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Learning from Domestic Abuse Related Death Review

This briefing provides an outline of key learning following the death of Azalea from a review led by independent chair Liz Cooper- Borthwick.

Azalea is a pseudonym chosen to protect anonymity.

What Happened?

Azalea had a history of mental health issues dating back to her time at university. Azalea was diagnosed with depression. Faith was a big part of Azalea's life.

Azalea met her husband, and they had two children. They moved from London to a rural area. The Covid 19 pandemic played a part in exacerbating Azalea's mental health and the domestic abuse she was experiencing.

Evidence from agencies and friends identify that Azalea was suffering controlling and coercive behaviour from her husband, including emotional and economic abuse.

Azalea tragically took her own life through suicide despite support being in place.

Agencies involved in the Review

- The Police
- GPs
- Mental Health Services
- Specialist Domestic Abuse Services
- NHS Trusts
- Local authority
- Children and Family Health
- Azalea's church

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Themes for Learning

- Professionals only saw Azalea's issues through a mental health lens - the review identifies that Azalea was experiencing domestic abuse but that the focus by professionals related to her mental health. It is important that professionals understand the links between domestic abuse and suicide and factor the link when evaluating risk.
- All professionals need to be aware that domestic abuse can happen to anyone regardless of their socio-economic background.
- Better understanding required of domestic abuse by the faith sector
- Better understanding for the local community of controlling coercive behaviour
- The impact of Covid 19 on victims of domestic abuse
- Professional curiosity – there were missed opportunities to try to understand the underlying issues and to offer appropriate support to Azalea

Recommendations

- The relevant communities within the faith sector to review and update their Safeguarding policies to reflect best practice and to take on board the learning from this review.
- Taxi licensing teams to consider making suicide awareness training compulsory for all taxi drivers.
- For practitioners to understand the link between Mental Health and domestic abuse
- Domestic abuse briefings for staff
- Surrey Police to explore how they can ascertain any previous contacts with specialist DA services when a missing person is reported
- Domestic abuse services to review their policy on follow up calls
- Routine domestic abuse enquiry at every opportunity

Resources

Adult Safeguarding Essentials - surreyskillsacademy@surreycc.gov.uk

Suicide Awareness - Zero Suicide Alliance (ZSA) - suicide prevention and awareness UK

Mental Health Crisis Helpline Surrey - **https://www.sabp.nhs.uk/crisis-helpline**

Surrey Against Domestic Abuse - Surrey Against Domestic Abuse (SADA) | Healthy Surrey

Thank you for taking the time to read this learning briefing. If you would like to provide any feedback or have any questions, please email: dhr@surreycc.gov.uk

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13th April 2026

Dear Vicky,

Thank you for resubmitting the Domestic Homicide Review (DHR) report (Azalea) for Guildford Community Safety Partnership (CSP) to the Home Office Quality Assurance (QA) Board. I apologise for the delay in responding to you.

We have noted the changes made to the report and the Home Office is content that the report can now 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