment, but it was not.
- Health agencies did not refer or clearly signpost Mitchell to specialist domestic abuse services.

- GWH did not clarify whether Mitchell was a victim or perpetrator before discharge.
- The GP practice did not act on information that Mitchell had disclosed domestic abuse.
- Police followed procedures, but cumulative risk from repeated incidents required stronger consideration.
- Gendered assumptions may have contributed to Mitchell not being recognised as a male victim.
- Information sharing occurred but did not consistently lead to risk-informed action.
- Agencies have since made improvements in training, safeguarding, documentation, and recognition of domestic abuse as a suicide risk factor.

4.1 Conclusion

- 4.1.1 The purpose of the review is to determine the circumstances behind the death of Mitchell in November 2022 and ‘articulate life through the eyes of the victims.’
- 4.1.2 Mitchell was diagnosed with ADHD; however, the medication was discontinued in June 2021, as Mitchell had overdosed on the medication. He was discharged from the ADHD service in June 2022.
- 4.1.3 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.
- 4.1.4 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.
- 4.1.5 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.
- 4.1.6 Mitchell contacted the police to report Abe's domestic abuse towards him.
- 4.1.7 The review revealed no health response to Mitchell’s disclosures. According to [Safe Lives](#), only one in every five victims contacts the police, while many more seek medical attention. Health providers, whether at a GP's surgery, a maternity centre, or a mental health facility, are, therefore, well-positioned to detect signs of domestic abuse and provide timely help and information.
- 4.1.8 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.

- 4.1.9 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.
- 4.1.10 In 2021, the [University of Cumbria](#) conducted a study in which it examined twenty-two 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.
- 4.1.11 The police provided Mitchell with a directory of domestic abuse services he could access.
- 4.1.12 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.
- 4.1.13 As of June 2023, 43 organisations in the UK offer 302 shelter or safe home spaces for males (99 dedicated for men and 203 for men or women). The data presented is significantly distorted by a single organisation that controls 37 spaces. If these were eliminated, forty-two organisations would use 265 spaces. Four spaces are the median quantity per organisation ([ManKind](#)).

5.1 Lessons to be Learned

- 5.1.1 This section outlines the key thematic learning identified from the review. These themes are intended to inform future practice, strengthen professional responses, and improve multi-agency working. They are not case-specific findings but reflect broader systemic learning.

Male Victims of Domestic Abuse

- 5.1.2 Domestic abuse can affect individuals of any gender. However, male victims may face additional barriers to recognition, disclosure, and support, including stigma, societal expectations, and concerns about not being believed.
- 5.1.3 [Research](#) indicates that domestic abuse is often perceived as a gendered issue, which can influence both professional responses and help-seeking behaviour. This may result in male victims being under-identified and less likely to access appropriate support services ([Supporting Male Victims, Gov.UK](#)).
- 5.1.4 Services should ensure that responses to domestic abuse are inclusive and responsive to the needs of all victims. This includes recognising male victimisation, avoiding assumptions, and ensuring that support pathways are clearly communicated and accessible.

5.1.5 Wiltshire Police have implemented measures to strengthen awareness of male victims, including training programmes, internal communications, and improved visibility of specialist support services.

Coercive and Controlling Behaviour

5.1.6 Domestic abuse includes patterns of coercive and controlling behaviour, as defined in legislation. These behaviours may not be physical but can have significant psychological, emotional, and social impacts.

5.1.7 Coercive control may involve isolation from support networks, restriction of independence, monitoring of communication, and the creation of dependency. These indicators can be less visible and may require proactive enquiry to identify.

5.1.8 Risk assessment tools and training aim to support the identification of coercive control; however, their effectiveness depends on consistent application and practitioner confidence in recognising non-physical forms of abuse.

Response to Disclosures of Domestic Abuse

5.1.9 Professionals across health, social care, and criminal justice settings play a key role in identifying and responding to domestic abuse. Individuals may disclose abuse directly or present with indicators that require further exploration.

5.1.10 An effective response to disclosure should include:

- Appropriate risk assessment
- Clear documentation
- Consideration of safeguarding needs
- Information sharing where appropriate
- Referral or signposting to specialist support services

5.1.11 Timely and proportionate responses are essential to ensure that individuals are supported and that risks are appropriately managed ([Department of Health and Social Care published guidance](#))

Self-Harm, Suicide and Domestic Abuse

5.1.11 There is a recognised association between domestic abuse and self-harm, suicidal ideation, and suicide ([Domestic Abuse and Self-Harm](#)). Experiences of abuse can contribute to psychological distress, feelings of entrapment, and reduced coping capacity ([Refuge and the University of Warwick](#)).

5.1.13 Professionals should consider domestic abuse as a potential underlying factor when assessing individuals presenting with self-harm or suicidal thoughts.

5.1.14 Risk assessments should be holistic, considering mental health, interpersonal relationships, social circumstances, and safeguarding concerns.

5.1.15 While structured assessment tools are important, they should be used alongside professional judgement and contextual understanding

Professional Curiosity

5.1.19 Professional curiosity is a critical component of safeguarding practice. It involves actively seeking to understand an individual's circumstances, asking appropriate questions, and avoiding assumptions.

5.1.17 It is particularly important where abuse may not be immediately visible, where disclosures are partial or inconsistent, or where individuals may feel unable to speak openly.

Routine Enquiry and Identification

5.1.20 Professionals, particularly in healthcare settings, are well placed to identify domestic abuse due to regular contact with individuals ([Safe Lives](#)).

5.1.21 Routine enquiry can support identification where there are indicators such as mental health concerns, substance use, unexplained injuries, or repeated service contact.

5.1.22 To aid professionals in facilitating enquiries, a [report](#) revealed that an effective enquiry is supported by:

- Building trust and rapport
- Ensuring privacy and confidentiality
- Using empathetic, non-judgemental communication
- Validating disclosures and experiences
- Multi-Agency Working and Information Sharing

5.1.23 Effective safeguarding relies on timely and appropriate information sharing between agencies. This supports a more complete understanding of risk and enables coordinated responses.

5.1.24 Patterns of behaviour, including repeat incidents, may only become apparent when information is shared across agencies. Recognising cumulative risk is essential in domestic abuse cases.

5.1.25 Multi-agency processes, including referral pathways and safeguarding frameworks, should be used to support coordinated risk management and intervention.

Risk Assessment and Professional Judgement

5.1.26 Risk assessment tools are an important part of safeguarding practice; however, they should not be used in isolation.

5.1.27 Professional judgement, supported by training, supervision, and experience, is essential in interpreting risk, particularly in complex cases involving multiple vulnerabilities.

5.1.28 Practitioners should be supported to apply both structured tools and critical thinking to ensure that risk is accurately identified and managed.

The review highlights the following key areas for learning:

- The need to recognise and respond to domestic abuse affecting all victims, including men
- The importance of identifying coercive and controlling behaviour
- The need for consistent and effective responses to disclosures
- The link between domestic abuse, mental health, and suicide risk
- The importance of professional curiosity in safeguarding practice
- The role of routine enquiry in identifying hidden harm
- The value of effective multi-agency working and information sharing
- The need to balance structured risk assessment with professional judgement

5.2 Recommendations

Individual Agency Recommendations

5.2.1 Avon and Wiltshire Partnership NHS Trust

- 1.a A trust-wide update of the Crisis / Intensive leaflet will include welcoming carers, family, and friends to get in touch and work with the service to support the service user if needed (Triangle of Care).
- 2.a MHLT will ensure that safeguarding issues are recorded as incidents and that referrals to safeguarding are made, where appropriate, following current guidelines.
- 3.a SIS to ensure that referrals with Safeguarding themes are recorded, discussed, and escalated for further consideration where required.
- 4.a Review the Trust-wide Safety Assessment for those who present with suicidal ideation/self-harm/ overdose. Ensure domestic abuse is listed as a prompt for exploration as one of the risk factors for suicide.
- 5.a Offer a training update around domestic abuse risk assessment to Swindon MHLT and SIS. Include tools available within the Trust, such as the Domestic Abuse

Directory of Services, the DASH support tool and the safety planning toolkit. These are to be circulated to the involved teams.

5.2.2 **Great Western Hospital NHS Foundation Trust**

- 1.g AWP records the assessment outcome on Trust Electronic Patient Records on each relevant occasion.
- 2.g For Trust ED Consultants to have access to the AWP Electronic Patient Record.

5.2.3 **The Nelson Trust**

- 1.n Nelson Trust keyworkers who receive contact from anyone disclosing harm to themselves or others must act on this information immediately.
- 2.n Any concern for welfare, 999 is contacted immediately.
- 3.n Nelson Trust keyworkers receiving a disclosure of domestic abuse need to complete a DASH with the victim where appropriate. This also needs to be documented and followed up on.

5.2.4 **Wilshire Police**

- 1.p Wiltshire Police to continue to work towards implementing a new process for front-line officers to highlight domestic violence victims who have taken their own lives to the Practice Review Manager for consideration of a referral. Messaging will be written and delivered to staff to highlight this new process.

Multi-Agency Recommendations

5.2.5 **Recommendation One: Male Victims**

- 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 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 public. (This recommendation would also support recommendations two and three.)

5.2.6 **Recommendation Two: Coercion and Control**

- 2.1a Coercion, control, and unconscious bias should be addressed during clinical supervision by all agencies, as appropriate.

5.2.7 **Recommendation Three: Response to Disclosures of Domestic Abuse**

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

5.2.8 **Recommendation four: Self-Harm, Suicide and Domestic Abuse**

- 4.1a All individuals who present to services with suicidal ideation should be asked about their social situation, support network and domestic abuse.
- 4.1b For public health to include the risk of suicide for victims of domestic abuse within the suicide strategy.
- 4.1c When self-harm/suicidal thoughts are identified in the context of domestic abuse, services must have clear pathways in place to support the response and provide appropriate support to the victim/survivor. This could involve assisting the victim/survivor in submitting a referral or making a referral 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.

5.2.9 **Recommendation Five: Professional Curiosity & Routine Enquiry of Domestic Abuse**

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

Acronyms

Attention-Deficit Hyperactivity Disorder	ADHD
Avon and Wiltshire Partnership NHS Trust	AWP
Domestic Abuse Risk Assessment	DARA
Domestic Abuse-Related Death Review	DARDR
Domestic Abuse, Stalking, And 'Honour'-Based Violence	DASH
Domestic Homicide Review	DHR
Emergency Department	ED
General Medical Council	GMC
Great Western Hospital NHS Foundation Trust	GWH
High-Intensity User	HIU
Independent Domestic Abuse Advocate	IDVA
Individual Management Review	IMR
Keeping Swindon Safe Partnership	CSP
Multi-Agency Risk Assessment Conference	MARAC
Mental Health Liaison Team	MHLT
Multi-Agency Safeguarding Hub	MASH
Multi-Disciplinary Team	MDT
National Institute for Clinical Excellence	NICE
Public Protection Notice	PPN
Royal College of Nursing	RCN
South Western Ambulance Service NHS Foundation Trust	SWASFT
Swindon Intensive Service	SIS

Appendix A
Action Plan



Domestic Abuse-Related Death Review Mitchell Action Plan

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Confidential

Appendix B
Executive Summary



DARDR 7



**Executive Summary of the death of
Mitchell in November 2022**

Parminder Sahota 
DATE REPORT COMPLETED: APRIL 2025

Appendix C
Learning Brief



LEARNING FROM MITCHELL'S REVIEW

Improving responses to domestic abuse, mental health and suicide risk

 Our collective responsibility is to listen, believe, act and support.








KEY LESSONS LEARNED

<p>1 RECOGNISE ALL VICTIMS</p> <p>Domestic abuse can affect anyone, regardless of gender. Challenge assumptions and ensure male victims are believed, supported and signposted to appropriate services.</p> <p><i>No one should be overlooked or unheard.</i></p>	<p>2 IDENTIFY COERCIVE CONTROL</p> <p>Coercive and controlling behaviour is a serious form of abuse and may not be physical. Look for patterns of control, isolation, intimidation and restriction of independence.</p> <p><i>Look beyond the visible.</i></p>	<p>3 RESPOND TO DISCLOSURES</p> <p>When domestic abuse is disclosed or suspected: assess risk, document clearly, share information appropriately, and offer safety planning and referral to specialist support.</p> <p><i>A response can make a difference.</i></p>	<p>4 CONSIDER THE LINK TO MENTAL HEALTH AND SUICIDE</p> <p>Domestic abuse can contribute to self-harm, suicidal ideation and suicide. Take a holistic approach to risk assessment, considering mental health, relationships and life circumstances.</p> <p><i>Understand the whole person and their context.</i></p>
<p>5 BE PROFESSIONALLY CURIOUS</p> <p>Ask open questions, listen without judgement and explore inconsistencies. Curiosity helps us understand, identify risk and support effectively.</p> <p><i>Ask. Listen. Explore.</i></p>	<p>6 ASK ROUTINELY</p> <p>Routine enquiry is everyone's business. Create safe, confidential spaces and use empathetic communication to give people the opportunity to share.</p> <p><i>Make enquiry a normal part of good practice.</i></p>	<p>7 SHARE INFORMATION AND WORK TOGETHER</p> <p>Timely, appropriate information sharing helps build a fuller picture of risk. Recognise patterns and use multi-agency processes to coordinate responses.</p> <p><i>Information shared can prevent harm.</i></p>	<p>8 ASSESS RISK THOROUGHLY</p> <p>Use risk assessment tools alongside professional judgement. Consider cumulative risk and the impact of multiple vulnerabilities.</p> <p><i>Tools support us, but judgement is essential.</i></p>

HOW WE DO THIS

-  **Build Trust**
Create safe, private environments where people feel able to speak.
-  **Listen Actively**
Listen with empathy and without judgement. Validate what people say.
-  **Ask the Right Questions**
Use open, respectful questions to explore relationships and safety.
-  **Know Your Services**
Understand local pathways and specialist support. Signpost and refer appropriately.
-  **Record Clearly**
Document accurately, including risk factors, actions taken and information shared.
-  **Follow Up**
Check in, review risk and adapt support plans as circumstances change.







WHAT THIS LOOKS LIKE IN PRACTICE

-  Consider domestic abuse in all relevant assessments, especially where there are mental health concerns, self-harm, substance use or repeated service contact.
-  Look for patterns over time and across services.
-  Do not rely solely on one incident; consider the cumulative impact of behaviours.
-  Ensure safety planning is person-centred and reviewed regularly.
-  Involve families and supporters where appropriate and with consent.
-  Use multi-agency forums (e.g. MARAC, safeguarding meetings) to share information and manage risk.
-  Reflect on practice, learn from cases and implement improvements.

OUR SHARED COMMITMENT
We all have a role to play in keeping people safe. By applying these lessons, we can improve practice, strengthen safeguarding and save lives.



Together we can build safer communities where everyone is heard, valued and supported.

  Be inclusive |  Be aware |  Be compassionate |  Be proactive |  Be accountable

Appendix D

[Home Office QA Board letter and feedback form](#)



Interpersonal Abuse Unit
2 Marsham Street
London
SW1P 4DF

Tel: 020 7035 4848
www.homeoffice.gov.uk

Lead for Domestic Abuse and Violence Against Women and Girls
Swindon Borough Council
Civic Offices
Euclid Street
Swindon
SN1 2JH

21st April 2026

Dear Sam,

Thank you for submitting the Domestic Homicide Review (DHR) report (Mitchell) for Swindon Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. The report was considered at the QA Board meeting on 26 February 2026. I apologise for the delay in responding to you.

Please find the QA Board's feedback in the form below. On completion of the changes suggested the DHR may be published.

Once completed the Home Office would be grateful if you could provide us with a digital copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the report will be published. Please ensure this letter and the feedback form is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Board letter and feedback form should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Board, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Board