Executive Summary

A Domestic Homicide Review concerning the death of Jack (pseudonym)

(October 2021)

Author – Jackie Dadd

Date completed – September 2022

The Domestic Homicide Review Panel and the members of the South Cambs Community Safety Partnership would like to offer their sincere condolences to the family of Jack, who have lost their loved one in tragic circumstances, and which has caused this Review to take place. They have been left with a huge gap in their lives.

Contents

The review process

This review is into the death of Jack, an 83-year-old male, who was found hanging in his garage by his son in South Cambridgeshire in October 2021. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging.

A standard post-mortem took place.

The result of that post-mortem examination was: -

1a) Hanging

An inquest hearing was held on 1st March 2022 in which the death was registered as suicide by hanging. This was in accord with the findings of the post-mortem in which the toxicology showed a presence of alcohol at a concentration of 89mg/100ml, indicative of alcohol intake just before death. This level is just above the drink-drive limit. There was no evidence that drugs or alcohol contributed to the death.

No other injuries were found apart from the neck area with lacerations caused by the rope, and an abrasion to the shin on the left leg.

Cambridgeshire Police made a referral to the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board to consider a Safeguarding Adult Review (SAR) on 28th October 2021. This was because a death had occurred to an adult where the circumstances indicate he may have had care and support needs. Whilst there was no indication of abuse or neglect, it was felt that there should be consideration under the category of "A SAB may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs.)"

Following the gathering of relevant information, a sub- committee met on 25th January 2022 where it was unanimously agreed that there was no evidence of care and support needs so the case did not meet the SAR criteria. Members felt that if the case was to be reviewed under any process, due to the possible DA elements of the case it should be referred for consideration of a DHR. This referral was made on 1st February 2022.

South Cambs Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review on 17th March 2022. The Home Office were notified of the decision in writing on the same day.

The following pseudonyms have been in used in this review to protect their identities and those of their family members:

Jack - Deceased, who was an 83-year-old male at the time of his death.

Helen - Wife, living with Jack in the same household.

Emma – Only daughter and eldest child of Jack and Helen

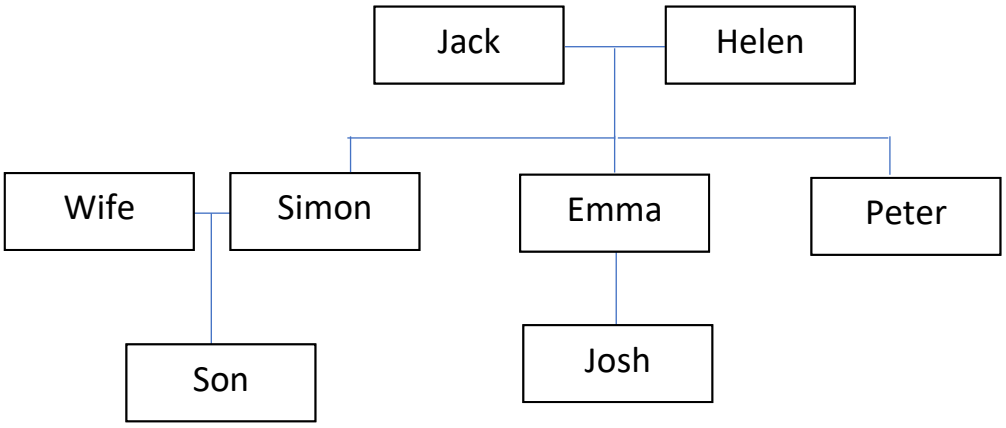
Simon – Second child and son of Jack and Helen.

Peter – Youngest child and son of Jack and Helen

Josh – Son of Emma, Grandson of Jack and Helen

Address – Name of City provided as Cambridgeshire

Genogram



All three children were initially sent letters by the CSP informing them of the review along with details of AAFDA for support and advocacy. Peter engaged with the author over the phone and by email as was his preference and Emma corresponded with the author in the same manner and also met with the chair at her place of work, as was her wish to do so. On all occasions, the author outlined the benefits of AAFDA support but these were declined, as was the opportunity to attend a panel meeting.

Peter and Emma were contacted at various times during the review by the author to provide updates. The intervals of contact were chosen by them and agreed.

Peter and Emma both received copies of the report prior to submission to the Home Office and had no further observations as they were satisfied with the content. They chose not to write a tribute as they felt that the funeral had completed this for them.

In Cambridgeshire, since May 2018, nine suicides relating to domestic abuse have been considered as requiring a DHR of which two were older persons. In 2018, three quarters of the total of 6507 deaths by suicide registered in the UK were those of men. (ONS, Suicides in the UK, 2018 registrations). Also, the suicide rate for males aged 75 years and over was 32% higher than in 2017 just a year later. (ONS, Suicides in the UK, 2018 registrations).

IMR's were requested from the agencies who had come into direct contact with Jack or Helen or held significant information. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including

age, carers, suicide and male victims. This was to assist in analysing the depth of knowledge and support already in existence and being required in these areas in the South Cambs community.

Review Panel members

The following individuals and agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review panel:

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection	Cambridgeshire Police
Julie Rivett	MASH Manager	Adult Social Care
Carole Morgan	Joint Lifecraft Operations Manager	Lifecraft
Ashley Holderness	GP Practice Representative.	NHS Cambs and Peterborough Primary Care ICB
Kathryn Hawkes	Communities Manager	South Cambridgeshire District Council and representing the South Cambs CSP
Rachel Robertson	Mental Health Domestic Abuse Safeguarding Lead	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Amanda Warburton	Partnership Officer (specialist in the elderly)	Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership
Jane Pollard	ISP assessor/ Quality & Compliance Officer	Multicare Community Services - MCCS
Kirsten Clarke	Named Nurse Adult Safeguarding	Cambridge Community Services – NHS trust
Susie Rogers	Senior Outreach worker	Cambridge Women's Aid
Miriam Martin	Chief Executive	Caring Together

Each panel member is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

A total of three panel meetings have been held during this review, excluding the initial meeting to decide on the commissioning.

Contributors to the review

The following agencies have contributed to the review: Each of the agency authors is independent of any involvement in the case including management or supervisory responsibility for the practitioners involved.

- East of England Ambulance Service NHS Trust (EEAST)
- Cambridgeshire Constabulary
- NHS Cambridgeshire and Peterborough Integrated Care Board (ICB) – on behalf of involved GP Practice
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Cambridgeshire Women's Aid
- Cambridgeshire County Council Domestic Abuse and Sexual Violence partnership (DASV)
- Lifecraft
- South Cambs District Council
- Caring Together
- NW Anglia NHS Foundation trust
- Public Health department – Cambridgeshire County Council
- Multicare Community Services (MCCS)

Author of the overview report and Chair

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has undertaken a number of DHR's having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

Terms of Reference

The Terms of reference were discussed and agreed upon during the first panel meeting on 13th April 2022.

It was agreed that the main areas of focus would be based on:

1) Domestic abuse (DA) in any form had been the causation or a contributory factor to Jack taking his own life
2) Services and agencies provisions to domestic abuse within South Cambs, specifically for carers, elderly, and male victims

3) Services and agencies provisions to suicide and those contemplating taking their own life within the Cambridgeshire area
4) Are recording processes and the sharing of information sufficient between agencies when a situation arises where the risk assessment and concern are for a person associated/related to the person being cared for?

The full Terms of Reference are below:

- The date parameters under consideration are from January 2015 until 30/10/21.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Jack.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Seek the involvement of employers and friends to provide contextualised analysis of the events.
- Establish whether agencies have appropriate policies and procedures to respond to domestic abuse and to recommend any changes following the review process.
- Could improvement in any of the following have led to a different outcome for Jack?
  a) Communication and information sharing between services.
  b) Information sharing between services with regard to the safeguarding of adults and their carers.
  c) Communication within services.
  d) Communication to the community and non-specialist services about the provisions of available specialist services.
  e) Identifying the vulnerability of carers to being either the abuser or subject to domestic abuse due to their role within the relationship and are adequate safeguarding measures and recording processes implemented in these situations.
- Establish if agencies have sufficient training and knowledge to identify signs of domestic abuse and how to appropriately refer and record this, specifically including both psychological and economic abuse and coercive and controlling behaviour.
- Establish accessibility of services for those contemplating suicide and bespoke training in relation to the effects DA may have towards this.
- Identify and highlight good practice for wider sharing
- Is there sufficient support available locally for male and elderly victims of domestic abuse and how accessible are they?
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and his wife? Was consideration for vulnerability and disability evident? Were any of the other protected characteristics considered in this case?

Summary Chronology

Jack had known his wife Helen, all of his life. He was a hardworking slaughterman in Essex up until the age of 40 years and they had three children within that time, two sons and a daughter.

They then moved to Hopton where they bought a house with a butcher's shop. Helen was not happy with the move and this unhappiness was set to fester and grow, playing a key part in their future relationship. They lived in Hopton for the next twenty years until 1998. Helen had a distaste for the property and she would regularly ridicule him in front of the children and Helen began to say that she had wasted twenty years of her life and that she hated all her time there. She was very resentful towards Jack and directly blamed him for her unhappiness.

Jack is described as taking things as they come and accepting them as they are in contrast to Helen, who has 'never been able to accept a certain situation and be content with how it is,' developing a distorted, unrealistic and rather child-like view of life. She had an unhealthy attitude and was obsessed with money.

The children remember that around 2000, their dad had said about moving out which Helen dismissed as ridiculous and it was after this that Helen began to state that to the family and to others that Jack had dementia, which was surprising as he seemed fine to them. This was the issue that became the main burden and frustration to Jack in the years to come. Helen disclosed a few days after his death that it was at this time, he had first mentioned to her that he would kill himself but she never told anyone.

During phone calls from the children, they rarely got to speak to Jack as the phone would be taken from him straight away if he answered. Even during visits, if Jack tried to join in a conversation he was told to 'stop interrupting' or 'be quiet' and Helen dominated the family unit, never being questioned as this behaviour seemed normal as it had always been like that. They were very affluent, but Jack was not allowed any money and did not have access to the joint account. Emma recalls that Helen hit Jack twice in in 2005 for pruning a plant. Helen had also threatened Jack with a pair of scissors whilst cutting his hair at one time to which when he was recalling it to Emma, he told her that he would never retaliate or hurt her as he knew if he did, then he would hurt her. These were things that he only felt able to tell his children in the last few years.

In 2015, a family meeting was held as they were concerned about their Dad as Helen had informed them that he was going to drink a bottle of alcohol and hang himself. When the subject of Jack's intention was brought up, Helen instantly responded with something along the lines of, "Oh no, we don't need to talk about this," before turning to Jack and saying, "We're all right aren't we?", to which he replied, "Yes", with a very strained and awkward look on his face. They persisted with the conversation, even though it was very uncomfortable for everyone, but Helen just kept putting up blocks to every suggestion made. It was stressed to them both that they needed to live apart to get out of this constant

cycle of misery and Helen responded that there wasn't enough money to be able to do this, although their assets at that time would have been between £600,000 and £700,000.

After some time, the conversation became too much for Jack to listen to. He said virtually nothing but appeared completely broken down and he simply wouldn't speak up for himself in front of Helen. He got up and said he was going for a walk and Simon went with him. On that walk Jack told Simon that it wasn't a bluff and he was going to do it, he'd had enough.

Helen continued to try and convince everyone that Jack had dementia and confiscated his bank card leaving him no access to money or their joint account and intercepted any new ones that came through the post. Due to the isolation Helen had caused Jack, the children bought him an electronic tablet so they could communicate with him directly. They had to pay for the internet between them as Helen refused to do so.

Emma continued to contact the doctor with concerns for her Dad and Jack underwent at least two mini-mental state examinations which he scored highly on and the Doctor had no concerns that he had dementia although this continued to be an obsession with Helen, even after the Doctor had shared this information with her (with consent). In August 2021, Helen screamed "I hate you" at Jack following him offering to help her with sending an email.

Helen had a severely arthritic hip which had been deteriorating over the years and in the middle of the night at the beginning of September 2021, she fell in the middle of the night, heading from the bathroom, breaking her left hip and left upper arm. She called for Jack who tended to her and kept an eye on her diabetic status during the three hours wait for an ambulance. Helen stayed in hospital for four weeks. During this time, Jack visited her and rang the hospital frequently and remained staying at the house. Helen informed the children she hadn't heard from him and never thanked him for what he had done which hurt his feelings. He cooked himself meals and got to do the gardening which he normally wasn't allowed to touch and he seemed confident and happy during this time.

Whilst visiting his mother, Peter was spoken to by a nurse about the care his mum would need when released from hospital and the nurse stated how she had been told by Helen how his dad had dementia and gets angry and violent. Peter assured her this was not the case and of the mental abuse his dad had received from her over the years. He told her that he was concerned regarding the mental wellbeing of his Dad having to cope with, and care for Helen's increase in needs.

In early October 2021, the Saturday before Jack died, Peter received a phone call from him and when he asked how things were, he replied,

'Just the same, still talks to me like shit'. He said things would never change and would never get any better.

The healthcare team who came into the house to assist with meals for Helen following her discharge from hospital witnessed Jack with a rope and bottle of whisky in his hand threatening to end his life. He was very agitated saying that he did not have dementia and hadn't been diagnosed. The carer escalated this to her seniors and then left the location

prior to their arrival where things had calmed down and Jack left to go to work. Due to this, the ambulance and Police did not attend.

A few days later, Jack was dressed for work when he and Helen had an argument over food. With this, Jack threw his wallet onto the table and said,

'You may as well have that. I won't be needing it'

He left the bungalow about 12.30hrs, informing Helen he was going to work and she watched him go through the back gate. She became worried around 14.00hrs that day and began to send texts to her two sons, failing to get hold of them as they were working and didn't see them straight away.

The text she sent Simon read:

'Bad news. I am pretty sure Dad has done the deed. He went out to go to work. Because he was a bit strange, I rang them an hour ago. He hasn't been there. I have sent Peter messages to come over. He wouldn't be out for a walk this long; his knees wouldn't take it. What am I going to do, the carers have finished today.'

On Peter attending, he entered the garage to find his Dad hanging from a beam with a blue rope around his neck. His face was grey and he looked calm and peaceful but was unresponsive. At 16.42hrs, the same day, the Police and Ambulance arrived. No resuscitation took place and Jack was pronounced deceased.

Jack had left a message to his children referring to a voice message on his tablet. The recording thanks his family for their support and wishes they had had a better life but felt he could not cope with life anymore and did not see a better future. A Police Officer listening to the recording has stated that 'you could hear the hopelessness and resignation in his voice.'

Helen did not attend the funeral or send flowers. She was in and out of hospital following this due to another fall. The carers reported that she didn't like them and kept shouting and being impossible to look after. Two days before Christmas that same year, after hitting a carer with her stick, she was sectioned. Early in 2022, she was diagnosed with Alzheimer's and now has residency in a care home in Cambridgeshire.

Key issues arising from the review

Lack of questioning and consideration of DA

There was no wider consideration as to what may be causing Helen's fixation of Jack having dementia or holistic thinking in the knowledge of the issues that this was causing Jack or the family. The whole situation from Emma's email through to Helen being informed of the results appears to be dealt with in isolation with no follow up and records of 'long chat' do not outline what issues were discussed and if any advice was provided. When Helen was in hospital, she informed CPFT that she was the victim of domestic abuse and that Jack had dementia. Although CPFT completed a referral to Adult Safeguarding in relation to domestic

abuse, CPFT did not act on either of these facts in regard to discharging her back home to his care. They did not conduct any safeguarding for Helen in relation to DA, no contact was made with the GP to ascertain if Jack did have dementia and Jack wasn't spoken to, yet Helen was discharged immobile, back into his care with some additional assistance commissioned to help with meals and bedtime. (Recommendations refer)

Poor advice when DA is disclosed

Poor advice was provided from more than one agency in relation to domestic abuse. Helen disclosed domestic abuse to CPFT staff which was recorded on the notes and a referral was made to ASC. However, although a referral was made to Adult Safeguarding, no immediate safeguarding provisions were made with the disclosures from Helen that Jack had hit her with a broom and when she stated that she had to lock herself in the bedroom with a piece of string, the advice was to get a lock on the door and she was discharged into his care. Staff felt that there were discrepancies when they completed a DASH with Helen but even if she were not to be the victim, there were clear issues between them both within the home and the suitability of Jack as a carer was not considered. The GP offered Couples counselling when Jack disclosed behaviours of Helen that showed Controlling and coercive behaviour and economic abuse which was inappropriate advice. (Recommendation refers)

Records not reflecting individuals

There is a question of wider learning around how referrals are recorded when there are care and support needs for more than one individual within the same referral and how this affects triage processes by agencies. In this case, appropriate referrals were made but they were not recorded under the name of Jack, meaning any quick research conducted during the triage process would not find any relevant history which could have the potential to affect decision-making.

There is a potential to improve how information is gathered about all involved parties, and links across made, when more than one person appears to have care and support needs. This was a safeguarding situation for both Jack and Helen but was viewed just through the lens of Helen as the referrals came in under her name and ASC would not then have created a file in Jacks name.

Both referrals were appropriate in relation to safeguarding but It would have been better if the referrals had been on Jack in his own right. (Recommendations refer)

Lack of assessment of carers and consideration of capabilities

Assessments are not routinely conducted on those who are either to become carers or who are already carers. As CPFT did not identify Jack as a carer and he didn't form part of their statutory duty, Jack was not offered a carer needs assessment prior to Helen being discharged into his care. A carer needs assessment was not conducted at any time for Jack by anyone who received information on him including Adult Social Care and his GP Practice. Had a carer needs assessment/open conversation with him been completed, this may have identified his suicidal tendencies, the cause of these (DA) and a care plan implemented for Helen that would address both her needs and those of Jack. (Recommendation refers)

Conclusions

Jack is described by his family as a strong, hardworking man who had 'sloping shoulders' in order to deal with the manner in which he was treated throughout their many years of marriage. However, during the latter years, it is accepted that he did try and 'stick up' for himself by speaking back to Helen and gained some independence with his tablet and phone, only for this to have no effect on the way he was treated.

The main issue that appeared to affect and frustrate Jack the most was Helen constantly telling the family and persons in authority that Jack had dementia when he knew he didn't. From 2013, when Helen first said this to their Doctor, Jack had three separate cognition/memory tests in which he scored very highly, showing no cause for concern. The last one of these being in July 2020.

Helen's cognition score on 29th September 2021 was 16/30 which is low but this panel has not seen any medical records to indicate that dementia was considered in relation to her. Due to the number of years that Jack suffered differing forms of domestic abuse dating back to the 1980's, Helen's behaviour cannot be attributed to dementia.

The accusation of dementia was utilised in the **controlling and coercive behaviour** by Helen, keeping Jack isolated from family and friends, even when the family were present or called on the phone, by not allowing him to participate or voice an opinion. Jack had no independence through **economic abuse**, with Helen not providing him access to their money by confiscating his bank card and access to the joint account, declaring his dementia as the reason why. This prevented him from buying himself essentials such as underwear whilst Helen bought herself any items she required.

The control she wielded extended to the whole family unit who only realised and became strong enough to 'push back' when they realised the seriousness of their dad's unhappiness and suicidal tendencies. Even then, Helen prevented him from speaking in the open family forum.

Helen utilised manipulative and controlling behaviour in the sense of informing different authorities that she was being abused by Jack which would be recorded and held on their records. Had some authorities taken it further or if it had been referred to the Police for example, then Jack would have been deemed the perpetrator which highlights the need for holistically assessing relationships where one party is caring for another.

The **emotional abuse** finally wore him down to the point where he just didn't want to go on anymore as he couldn't 'stick it any longer', which was evident in the final message he left to his children.

Missed opportunities by several authorities are apparent in providing Jack with support and safeguarding for his disclosure of both domestic abuse and suicidal thoughts as there is no record of them being offered to him or his family and he was not recognised as a victim of domestic abuse by the authorities, even when his family also raised their concerns. The GP

did not show any sense of identification or curiosity in relation to economic abuse when Jack specifically said he had no access to money. Opportunities to open conversation for disclosure are rare and not to ask or discuss issues properly at that time can have a detrimental effect. Jack was never asked about his suicidal tendencies but maintained them and the exact narrative for over five years. Consent is an issue in the fact that he has disclosed to his family who he trusts and the risk to him is obvious, but due to the fact that it is the family who have contacted the GP surgery and made them aware and not Jack himself, who refused to go on a couple of occasions, the authorities are very limited as to the response they can make. This is the same in the fact that Jack does not meet the care and support needs criteria. Although he did have the ability to self-refer to provisions such as Lifecraft and Caring Together, due to not having access to technology until his final years because of the controlling abuse, he may not have known about them or how to find out about them.

Numerous clinicians missed the need to assess Jack as a carer. There is no indication or record of any CPFT staff speaking to Jack to ask him of his welfare and capability of caring for Helen after discharge. CPFT were aware of his age and that there were issues in the relationship based on the information Helen had disclosed, whether inconsistent or not.

South Cambs CSP have concerns that with an ageing population such as it is in South Cambridgeshire, they could see more of these cases in the future and need to put measures in place now to safeguard those with caring responsibilities who, themselves perhaps having capacity and not being deemed to be in need of care and support, might eventually face similar challenges.

When risk is identified in any individual, a record should be held in their name to prevent it being 'hidden' in another file and not being identified in any quick research conducted during a triage process. Health authorities must also ensure that when referring a person at risk, they complete this in their name and not the name of the patient they are treating if this differs.

Standard domestic abuse risk assessment and safety planning can be ineffective where care and support needs are present because the widely used DASH Risk Assessment Checklist was developed around homicides – and these feature a generally younger cohort. These are not usually so relevant in people with care support needs, but other risks such as ill health and the abuser being the carer are relevant but not included in the current DASH Risk Assessment Checklist. The utilisation of the elder DASH risk assessment should be encouraged within Cambridgeshire, although a DASH was not completed at any time for Jack.

Regional work and the completion of a suicide prevention strategy and four-year plan evidences the realisation and commitment in this area. It has a strategic action plan incorporating the following actions:

1. All those who have made a suicide attempt to be asked about domestic abuse and sexual violence, and to be responded to appropriately.

2. Training in the impact of domestic abuse and sexual violence to all staff – in particular, those working in emergency medicine departments and liaison psychiatry
3. Wider understanding that those suffering domestic abuse and sexual violence who are expressing suicidal ideation, they are likely to be suffering psychological injury from the abuse, rather than having a psychiatric illness.

The absence of CPFT information in relation to Helen that intrinsically involved Jack leaves some significant gaps around the discharge process and the considerations that took place in the discharge plan.

Lessons to be learned

Cambridgeshire County Council need to include domestic abuse as part of their Carers strategy as it is not at this time. Carer's do not generally meet the adult safeguarding threshold, with agencies 'bouncing' referrals between them. Inclusion will provide a framework to address the specific issues that carers are subjected to as a result of domestic abuse.

It is important for organisations and professionals to be aware of the support provisions provided within Cambridgeshire to ensure appropriate referrals and additional support is offered. It is also important for the organisations who offer this support to have a plan to promote the services they can offer in a way that can be easily identified.

When organisations are provided information from a patient/client, it is important for them to check the accuracy of this information and not accept it on face value eg. Helens claims that Jack had dementia.

Recommendations

National

1. **Policy and protocol to reflect that an individual should not be left alone until further assistance has arrived when high risk/immediate safeguarding needs are identified and this should be built into the commissioning of homecare providers.**
   Having stated that he was going to kill himself and it being perceived as a 'real' threat, the carer then left Jack and the premises prior to an assessor from the company arriving, to go and attend to a patient at a different location. This will prevent this situation occurring in the future, whether the person identified as high risk is the specified patient or not.

Local

2. **Cambridgeshire County Council to consider the Community Response Framework that Hourglass operate in other areas of the country (including neighbouring Norfolk) and how this could be implemented in Cambridgeshire.**

   There are currently no provisions for the elderly or male victims in Cambridgeshire. This would provide a local provision for specialist support for the older person who is suffering from domestic abuse and offers group or self-advocacy to cater for all, incorporating males.

3. **Cambridgeshire County Council to include domestic abuse as part of the carer's strategy.**

   Domestic abuse is not included in the carer's strategy at this time and carer's do not generally meet the adult safeguarding threshold, with agencies 'bouncing' referrals between them. Inclusion will provide a framework to address the specific issues that carers are subjected to as a result of domestic abuse.

4. **Cambridgeshire County Council to implement a communication strategy to inform and remind statutory agencies and professionals to:**
   - **Increase their awareness of carers to refer them on to specialist services and to help them identify themselves as carers**
   - **Re-affirm that there is a choice regarding being a carer and not to assume family members will automatically take on this role**
   - **Increase their understanding of the 'whole family' rather than solely focussing on the patient and their needs**
   - **Inform a carer that they can undergo a carers needs assessment for the purpose of their own wellbeing without having to disclose their finances**

   This would increase referrals and needs assessments to ensure carers were considered on each occasion and would help in appreciating that being a carer is incredibly challenging and more so when there is a relationship breakdown as in this case. This should be a holistic Countywide approach so the processes mirror each other and not be dependent on the CSP area.

5. **Caring Together and Lifecraft to increase promotion of their services to enhance awareness amongst the public and professionals of what services are available.**

   This would highlight the provisions available and increase referrals for both carers and those who are suffering from mental health issues and have

suicidal ideation as the panel discussions highlighted limited knowledge amongst professionals.

6. **With support of Cambridgeshire and Peterborough Integrated Care Group, the GP practice is to review the practice's safeguarding policy to ensure it includes older adults domestic abuse and professional curiosity.**
   This is to address, educate and structure appropriate advice, referral pathways and identification of victim and carer issues.

7. **With support of Cambridgeshire and Peterborough Integrated Care Board, the GP practice to review how practice staff build in questioning around impact on mental health where disclosures of abuse are made.**
   This is to ensure conversations are taking place with patients, particularly in respect of Jack when the GP was made aware of the suicidal tendencies by the family but there is no record of any conversation or advice provided.

8. **Statutory agencies to review recording protocol and policy to ensure that a separate file is recorded for each individual of concern under their given name and in any case of safeguarding.**
   This will ensure that each individual's need is recognised, addressed, and met and that a given name can be searched for and found on records as they will have a file allocated to them and not be 'hidden' in another individual's file.

9. **Statutory agencies and voluntary sector to include in their policies the need for professional curiosity for domestic abuse and any stress relating to possible caring responsibilities.**
   This will ensure that there is the opportunity to identify any mental health issues, potential domestic abuse in the relationship, capabilities and any other needs the individual may require because of the additional responsibility and to implement assistance and preventative measures. The carer assessment should not be a 'tick box' exercise but a conversation to identify pressure areas, capabilities and the recording of safety netting and thought process for any action that is either taken or not.

10. **CPFT to ensure that their procedure and protocol for discharge includes a discharge plan that incorporates 'think family' and that consultation with the family takes place as well as the patient to identify any issues or needs the discharge into their care may cause.**
    CPFT Carers policy states that carers should be offered a carers assessment as per their statutory duty. Jack was not offered a carers assessment or spoken to prior to Helen's discharge. If they had considered this approach, they may have identified him as a carer and an older person and assess whether he would have had the capabilities of additional responsibility and stress, already knowing that there were issues within the relationship.

11. **All statutory and non-statutory agencies within Cambridgeshire to review the use of the older persons DASH and always consider its use alongside the standard DASH when dealing with older persons.**
    Cambridgeshire's pilot of the older persons DASH is due to conclude in July 2022 but participation has not been high enough to allow accurate analysis of how effective it could be. It is based on research that identifies specific risks to older people and may enhance the understanding, safeguarding and support that can be provided for them.

12. **CPFT and GP surgery to ensure their processes and pathways are reviewed when dealing with domestic abuse to ensure appropriate advice is provided.**
    This will ensure all staff and clinicians are aware of how to respond and converse with patients and family if disclosures or identification is made in relation to domestic abuse.