South Cambridgeshire DHR: Deborah 2010

ACTION PLAN

Recommendation	Scope of Recommendation	Action to take	Lead Agency	Key Milestones achieved in enacting Recommendation	Target Date	Completion Date and Outcome
1.Domestic Abuse Commissioner The Overview report is sent to the Office of the DA Commissioner to request that: 1.1 The Office of the Chief Coroner issues a reminder to Coroners to ensure the Guidelines on SUDEP are followed 1.2 The Royal College of Pathologists issues a reminder to Pathologists to ensure the Guidelines on SUDIP are followed. 1.3 Family members and friends should be advised on how they can bring their knowledge of the victim and	**National**	Send the Overview report to the DA Commissioner requesting they contact the Chief Coroner and the Royal College of Pathologists with a reminder to make sure Guidelines on SUDIP are followed. 1.3 Ensure guidelines are in place for all ambulance staff where there is a sudden and unexpected death.	**DA Commissioners Office**	1. Request is made to the Domestic Abuse Commissioners to contact The Chief Coroner's Office and the Royal College of Pathologists and request a reminder is issued about following SUDEP Guidelines. 1.1 Decision made on best route to disseminate information. 1.2 Information disseminated. 1.3 Training and guidance rolled out to all serving and new ambulance staff.	Sept 2023	**30 September 2023.** 1.Coroners and Pathologists are aware of SUDEP guidance and the need for a full toxicology report before SUDEP is recorded as an explanation for death. 1.3 Ambulance personnel have increased awareness of the protocol following

the perpetrator to the investigation. 2. W**arnings on websites** That warnings are flagged on bereavement and support sites to take precautions against possible perpetrators who come from all backgrounds. We recommend that anyone concerned after they, or a family member/friend starts to date a partner after meeting on a website, uses Clare's Law[1] to check with the police if the person has a history of domestic abuse.		Ensure that warnings are flagged on bereavement sites about caution if meeting up with people you have met on the site.		1.Create list of popular bereavement support sites. 2. Discuss with the sites and agree a common language to include caution and information about Claire's Law. 3. Ensure warnings are put onto sites.		sudden and unexpected death. **March 2024.** Increased protection from exploitative men for women made vulnerable by bereavement.
2. HMPPS That this Overview Report is held as part of His Majesty's Prison and Probation Service (HMPPS) records relating to Robert and is included in the parole dossier should Robert's case be considered for Parole.	**National**	The Overview report is sent to HMPPS with a request that it is held in Robert's records.	**HMPPS**	1. Request made to HMPPS to file this Overview Report in Robert's records. 2. Confirmation this is now completed.	Sept 2023	**30 September 2023.** Any future parole board is aware of the concerns raised in this report about Robert.

[1] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/

5. Cambridgeshire Coroner's Office That this Overview report is sent to the coroner to assist with the new inquest.	**Local**	Coroners Court are notified that the Overview report is ready to be shared.		1.Report agreed by Cambridgeshire Community Safety Partnership. 2. Check with the Home Office that the Overview report can be shared with the coroner. 3. Report shared.	Sept 2023	**Sept 2023.** The Overview report assists the coroner in the inquest.
6. Cambridgeshire Constabulary a) Cambridge Constabulary to ensure all officers are trained on procedures where there is an unexpected death. b) Officers should inform family members and friends on how they can bring their knowledge of the victim and the perpetrator to the investigation. c) Officers should be aware of the potential for confirmation bias when attending a crime scene and the influence that	**Local**	Cambridge Constabulary to (re-issue) guidelines and ensure that officer's training and practice includes awareness of the guidance in relation to unexpected and sudden death. Guidance to include awareness of confirmation bias.	**Cambridgeshire Constabulary**	1.Training and guidance ready for roll out. 2. Training and guidance rolled out to all serving and new officers.	Dec 2023	**January 2024** All serving officers are aware of the protocol for sudden and unexpected deaths.

stereotyping and/or prejudice might have on their decision making. They should refrain from relying on explanations for a death given by a personally connected witness.						
7. Cambridgeshire County Council 7.1 All agencies are aware of the therapeutic support available for families of victims of domestic homicide. This is available at any time they choose from the National Homicide Service.	**Local**	All agencies made aware of the support available to families of victims of domestic homicide.	**South Cambridgeshire Community Safety Partnership**	1.Colate a list of local and national agencies able to offer therapeutic, trauma-based support to families of victims of domestic homicide. 2.Ensure the list is regularly updated on relevant websites. 3. Ensure all agencies are made aware of the support available.	Sept 2023	**Sept 2023** The trauma experienced by the close family of victims is recognised and provision is made for them to be able to access relevant therapeutic support. Support to prevent the escalation of mental health issues Is in place. Support to

7.2 The DASV Partnership to ensure there is a service is in place for Friends and Family to contact if they have concerns about Domestic Abuse.		Establish and promote the service widely. Monitor usage and impact.		1.Funding in place 2. Service established. 3. Service publicised clearly including accessibility for disabled people and in community languages.		friends and family who have concerns but are uncertain about what action to take.