Overview report

A Domestic Homicide Review (DHR) concerning the death of Richard (pseudonym)

(March 2022)

Author – Mrs Jackie Dadd

Date – September 2023

The Domestic Homicide Review Panel and the members of the South Cambs Community Safety Partnership would like to offer their sincere condolences to the parents of Richard, 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.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a Domestic Homicide Review according to Statutory Guidance 1 under Section 9 (3)(1) of the Domestic Violence, Crime and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office defines domestic violence as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional.

Controlling behaviour is:

A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim The term domestic abuse will be used throughout this Review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

A glossary for assistance with acronyms can be found at Appendix B at the conclusion of this report. The use of pseudonyms throughout the report is for confidentiality compliance.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review is into the death of Richard, a 32-year-old male, who was found, having taken his own life at his workplace by a colleague in South Cambridgeshire in March 2022, following Richard's disclosures of domestic abuse subjected to him by his mother-in-law. The Police have investigated the circumstances and submitted a report to the Coroner with a finding that the death was non-suspicious and believed to be suicide by way of hanging.

Due to information provided by work colleagues, a criminal investigation into controlling and coercive behaviour was raised and transferred to the Metropolitan Police, Enfield Borough as this was the area that the crime would have been committed in.

Cambridgeshire Police initially referred the matter to Enfield CSP due to the victim living with his wife and her mother (the alleged abuser) on weekends within the Enfield borough. There was a delay in commissioning the review whilst the area for responsibility was established, as Richard owned a property within Cambridgeshire, where he worked and lived alone during the week.

Cambridgeshire Police then made a referral to South Cambridgeshire CSP in July 2022 and following a meeting held in August 2022 with representatives from local authorities, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
IMPAKT Housing Support	Summary report, Panel member (3rd sector)
NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)	Summary report, Panel member
Peterborough and Cambridgeshire Domestic Abuse and Sexual Violence Partnership	Panel member, Oversight
South Cambs District Council/CSP	Panel member, Oversight
Cambridgeshire Public Health	Panel member
Barnet, Enfield and Haringey Mental Health Trust	IMR, Panel member
Adult Social Care (ASC)	Summary report, Panel member
Enfield Borough CSP	Co-ordination
North Middlesex University Hospital NHS Trust	Panel member, IMR
East of England Ambulance Service NHS trust (EEAST)	Panel member
Cambridge Community Services NHS Trust	Panel member

1.1.3 Review Panel

Agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports, chronology, and discussion from two separate Local Authority areas. Individual Management Reviews (IMRs) have been requested and supplied.

The panel comprised of the following:

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection Lead	Cambridgeshire Police
Elaine Joyce	Section Safeguarding Lead	East of England Ambulance Service NHS trust (EEAST)
Ginika Achokwu	Head of Safeguarding	Barnet, Enfield and Haringey Mental Health Trust
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
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Charley White	Resettlement Manager	IMPAKT Housing & Support
Tracy Brown	Adult Safeguarding Lead	Cambridge University Hospitals NHS Foundation Trust
Zoe Ward	Named Nurse Adult Safeguarding	Cambridge Community Services – NHS trust
Anna Young	Domestic Abuse and Sexual Safety Co-ordinator	Barnet, Enfield and Haringey Mental Health Trust
Jennifer Elliott	Adult Safeguarding Advisor	North Middlesex University Hospital NHS Trust

1.1.4 – All members of the panel and authors of the IMRs and summary reports have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided for the overview. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.5 – Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is also 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 completed the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed several DHRs.

1.2 Purpose of the review

The purposes of a DHR are to:

a) Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

The death of Richard has been submitted to the Coroner as suicide by way of hanging. This review will ascertain whether domestic abuse could have been the cause or a contributory factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Richard.

1.3 Timescales

1.3.1 – 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.

Following the death of Richard, colleagues provided police with information that Richard had confided in them, in relation to ongoing abuse he was receiving from his mother-in-law and at times, his wife. Based on this information, a referral was made to the Metropolitan Police for forwarding to Enfield CSP as this was the address where he lived at weekends with his pregnant wife and his mother-in-law.

Following discussions between both Police areas and Enfield CSP, a decision was finally made that the responsibility for the DHR should be with South Cambs as this was the location of his residential home during weekdays. A referral was then made to South Cambs CSP whereby following a panel meeting of partners, a decision was made to commission a DHR, which the Home Office were notified of shortly afterwards.

1.3.2 - Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 15th August 2022. The first panel meeting took place on 21st September 2022 following the initial scoping of agencies. Based on the information received at this stage, the panel felt that there may be a safeguarding concern regarding both Geetika, the wife of Richard and the newborn baby, based on the information of controlling behaviour that had been received in relation to Ishika. Relevant health care professionals within Enfield Borough were made aware of the concerns and enquiries were completed to satisfy the panel that there were no ongoing safeguarding risks.

A further two panel meetings took place thereafter. The completed report was handed to the South Cambs CSP on 27th September 2023.

1.3.3 - Timeframe of Review process

March 2022	Richard was found deceased at workplace
01/04/22	Cambridgeshire Police sent a referral to Metropolitan Police for forwarding to Enfield CSP
July 2022	Declined by Enfield CSP as not in their area for responsibility
23/07/22	Cambridgeshire Police sent a referral to South Cambs CSP
02/08/22	Decision to commission a DHR made by South Cambs CSP and partners
11/08/22	Home Office notified of decision to commission DHR
15/08/22	Mrs Jackie Dadd commissioned as Author and Chair
21/09/22	First panel meeting
09/11/22	Second panel meeting
12/09/23	Third panel meeting
27/09/23	Completed report handed to South Cambs CSP by Author

1.3.4 - Home Office guidance states that the review should be completed within six months of the initial decision to establish one. The writing of this report had significant delays whilst awaiting the conclusion of the criminal investigation and updates from the Metropolitan Police. The panel agreed that any decision to proceed with a criminal investigation at this stage would not alter the findings of this DHR and the Metropolitan Police were content on its submission.

1.4 Terms of Reference

1.4.1 - The Full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 21st September 2022.

1.4.2 - It was agreed that the main areas of focus and discussion would be based on the following:

a) If Domestic Abuse (DA) in any form had been a contributory factor to Richard taking his own life
b) What literature and communication in relation to domestic abuse, specifically familial abuse is available to the public and employers so that the behaviour can be recognised as such and support obtained
c) What training have professionals received in relation to recognising signs of DA, in particular, familial abuse and are sufficient opportunities provided for disclosure
d) What provisions are available within Cambridgeshire for males suffering from domestic abuse and mental health issues.

1.4.3 - It was agreed by the panel that the scoping dates would take place from 2016 until the date of Richard's death. This was to gain an understanding of Richards medical and mental health issues prior to and throughout his marriage for context.

1.5 Subjects of the review/Family and friends' involvement

1.5.1 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following:

Richard – Deceased. A white British Male, who was 32 years old, at the time of his death.

Geetika – Wife of Richard. A 34-year-old Indian female.

Alice – Mother of Richard. A white British female.

Brian – Father of Richard. A white British male.

Ishika – Mother-in-law of Richard, mother of Geetika. A 74-year-old Indian female.

Address – Name of areas provided as South Cambridgeshire and Enfield.

1.5.2 Family involvement

Richard's parents were engaged throughout the review and the author would like to express their gratitude for the significant contribution and assistance that they have provided. Pseudonyms have been used in this report for confidentiality and were agreed by them as they did not wish to choose any themselves.

They were informed of the review by letter on the 4th of October 2022 and then contacted by the author on several occasions by phone, email and through Microsoft teams meetings as was their preferred means of contact. They were provided leaflets in regard to AAFDA for support through this process and had this explained by the author on more than one occasion but declined assistance. They have received counselling through a local referral. An invitation to the panel meeting was declined as they were content for the author to keep them updated.

The wife of Richard (Geetika) was not initially contacted as she had been named as a suspect on the police report for controlling and coercive behaviour along with her mother. Once permission was granted from the Police, the author contacted her by phone to request a meeting with a message being left on voicemail. This was initially responded to by email, with correspondence from a solicitor representing Geetika. The author provided contact details for AAFDA and confirmed that the DHR process was separate to any criminal investigation. Following an email request direct from Geetika, the author sent her an email explaining the DHR process and asking to speak with her. The author has had no response to this.

An analysis of the family, friends and work colleagues of Richard is found later in the report at 3.1. They have all contributed to the background information outlined in this report at 2.1.

The parents of Richard have read this report and were satisfied with its content and the way Richard was portrayed.

1.6 Parallel reviews

1.6.1 Coronial process

The Coronial process was suspended awaiting the outcome of the Police investigation and is taking place parallel to this review. This is still the case at the time of publication.

Richard's death was reported to the Coroner by Cambridgeshire Police. The report submitted stated that the death was to be considered as non-suspicious, indicative of suicide by way of hanging.

A post-mortem was subsequently held.

The result of the post-mortem examination was: -

1) Neck compression due to hanging

There were signs associated with a neck ligature circumferential mark around the neck, of width consistent with the accompanying belt.

There were superficial marks found on the body within the spectrum one might see in association with sports activities and hobbies and also marks caused by medical intervention during attempted resuscitation. There was no sign of recent trauma or defensive wounds.

1.7 Equality and Diversity

1.7.1 - The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010. The relevant legislation that provided the context for the panel was The Disability Act 2016 and The Equality Act 2010.

Throughout this review process the Panel has considered the issues of equality in particular the nine protective characteristics under the Equality Act 2010. These are:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Key considerations for the panel were whether sex, disability and race had any relevant impact on the available services and response that Richard and the family received.

It was considered that Richard's sex was relevant to the review as it took into consideration the support provisions within the area available to him as a male and the fact that although he disclosed his abuse to work colleagues, the abuse wasn't specifically recognised as domestic abuse by them but was identified as being wrong and that he was at risk of harm. Consideration was taken by the panel as to whether it is accepted behaviour due to him being male. Also, this report explores whether the abuse by the mother-in-law and wife was normalised as Richard was a male.

1.7.2 - Disability is relevant to this review in order to explore the fact that although never diagnosed with autism, this was a belief held by Richard, potentially manifested by those around him due to some of his mannerisms being ridiculed by Ishika. It is to be considered as to whether having some Neuro Diverse traits made him more vulnerable to the abuse inflicted against him and affected the response to his disclosures. His employers made reasonable adjustments for him in the workplace to accommodate his needs and he built a close relationship with them.

Richard had a history of mental health difficulties and suicidal ideations. As a result, consideration has been given by the panel as to whether this was exploited and used as a means to gaslight him.

1.7.3 - Race is to be considered relevant to ascertain whether the dynamics of the marriage, a white male marrying an Indian female with an Indian mother, contributed towards his treatment. Ishika maintained a prominent and significant influence over Geetika and Richard into their marriage. However, it is important that assumptions are not made as there is little knowledge or understanding of Geetika and Ishika's beliefs.

It is known that within Asian, Middle Eastern and African cultures that the Mother figure holds a powerful and irreplaceable role as the matriarchal head of the family.[1] Therefore, the review must consider whether race and culture had any impact on the opinion they held of Richard.

Equality is about ensuring everybody has an equal opportunity or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

Intersectionality has been considered and deemed not to be relevant to this review from the information available.

1.8 Dissemination

Recipients who received copies of this report before publication:

Panel Members (listed in 1.1.3)

Richard's parents

Coroner's Office

Selected members of South Cambs CSP Board

1.9 Contextual background

1.9.1 South Cambridgeshire is the second largest district in Cambridgeshire covering approximately 90,200 hectares, mainly rural with no towns. South Cambs District Council is in the County of Cambridgeshire and has a population of 162,119 of which over 3% were males aged between 30-34 years, being the largest age group in the area.[2]

[1] David Livermore, Cultural Intelligence in America 2015
[2] ONS, Population of England in 2021

The South Cambs Community Safety Partnership has the statutory responsibility for DHRs within their area. In April 2021, the Domestic Abuse and Sexual Violence (DASV) partnership took over a centralised DHR commissioning process for Cambridgeshire and Peterborough. This enables them to analyse issues across Cambridgeshire and Peterborough for wider implementation and uniformed processes.

1.9.2 The London Borough of Enfield is in North London which is just over fifty miles South of Cambridge. Its population is estimated to be 333,794.

Familial abuse includes abuse from an adult to another adult who is a close family member. This could include a father or mother-in-law abusing a daughter or son-in-law. The term familial abuse will be referred to throughout this report.

Suicide rates in all districts in Cambridgeshire and Peterborough are statistically similar to England for the three-year period 2017-19. However, all have seen an increase in suicide rates from 2015-17 to 2017-19.

Following a recommendation from a previous DHR, the DASV and Cambridgeshire Public Health compiled a report outlining data in relation to the comparison of statistics within their previous DHRs.

1.9.3 In Cambridgeshire, since May 2018 up until and including Richard's death, ten suicides relating to domestic abuse have been considered as requiring a DHR of which five were male. This is the third DHR in the County relating to a parent-in-law and is the third male victim in the South Cambridgeshire area for a DHR.

The DASV worked alongside Public Health to review the correlation between suicide and domestic abuse from which the outcomes have been shared with key stakeholders working on suicide prevention in Cambridgeshire and Peterborough. The joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025 was published in January 2023.[3]

The World Health Organisation undertook a multi-country study using population-based surveys. This showed that women with experience of physical or sexual violence were nearly 4 times more likely to attempt suicide than women without such experiences, but it provided no associations for men[4]. In addition:

1. 25% of those in domestic abuse services have felt suicidal due to the abuse
2. Domestic abuse victims are eight times more at risk of suicide than the general population
3. 50% of domestic abuse victims who attempt suicide will undertake further attempts within a year

[3] Suicide Prevention Strategy - Cambridgeshire County Council

[4] **Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry** Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - The Lancet Psychiatry

4. “Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible” Williams (2001)

1.9.4 To place this suicide into some form of national context, in 2018 three quarters of the total of 6507 deaths by suicide registered in the UK were those of men.[5]

The Vulnerability Knowledge and Practice Programme (VKPP) research into Domestic Homicides and Suspected Victim Suicides during the Covid-19 Pandemic 2020-2021 reported that the most common cause of suicide was by hanging at 46%. In comparison, 75% of the DHRs involving suicide within Cambridgeshire were carried out by way of hanging.[6]

Section 2 – The Facts

2.1 Background information

2.1.1 The majority of background information has been provided from Richard’s Parents and colleagues to help gain an understanding of him as a person and context to his life as there are few records of Richard held with agencies as he did not have a lot of contact with authorities.

Richard was born in 1989 at the Royal Sussex Hospital a couple of weeks late and Alice tells how he had a traumatic birth as he was’ round the wrong way’. He was born as an only child to his parents, Brian and Alice who describe him as a beautiful baby with long legs. He grew up in a loving home in Brighton with them.

From an early age, Richard liked to build things, constantly playing with Lego and then moving onto taking the remote control for the TV apart and putting it back together. He would be intense whilst doing things and would not give up. He was successful at school and had a few close friends. He would mix and wasn’t shy but would mix mainly with people with the same mind set and with similar interests.

He was successful at school with no issues identified and took part in basketball, athletics and was in the Cubs and Scouts. No autistic tendencies or concerns were identified or brought to the attention of his parents.

When he was 19 years old, Richard and his long-term girlfriend at the time went to a university in London where Richard studied a design innovation degree. Richard was successful there but the relationship eventually came to an end which Richard did not cope with well. He suffered with anxiety and depression and took medication for this.

[5] ONS, Suicides in the UK, 2018 registrations

[6] VKPP- Domestic Homicides and Suspected Victim Suicides during the Covid-19 Pandemic 2020-2021

Having obtained his degree in 2013, he lived in 'digs,' being self-employed and obtained some contracts. He started a business with some friends he had made at university, but this didn't work out and he was short of money.

In 2014, Richard proudly told his parents that he was going travelling to Vietnam for a month which is a place they had been previously and told him about. This was a trip that Richard would refer to and tell people stories about for the rest of his life.

2.1.2 Late in 2016, Richard went to his GP who arranged for him to receive Cognitive Behaviour Therapy as he was having suicidal thoughts. This was delivered by Crisis Resolution Home Treatment Team where he received five sessions of counselling as he had a history of self-harm which took the form of hitting himself and other objects and had increasing suicidal ideations that had been ongoing for two years. He stated he was single and expressed suicidal thoughts of escaping as a means to end his current situation. He felt hopeless, angry and worthless due to his unemployment.

In February 2017, Richard was employed as a design engineer at a Medical Technology company in South Cambridgeshire. He was good at his job and highly thought of. He showed some autistic traits through his anxiety which were recognised by his employers and they made allowances for this in relation to working hours and support, even though he was not officially diagnosed.

Richard registered at a Cambridge GP in 2018 and although he remained on medication, he reported that he had felt better since the cognitive therapy.

In April 2018, Richard started speaking to Geetika through online dating and they met each other in the summer. They became engaged in December 2018. Ishika chose a ring and had it made. She initially paid for it as Richard could not afford it and he had to pay her back in instalments. They were married in August 2019. A number of Richard's colleagues attended and noted a remark made by Geetika's brother during his speech warning him of his mother, although it was said as a veiled joke.

His parents noticed a change in Richard once he was married. They never saw Richard without Geetika and Ishika present. She went everywhere with them. A celebration of the wedding was arranged in India for Christmas 2019 in which Richard and Geetika paraded through the family's home village. The trip to India caused a lot of stress and anxiety to Richard, who did not have any say in its planning. His parents attended for the two-week event.

2.1.3 It was after this trip that things really changed. His parents only saw Richard 5-6 times after that with Covid restrictions limiting visits and also Richard distancing himself. His messages became strange and he always seemed stressed, never laughing. Richard was to confide in his colleagues that his mother-in-law would make nasty comments about his parents, criticising them and blaming his bad upbringing for the fact that he had autism.

Richard began to confide in his colleagues about how he was being treated by his mother-in-law and then eventually, his wife, but chronology is difficult as they have informed the review from memory. He told them how he was made to say awful things to his parents

which he knew upset them and that any texts he sent to his parents were dictated to by Ishika and eventually Geetika. He therefore contacted them less to prevent upsetting anyone.

Ishika told Richard he could not leave any belongings in her house although it was large and spacious. He stayed there on weekends and lived in Cambridgeshire during the week, riding a bike to work. When he stayed in London, Richard and Geetika had to leave their bedroom door open at all times. Ishika put pressure on him to earn more money and Richard disclosed to colleagues that half of his wages went into an account in Ishika and Geetika's names that he did not have access to.

Richard bought a house in Cambridgeshire in March 2021. It was solely in his name and he had financial help from his parents and Ishika in order to buy it. The mortgage was in his name. Geetika only ever stayed there if her mother came as well.

In April 2021, Richard told his Doctor that he would like to Know if he had an Autism Spectrum Disorder (ASD). The GP advised him that the NHS assessment service was closed due to Covid but provided information about private assessments. In addition, Richard reported an increase in anxiety since A Road Traffic Accident (RTA) for which he was encouraged to self-refer to counselling and was prescribed medication.

Richard and Geetika were trying for a baby but could not conceive which Richard was ridiculed for by his mother-in-law. He went to the Doctors for fertility tests in July 2021 and Geetika fell pregnant in August 2021 prior to him obtaining the results. Richard was excited about being a father. When he met with his parents to tell them in the October, it was Ishika that broke the news and told them that they had to have fertility tests as he struggled to get her daughter pregnant, then criticised them to Richard afterwards for not reacting in the right way. They felt shocked that Richard had not been given the opportunity to tell them himself and felt the information in regard to the fertility tests was unnecessary at that time.

Medical records show that Geetika attended a pregnancy booking appointment that same month in which she went in with her mother and named her as the next of kin for the records. Richard was recorded as the father.

2.1.4 Ishika would constantly ring Richard at all times of day or night 'having a go' at him which his colleagues would witness as he would just reply 'yes mum' during lengthy conversations.

On one occasion whilst in Great Yarmouth (date not known), he told his wife and mother-in-law that the way they treated him made self-harm and have suicidal thoughts. Ishika mocked him telling him to walk into the sea or step in front of a bus. She threw away his medication, telling him that he would not be able to hold his baby when it was born and threatening him that it would be easy to get him a divorce from her daughter and he was easily replaceable. Geetika went along with this to the point that Richard disclosed to a colleague that he feared they would both stop him seeing his child when it was born.

Richard told colleagues how he was not allowed to attend any antenatal checks. He would drive them there and Ishika would go into the appointment with Geetika. They would show him a scan photo afterwards. Hospital records confirm he was not present. This did not raise suspicions with the nurses as mothers frequently attend appointments with their pregnant daughters.

Richard was constantly being criticised for the way he ate his food and held his arms when he walked and due to what he was being made to say to his parents, which he knew hurt their feelings, he stopped contacting them. He told colleagues 'they would find out if he tried to contact them privately'. He did not mention how they would find this out but indicated he meant Ishika and Geetika.

2.2 Circumstances of the death of Richard

2.2.1 - One day in late March 2022, Richard completed a presentation in the morning at work and did well in something he always found a little difficult. His colleagues comment that he spent most of the afternoon on the phone, taking the calls in a private room. His colleagues state that he was arguing with his mother-in-law. CCTV and phone records confirm this and Richard disclosed to a colleague via text that his mother-in-law had been on the phone on and off since 3am that morning. This was explained by him as he had been unable to respond to his colleague instantly.

CCTV shows him entering the shower room at 15.55hrs that day. Richard often worked later than others and had a set of keys. As a colleague was locking up the premises, he heard the shower running so completed the remainder of the building before returning. The shower was still running and the door was locked so he let himself in. He saw Richard slumped on his knees in the corner with his belt tied around his neck and tied to the railing pole.

The Police and ambulance were called and CPR was given by all to no avail. This was at 19.28hrs, the same day and it was estimated that he had been deceased for about two hours. The Police began an investigation. An envelope was found on Richard's desk with a list written on one side entitled 'reasons why…' which appeared to be a list of issues in his life, which, from information already received from colleagues was assumed to relate to his wife and mother-in-law.

2.2.2 It reads:

Reasons why…

- Feel emotionally manipulated
- My problems, fears, pain don't matter and are less than yours
- Always being told to 'man up'
- Being told it is all in my mind and I am making it up
- If I just think positive, I choose to be negative all the time
- My negative energy is bringing everyone down and is the reason for all these bad things happening

- Controlling my relationship with my parents to supposedly improve my relationship with them
- Calling my father a bad person all the time
- Always questioning everything I do, hurting me, correcting me, threatening me to improve
- Orchestrating my messages and what I should say and how behave
- Completely dismissing and undermining my pain and shutting me down, always saying you and your family's pain is greatest
- I'm afraid to voice my true feelings or concerns, in fear that they will cause arguments as they usually do
- If you mean you love and care for me as you say you would recognise what you are doing to me, listen to me, recognise the pain that you are causing rather than continue to pressure me to change, use emotional manipulation, upset me, cause me to self-harm, hit myself, want to die

On the opposite side:

- Controlling how and when and how I talk to my parents is causing me pain and hurt that you feel I should do this
- My family is often contacted just like myself, this brings me down and makes me sad
- Drug addict has to go through shit to become a better person

Richard's mobile phone data showed that he had rung two domestic abuse helplines on the morning of the day that he died.

A file was submitted to the coroner stating that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

Richards baby daughter was born less than three weeks after his death. He will never get to hold her as he dreamt of doing.

2.3 Individual management reviews (IMRs) inc Best practice

2.3.1 - Vast scoping in both the Cambridgeshire and Enfield area was completed at the commencement of the review. Richard had very little contact with any agencies. IMRs were requested from the following organisations due to the contact they had with Richard, Geetika or Ishika over the areas considered in the terms of reference.

2.3.2 - Cambridgeshire Police

There is no previous history of Richard on Police systems.

The Police were called to Richard's workplace one day in March 2022, where they commenced CPR on him taking over from one of his colleagues. A Detective Inspector arrived at 19.17hrs to oversee the investigation and the ambulance staff recognised life extinct at 19.28hrs the same day. They estimated that he had been deceased for two hours. It was established that Richards colleague had first heard the shower running at 18.30hrs and had last seen him a few hours previous to that. CCTV shows him entering the shower room at 15.55hrs that day.

The Police were provided information about Richards circumstances and home life including issues he had with his wife and mother-in-law. An envelope was found on Richards desk that had what appeared to be an old message providing directions on one side and the other side was entitled 'reasons why…' which appeared to be a list of issues in his life, which, from information already received from colleagues was assumed to relate to his wife and mother-in-law.

The Police submitted a report to the Coroner stating that the death was considered as non-suspicious, indicative of suicide by way of hanging.

2.3.3 – As a result of the information provided by Richard's Colleagues regarding what he had disclosed about his home life, Cambridgeshire Police raised a crime report for Controlling and Coercive behaviour on behalf of Richard and named his wife, Geetika and his mother-in-law, Ishika as suspects. This was then transferred to the Metropolitan Police, Enfield Borough for further investigation as this came under their jurisdiction.

The Detective Inspector spoke to Geetika on several occasions during which she said that Richard had been looking forward to the birth of his baby but he felt inadequate about some things which made him unhappy. She knew that he had been depressed before she met him and on medication for this, receiving counselling after difficult previous relationships (details unknown), making it difficult for him to trust people.

Geetika stated that she had spoken to Richard about 1pm on that day and he seemed stressed and said he was under pressure at work but this wasn't unusual. She tried to call and text later but thought that was after he had died. She said her mother tried calling when she couldn't get hold of him but did not believe she had spoken to him that day.

Cambridgeshire Police completed a low-level phone download on Richard's phone in which it was found that on the day he died, Richard's phone called two numbers for male domestic abuse victims. This phone was forwarded to the Metropolitan Police for a more in-depth interrogation.

Cambridgeshire Police, with the permission of the Coroner forwarded relevant statements obtained from work colleagues and Police Officers who attended the workplace in response to Richard's work colleague finding him.

2.3.4 - Colleague 1

The CEO of the Company describes Richard as a kind-hearted, incredibly generous, creative individual. He would get frustrated at times and was clearly socially awkward but was offered support and was a valued member of staff.

The CEO was aware of issues that Richard had in his private life due to two significant conversations with him and being updated by his supervisors in early 2022. The first concern arose at his wedding where during the brother in laws speech, a remark was made advising Richard to be wary of his mother-in-law which although it was said in a joking manner, it felt like it was a pointed remark with a veiled warning.

Richard continued to live in property in South Cambs whilst his wife remained living with her mother in Enfield. Richard had said that this was because she wanted to be close to her mum. Although aware that Richard's wife was expecting a baby, his supervisors updated the CEO of some concerning treatment that he had been experiencing from his mother-in-law during the pregnancy and due to this, she spoke to him directly one night once the rest of the staff had gone home. Richard said that his mother-in-law had worked out that he had got autism but he was not aware he had it until she spotted it. In discussing whether he should try and get a formal diagnosis, he said that he didn't want to as his mother-in-law had said that if Social Services found out, they would take the baby away from him and she made him throw all of his current medication away that helped him with depression, stating it was rubbish.

Ishika blamed all of Richard's problems on his parents for not realising and told him that everything that had gone wrong in his life was due to 'bad parenting.' Richard had told his parents this and regretted it as he knew they were incredibly upset and he had always been close to them but was no longer speaking to them.

2.3.5 - The CEO encouraged him to call his parents and in response, Richard said he couldn't as 'they would know'. He went on to explain his mother-in-law would not allow him to ring his parents and that he couldn't hide anything from them. He wasn't sure if they would be allowed to have a relationship with his child when it was born. Richard was quite upset at this time.

He was encouraged to contact a trained counsellor in the company who he had worked with previously as she may be able to give him communication strategies to make boundaries within his relationship with his wife. Richard explained that his brother-in-law confronted his mother-in-law about the treatment of his own wife and not to speak to her like that again. Richard agreed to contact the counsellor.

A few weeks later, a further conversation was held in which Richard disclosed that his mother-in-law holds his head in her hands and screams right in his face to 'try and make me a man and trying to stop the autism.' When asked why she thought this he explained that in past social situations, he asked if it was ok to drink wine and was told that it was an inappropriate question and he should know this. He was never allowed out with just his

wife, his mother-in-law would always attend, including any holiday. When he stayed in London, they would have to sleep with their door open.

Richard was afraid both his parents and he could be cut out of his daughter's life as he was not allowed to go into any scans, appointments or the birth as his mother-in-law went and he was shown photos afterwards. He was only allowed to drive them there.

Advice was given to Richard and the CEO contacted HR who were trying to book a psychiatrist for him.

2.3.6 - Colleague 2

Richard's second line supervisor had known Richard for the five years he had worked for the Company and was the person who recruited him. Throughout his time there, Richard struggled mentally and emotionally and was provided additional support for this. He had flexible working hours and as he liked to work late, he was given a set of keys to lock up when required. Richard struggled with change and had his own desk to leave messy whilst others had to hot desk.

His colleague was surprised when he got married in 2019 as it happened quickly after meeting her. He remembers him being excited at the time. Around Christmas 2021, he held a conversation with Richards first line manager in which he was asked if he could give Richard more managerial responsibility because his mother-in-law was pressurising him to become a manager.

In February 2022, he had a conversation with Richard in relation to career progression and was aware his wife was pregnant. During this conversation, Richard disclosed that his mother-in-law had informed him that she didn't think he should be allowed to hold the baby when it was born as he was not responsible enough and felt his wife would have the same view. He said his wife would do whatever her mother said.

This undermined Richard's confidence and so a meeting was held between his first and second-line manager with the CEO to share and discuss their concerns. Richard had been confiding in a mental first aider but she had gone off sick with stress, partly due to the emotional impact of providing support for him. They arranged to pay for a counsellor for him. This colleague last saw him three days before he died and described Richard as on really good form in a client demonstration, being bright and enthusiastic.

Richard had not given any indication that he would take his own life.

2.3.7 - Colleague 3

Richard's first line supervisor had known him for the two years he had been in this role and describes Richard as friendly, kind and open and caring towards others. He was aware that Richard could get frustrated and flustered when he was stressed. At first, Richard was excited, planning his upcoming wedding but 3-6months after the wedding in Autumn 2020, Richard appeared particularly distressed and distracted and so they went for a walk and a chat. This was the first of several chats that they had together in which Richard disclosed that he was having problems with his wife and mother-in-law.

Richard stated that after the wedding, his mother-in-law had a 'personality change', claiming he was messy and not allowing any of his belongings in her large house in London. Throughout his marriage, she pressurised him to progress his career and make more money, subjecting him to criticism and verbal abuse late into the night. In one of these episodes, she had threatened him with a knife.

His mother-in-law criticised Richard's parents' behaviour at the wedding with issues of them not paying for certain things, booking their hotel room near the honeymoon suite and 'nit-picking' how they conducted themselves. She pressurised Richard to bring these things up with them using hurtful and unpleasant language, telling him he had to build a stronger family and to shape his parents for his own good. His entire conversation or message with them would be dictated to by his wife and mother-in-law and he couldn't have a private conversation with his parents as he was worried his wife and mother-in-law would find out.

The criticism of his parents then started to take a different tone and focused more on saying Richard had autism because his parents raised him wrongly. The more he was made to speak to them unkindly due to duress, the more he became distressed which made the mother-in-law criticise him even more. He knew he was upsetting his parents and his mother was becoming unwell from the distress their estrangement was causing them and he became so uncomfortable with the conversations he was forced to have that he stopped communicating with them. His supervisor thought that his mother-in-law was gas-lighting him and shared an article with him on the subject. His wife had also started dictating messages to him 'just parroting' what her mother was saying.

Richard was questioning his own sanity and his mother-in-law made him think he was misconstruing what she said and misinterpreting her intentions. When he disclosed to her that he was depressed and self-harming, she threw away his anti-depressants, telling him if he was diagnosed with autism, it would affect his children.

Richard and his wife could not go anywhere without his mother-in-law, including on holiday. On one occasion when he told them the affect their constant criticism was having on him, causing him to be suicidal and self-harm, his mother-in-law mocked him say 'Why don't you go and walk into the sea or step in front of a car.

Richard would only reply 'yes Mum' when she ranted to him on the phone which was witnessed by the supervisor on several occasions including for over half an hour when driving to a meeting together on one occasion. He would shut down and give no emotional response.

2.3.8 - When he stayed in the London house, Richard said that they would have to sleep with their door open and they couldn't buy their own house together as his wife didn't want to leave and wanted to raise their children in the same home that she had grown up in.

Richard confided that his mother-in-law had helped financially to buy his house in Cambridge and since then, she and his wife were pushing to have a baby, but he was criticised as they had trouble conceiving and he underwent fertility tests. Once she fell pregnant, his mother-in-law wouldn't allow him to attend scans for the child. He would

drive them there and she would go in with his wife and she told him that due to his mental state, he wouldn't be allowed to hold the baby when it was born. It was insinuated that he would be a terrible father and could easily be replaced.

Richard was excited about being a father and kept asking for advice, borrowing a funny book on parenting. He was concerned about money as he needed to show he was a better provider. Richard paid half his salary into an account owned by his mother-in-law and wife and said that he did not have access to it.

Richard told his Supervisor that his brother-in-law had stood up to his mother as he seemed to be the focus before Richard came along but Richard was not confident enough and had learned to live in that environment. His wife was used to it and filtered it out but had started playing into it. She had initially been passive but as time went on, she started dictating messages to send to his parents as well.

On the day that Richard died, his supervisor was in Boston USA on a business trip and exchanged messages with him around lunchtime in the UK. Richards replies were short and he told him how he had been up since 3am arguing with his mother-in-law.

2.3.9 - Colleague 4

Colleague 4 was a keyholder at the premises. They both used to work late and would chat to each other before they left. Richard confided that his mother-in-law constantly belittled him and made him feel awful all of the time. She told him he wasn't good enough and to cut off his family.

On the day Richard died, he was locking up and heard the downstairs shower on so he went to lock up elsewhere and when he came back, it was still on with no answer when he knocked on the door. He unlocked the door and entered to see Richard slumped on his knees in the corner with his belt tied around his neck and tied to the railing pole.

He called 999, put Richard on his back and began CPR until the Police and paramedics arrived.

Best practice/Reflective Considerations:

Cambridgeshire Police are currently working alongside Cambridgeshire Public Health Suicide Prevention as to how to improve their response to families who have lost loved ones to suicide. This includes leaving helpful and supportive material that can be looked at in their own time. Following learning from a recent DHR, an Inspector from both the North and South of the County will also be available as a point of contact to families following a death where they may be a review to assist with any questions and provide updates where necessary.

2.3.10 - Barnet, Enfield and Haringey Mental Health Trust (BEHMT)

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) have had limited involvement within the scoping period. Involvement with Richard occurred before the relationship with

Geetika commenced. Richard had short term contact in 2016 around suicidal ideation following a referral from Improving Access to Psychological Therapies (IAPT) to the Hub. Richard was assessed by the Crisis Resolution Home Treatment Team (CRHTT) but did not meet the criteria for admission. Richard continued to receive support for his mental health via IAPT Haringey.

There was no involvement with Ishika during the scoping period. Prior contact was health related and not of relevance to the DHR.

Due to the birth of their child, Geetika was known to the health visiting team, part of Enfield Community Services. The health visitor had short term involvement with Ishika after the death of Richard and was open to health visiting due to the recent birth.

2.3.11 - Richard

11/11/16 - Improving Access to Psychological Therapies (IAPT) Haringey – Richard had five sessions of counselling but they were unable to view the content as this was held on a system that was not accessible. IAPT referred Richard to the Hub due to his increasing suicidal ideations that had been ongoing for two years. There was history of self-harm noted by hitting himself and other objects. The Hub contacted Richard who stated he struggled to interact with people and to form relationships and said that he needed help to regulate his emotions. He reported having depression in his late teens and being single at the time of contact but spoke about an ex-girlfriend that had moved to India (3 years prior). Richard expressed suicidal thoughts of escaping as means of ending his current situation, he also expressed feelings of anger, hopelessness, and worthlessness due to his unemployment situation. The Hub referred him onto Crisis Resolution Home Treatment Team (CRHTT) for an assessment.

18/11/16 - A CRHTT assessment took place. Richard had six further therapy sessions already planned with IAPT with no previous suicide attempts noted. He did not meet the criteria for admission and was signposted back to his GP to discuss medication and to continue with therapy provided by IAPT. He was provided with the contact details for Samaritans, CRHTT and A&E should he be in crisis.

2.3.12 – Geetika (*This information has been included as enquiries were made from the review panel to ensure safeguarding of the child and Geetika as part of the review concerns. This can be redacted if required as consent has not been obtained from Geetika*)

03/05/22 – The Health Visitor (HV) undertook a home visit for new birth (11 days post-delivery). HV agreed listening contacts due to Geetika mourning for her partner. Geetika was also referred to IAPT 'let's talk.' Ishika was present. There were no concerns for mother or baby.

23/05/22 – Health visitor – A home visit took place and it was noted that Ishika answered all the questions for Geetika during this visit.

May – July 2022 – Further contact with Geetika not relevant to this review.

Best practice/reflective considerations

BEHMT have a DA policy in place currently. This has just been ratified following updates being made in line with the DA Act (2021). DA within a family setting is incorporated throughout the policy and in work delivered within the trust.

2.3.13 - North Middlesex University Hospital NHS Trust

The North Middlesex University Hospital NHS Trust covers the Enfield area. There are no records for Richard held on their systems.

Geetika

08/10/21 - Pregnancy booking appointment. Geetika attended with her mother Ishika. Geetika spoke and read English fluently and therefore interpreters were not required. This was her first pregnancy.

There were no social concerns or domestic abuse disclosures at the booking. Geetika's ethnic origin was recorded as Indian. Ishika was recorded as her next of kin and emergency contact. Richard was recorded as the father. His ethnic origin was recorded as English/British European. The pregnancy was recorded as a spontaneous conception.

24/11/22-16/2/22 - Regular and routine antenatal appointments took place. There was no record that Ishika attended these appointments. Geetika attended alone. No domestic abuse or social concerns were disclosed.

01/03/22 - Routine antenatal appointment. Geetika attended this appointment with Ishika. No concerns were raised.

23/03/22 – 05/04/22 - Regular and routine antenatal appointments took place. There was no record that Ishika attended. Geetika attended alone and disclosed that she had lost her husband. A reassurance ultrasound was scheduled.

19/04/22 - Routine antenatal appointment. Ishika attended this appointment with Geetika. Geetika consented to IAPT referral due to anxiety around her husband's death.

The remainder of the record refers to the birth of the child and is not relevant to this review.

2.3.14 - Best practice/Reflective considerations

A bespoke Domestic Abuse Policy is held by the Employed and Vulnerable Case loading Women Midwife that links into further Safeguarding policies. This includes guidance on early identification and states all pregnant women are routinely asked about domestic abuse during their pregnancy and seeing the individual alone is best practice. This policy was followed in relation to Geetika.

2.4 Summary reports

In addition to the IMRs, certain agencies/organisations were requested to provide supplementary information into processes and provisions.

2.4.1 - Impakt Housing and Support

Impakt Housing and Support are providing a countywide advocacy/outreach service, offering a range of support to victims and survivors of domestic abuse with effect from 1st October 2022 in the Cambridgeshire and Peterborough area.

They work with victims, survivors, and those at risk of domestic abuse, delivering confidential professional services through a trauma informed approach, ensuring they understand the needs and wishes of everyone. Through the development of tailored safety plans, they help victims to remain safe, enabling them to retain and regain a sense of autonomy and control.

Impakt deliver their services in a joined-up way, working through a strong partnership ethos with the County Council and other agencies to ensure any victim of domestic abuse can access effective support when and where they need it. In doing this, they work collaboratively with other specialist services across the county providing regular local drop-in services and support.

They will be offering support to individuals including, issues around security so survivors can remain safely in their own homes, accessing benefits and signposting or referral to specialist services such as legal representation, mental health, and substance misuse.

They will also be working with local and national organisations to educate people in recognising what domestic abuse is, helping to increase access to support and decrease incidents of abuse.

Domestic abuse comes in many forms. They believe that all survivors of domestic abuse should be able to get the support they need to feel safe and move on from the impact of the abuse they have experienced. This includes timely interventions to escape the abuse as well as longer term support to help them rebuild their lives and have a safe future for themselves and their loved ones.

The services offered are available to both male and female survivors and are communicated as such.

2.4.2 - Cambridgeshire Public Health

Cambridgeshire Public Health run STOP suicide workshops which are suitable for businesses but this does not come under the funding stream which is reserved for community/statutory organisations. Businesses would have to self-fund and these workshops are not widely known about outside of the funding stream.

There is no central support for employers but each individual workplace should have procedures in place. The Samaritans provided some training for businesses some time ago within Cambridgeshire but this is believed to have been prior to Covid.

The new National Suicide Prevention Strategy states:

Evidence suggests autistic people, including autistic children and young people, may be at a higher risk of dying by suicide[7] compared with those who are not autistic. It is essential that health, mental health, and local authority services and education providers consider the needs of autistic people in suicide prevention activity. While many actions in this strategy will support autistic people, we need to tackle the specific preventable risk factors and tailor support to their needs.

Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide and, therefore, earlier identification and timely access to autism assessment services is vital.

2.4.3 - South Cambridgeshire District Council

Records show that Richard bought a house in South Cambs on 5th March 2021. His name was registered as the sole owner. He bought the house for £202,000 and it was mortgaged.

2.4.4 - NHS Cambridgeshire and Peterborough ICB – GP

Richard registered to a local GP Surgery in South Cambs in 2018 having previously been registered in London.

2.4.5 - London surgery

From June 2016, Richard was treated for a period of depression by his GP surgery. Richard reported that he felt he was experiencing depression, which he felt started around the age of 18. He reported cycles of feeling up and down with periods of self-isolation from family and friends.

Richard reported experiencing a lack of confidence and tending to worry about lots of things, disclosing that he previously self-harmed and does sometimes hit himself when feeling negative. Richard was referred to IAPT (Improving Access to Psychological Therapies) where he received Cognitive Behaviour Therapy (CBT).

In November 2016, a conversation was held between his GP and his counsellor who expressed concerns about his mental state. The counsellor reported Richard was having suicidal and homicidal thoughts, there was no immediate risk identified and the thoughts were well contained. Richard was referred to the crisis team but asked for the GP to follow up with an appointment.

Richard was seen by the GP three days later. He reported feeling quite stuck, seeking work and living in a flat share but not getting on with flatmates. He reported he struggles talking to people and gets anxious about social situations. Richard stated he often has dark thoughts and thinks about not being alive. He added that he gets angry with his flatmates but has no

[7] Premature mortality in autism spectrum disorder - Cambridge University press. 2nd January 2018

intention on acting on this anger. Anti-depressants were commenced. A GP review was undertaken in December 2016 at which Richard reported he was feeling much better, more positive and had energy to find work and was socialising more.

2.4.6 - South Cambs surgery

In 2018, Richard registered with a GP surgery in Cambridgeshire. Richard's first contact with the Surgery was in February 2018 for a medication review. He reported feeling well and to be receiving a benefit from Sertraline. He added that CBT was successful and that he had made some lifestyle changes.

In between 2018 and 2021, Richard's contact with the GP surgery was in relation to medical appointments/issues, unrelated to the scope of this report. In April 2021, when discussing pain in his wrist following a Road Traffic Accident (RTA) over a year ago, Richard stated that he would like to know if he had ASD (Autistic Spectrum Disorder). The GP advised him that the NHS assessment service was closed due to Covid but provided information about private assessments. In addition, Richard reported an increase in anxiety since the RTA for which he was encouraged to self-refer to counselling and was prescribed medication.

In June 2021, Richard contacted the surgery as he reported he and his partner had been trying to conceive for a year without success, so the GP requested a semen analysis. In September 2021, Richard met with the GP to discuss the semen analysis results. At the appointment, Richard referred to experiencing some family stress over the past 12 months but the records do not go into any further detail.

This was the last contact the GP surgery had with Richard in which any of the areas requested as part of his report were discussed. There is no reference to domestic abuse in the records from either GP surgery.

2.4.7 - Metropolitan Police Investigation

The Metropolitan Police received a transferred report of controlling coercive behaviour from Cambridgeshire Police with the victim recorded as Richard and the suspects recorded as his mother-in-law, Ishika and his wife, Geetika. This was assigned to a dedicated department that deals with Domestic Abuse in Enfield Borough.

Early on in this investigation, Geetika was eliminated as a suspect without being spoken to. Rationale has not been provided to the author on request both verbally and via email from the Detective Sergeant overseeing the investigation and can therefore not be included. A voluntary interview was held with Ishika during which she replied no comment to the majority of questions put to her and she denied all controlling and coercive behaviour. She surrendered her phone which was forensically examined and no material supporting the allegation was found on the device. A file has been submitted to the Crown Prosecution Service (CPS) for a charging decision.

Forensic examination of Richard's phone showed that at 11.45hrs on the day he died, he had made a phone call to the Mankind anonymous helpline of which the number to contact is displayed on their website. A Google search showed the result of the phone number as Mankind Initiative Help for Male Victims (mankind.org). The website states 'if you are a male victim of domestic abuse, you are not alone, we are here for you.' The call lasted 0 seconds indicating that Richard did not speak to anyone on that occasion.

A further phone call was made twelve minutes later to a phone number which when searched through Google shows that it was made to Men's advice line managed by the charity Respect. It is a Domestic Abuse Helpline for Men, Men's Advice Line UK (mensadviceline.org.uk). The website says, 'The helpline for male victims of domestic abuse'. The call lasted 2 minutes and 12 seconds indicating that the call was connected and Richard may have spoken to someone. An email was sent to the Coroner in relation to this from the helplines manager of the charity Respect which manages Mensadviceline.org. The email outlines the below:

Their helpline service has three access points with telephone, email and webchat support.
The telephone helpline service does not record any identifiable information for callers and they are therefore unable to confirm if a person has been in touch with them.
The email support service has identifiable information by way of the email address for users and at times, content shared may contain personal details. Emails are kept for a period of 6 months and permanently deleted from the system.
The webchat service does not collect identifiable information unless the chatter reveals their personal details or information for others. These records are also deleted after 6 months.
They have searched their system and have no record of any emails from Richard's email address.

Throughout the review, the investigation has been awaiting the submission and download of Richard's laptop. At the time of publication, the results of this have still not been received and therefore, the investigation is still ongoing.

2.4.8 - Cambridgeshire and Peterborough Domestic Abuse & Sexual Violence Partnership - DASV

Within the last few years, leaflets and posters of DA literature have been placed within the community at GP Surgeries, public buildings, libraries ensuring its availability in multiple languages. The website contains an easy search facility for domestic abuse and outlines familial abuse within the vast array of information contained. The website provides information for support.

Over the period of 2020 and 2021, the DASV provided focus on male victims and completed the following:
Poster aimed at male victims giving the number of the Men's Advice Line available for free download on our website. These were sent out to community venues in 2019. We also have a poster aimed at LGBTQ+ victims and one aimed at older people experiencing familial abuse (both posters feature male and female images)

Page on Cambs DASV website aimed at male victims of DA Welcome to Cambridgeshire DASV Partnership (cambsdasv.org.uk)

The leaflet aimed at the public doesn't specify gender of victims and includes a section on male victims.

- eLearning for professionals includes a section on male victims.
- All services (IDVA and Outreach) support male victims
- January 2020 DASV Partnership Newsletter included an article about the Safe Lives Voices of Boys & Young Men project
- Cambs DASV Partnership featured on BBC Radio Cambridgeshire Feb 2020 talking about local support services and stigma around male victims of sexual violence and domestic abuse.
- May 2020 Newsletter included information about the male version of the Freedom Online programme.
- June 2020 Newsletter featured a film called '1 in 5' about male victims, a link to the film was also shared on their social media.
- January 2021 Newsletter included information about a film from Yorkshire Police and Mankind about male victims, this was shared on social media too
- On International Men's Day the service shared social media posts to encourage male victims to seek support and also re-shared posts from partner agencies such as the police.
- Highlighting support to male victims is part of their communications strategy and other key dates are also used to highlight support via social media channels (such as Men's Health Day).

The June 2021 training sessions for the DASV Champions Network had a speaker from Respect who talked about support for male victims, increases in contacts to the Men's Support Line since the beginning of the Covid-19 pandemic

October 2021 Newsletter included information about the Own My Life course from Refuge in Cambridgeshire which is also available to male victims. This was also shared on social media. This featured again in September 21 newsletter

Respect training for professionals around supporting male victims was offered to all staff across IDVA and DA Outreach services in 2021

Specialist IDVA to support male victims of DA launched in November 2021 on International Men's Day and posts were shared about this across social media. This IDVA takes referrals at all risk levels (over 60 referrals Nov-Dec 21)

DASV Partnership Officer attended the virtual Mankind annual conference in 2021 and shared messages on social media to link with those being shared from the conference.

December 2021 Newsletter featured information about funding from the Police & Crime Commissioner for specialist support for male and female deaf survivors. This was also

shared on social media. This newsletter also included information about local organisation Free Spirit and their support to male victims.

In 2023, the DASV Partnership have offered four free webinars to employers regarding domestic abuse and what to be aware of. This has been commissioned from “Domestic Abuse Education” – an agency that works closely with EIDA – Employers Initiative on Domestic Abuse.
All services provided in the community since October 2022 are gender neutral. The IDVA service has been working with both male and female victims of domestic abuse since 2003.

2.4.9 - Employment

Richard had worked for a Medical Technology Company since February 2017 when the company was quite small. Statements found under 2.3 (Cambridgeshire Police) provide information directly from colleagues in relation to Richard.

The company have well-being coaches and mental first aid trainers to assist any employees who need support. They also employ a professional coach and mentor who also works for the Samaritans.

His bosses had recognised that Richard had some autistic traits and always ensured adjustments were made to make him more comfortable in the workplace, such as he kept his own desk when they changed to hot desking and allowed him flexible working hours to suit him as he preferred to work later into the evening and was provided keys to lock up if necessary.

The company does not have a bespoke domestic abuse or suicide policy and staff have not received training in either. They identified that Richard was at risk of harm, worried that he may be physically harmed. They did not identify any signs that he may end his own life. Phone records and CCTV showed that Richard had been on the phone to his mother-in-law in a private room for long periods throughout the day he died.

All his colleagues liked him and he was very good at his job. The company are open to receiving training on domestic abuse and suicide and having policies put in place. Since this has happened, they have revised their policy for all mental first aid workers to immediately escalate any concern for an employee to Senior executives as this was not done when Richard disclosed his abuse and how he was feeling.

Section 3 - Analysis

3.1 Family and friends' perspective

Richard's parents

Alice and Brian are understandably devastated at the loss of their son. They had always been close to their only son and could not understand why they became isolated from him from about six months into his marriage and why he spoke to them so out of character during this time. The decline in Richard's emotional wellbeing severely impacted on them during covid and in his last few months and they will now never have the opportunity to help him and assure him they still love him. Both have assisted with the review and provided information on Richard's upbringing and character. They are conscious that they must maintain a relationship with Geetika and Ishika as they wish to be involved in their granddaughter's life as she grows up. This was understandably a factor borne in mind when providing the author with information.

They have felt frustration and disappointment in the response from Cambridgeshire Police in the first instance, following Richard's death as they felt they were treated more like an 'admin tick box' rather than parents who had lost their only child when providing a statement as the officer told them she needed to get it before she went on leave. Further disappointment and stress have then been caused when the crime was transferred to the Metropolitan Police with an agreement of weekly updates on the investigation's progression. There have been months passed in between contact with little information provided when there has been. The lack of updates they have received from the Police and struggle they have faced for support since his death have added to their trauma. They have informed the author that they have not made a complaint purely because they have so much to worry about at this time and did not wish to add to this.

Colleagues/friends

The colleagues and friends of Richard have been commented on as an entirety as they all had similar thoughts and observations. They all found Richard to be a lovely, kind man who was very good at his job and would do anything for others.

Richard was very organised and his pet hate was to not complete work on the computer before being away or making appointments that he would not be able to keep. He had appointments made for the following week and had not written up his days work at the time he died which made them think that this may not have been planned ahead of time.

Richard confided in a number of colleagues about the way he was treated and talked to by his mother-in-law and then his wife. He was distraught at the way they had made him speak to his parents but said that he did it to keep his mother-in-law happy and to make his marriage work. Once his wife was pregnant, he feared he would not be able to see the baby when it was born.

His colleagues were worried about physical harm coming to him but did not ever consider that he would end his own life. They knew the treatment to him was wrong and although they identified it was domestic abuse from his wife, they had not realised that the treatment he received from his mother-in-law was classed as domestic abuse.

3.2 Terms of reference areas

Has Domestic Abuse (DA) in any form been the causation or a contributory factor to Richard taking his own life?

Richard grew up in a loving family as the only child to his parents. The end of a long-term relationship whilst he was at University saw him struggle with depression and his mental Health. This was the first time he had suicidal thoughts and he received Cognitive Behaviour Therapy. He arrived in Cambridgeshire with a new job reporting to his GP that he felt better but remained on medication.

He was successful in his new job and liked by colleagues. They noticed some traits in him consistent with neuro diversity which had not been diagnosed and adapted working conditions for him to assist. This was not detrimental to his quality of work in any way. However, belittling and demeaning Richard by criticising his mannerisms such as the way he ate and the way he held his hands when he walked caused **emotional abuse** by his mother-in-law and throwing out his tablets, which were to assist with depression and telling him to 'man up' made him more aware of his traits and caused him to doubt himself. Blaming his parents and his upbringing for the autism she accused him of having caused anguish to both Richard and his parents.

Economic abuse came in the form of Richard having to give half his wages each month into a bank account owned by Geetika and Ishika to which he did not have access. Additional pressure was put on him to earn more money to the point that his employers considered a managerial title to assist taking some pressure off him as this made him feel he was inadequate and would not be able to provide sufficiently for his child. Ishika also loaned him money to purchase his home which will have provided a financial hold over him whereas his parents also loaned him money for the home that he would not have to pay back.

Controlling and coercive behaviour came in many forms including not allowing any of his property in the London home that he stayed in on weekends, even though this was a large house, leaving the bedroom door open when he stayed, dictated phone calls and messages to his parents and eventually causing the isolation between them. Constant phone calls day and night including the day Richard took his life, even though he was at work in order to berate him was a way to constantly keep his mood and mind low and in his mother-in-law's control. Certain incidents, such as his mother-in-law choosing the engagement ring and arranging the wedding, although potentially considered as controlling is also cultural and may have occurred as a result of this and cannot be commented on either way.

Due to his disclosures to several colleagues, the opinion was formed that although he was initially being belittled, abused and gaslighted by his mother-in-law, his wife was equally as culpable towards the end and Richard not only feared a failed marriage but also feared not being able to hold or see his child when it was born.

On the day Richard took his own life, his behaviour did not portray that he was planning this as he had made several meetings including one with a counsellor for the following week and had not updated the vault software which is something his colleagues stated that he would always do if he was going to be absent from work and unavailable if any queries arose. This was the day colleagues reported that he had been on the phone in a side room all day to his mother-in-law and that he had told a colleague she had been on the phone since 3am that morning.

What literature and communication in relation to domestic abuse, specifically familial abuse is available to the public and employers so that the behaviour can be recognised as such and support obtained.

Richard's Colleagues and employers all recognised that the behaviour he received from his mother-in-law was wrong but did not recognise this as a form of domestic abuse and did not know what familial abuse was. They did however recognise domestic abuse in relation to the treatment from his wife when he began to disclose how she had also started to dictate and belittle him.

The company had mental first aiders to assist staff who were struggling and provided them someone to talk to. The trained employees for Richards company had not been trained in domestic abuse and were not aware of pathways they could signpost him to for support. There was no escalation policy in place for disclosures or identification of any person at risk and therefore, there was a delay in the senior members of staff being aware of Richard's situation. This has already been addressed by the company from their learning of Richard's death and a policy is now in place showing effective learning and prompt response to safeguard this area for the future.

Richard's employers also provided a mentor and coach who had worked for the Samaritans and they were prepared to pay for Richard to seek counselling from her for which he had made his first appointment but did not get to attend it due to his death. The empathetic response to disclosures made by Richard to his colleagues and supervisors is to be applauded as there was no difference in their approach because he was a male and although they did not specifically identify the familial abuse, they identified that it was not acceptable behaviour and tried to provide support and advice where they could. (Recommendation refers)

All websites of the organisations represented on the panel in both the Cambridgeshire and the Enfield area have excellent literature on domestic abuse and support services including familial abuse and its definition if you use the search criteria. However, if you cannot identify that you or someone else are suffering from familial abuse and it is seen as just an

'an evil mother-in-law' as described verbally by one colleague, then the search for domestic abuse would not be made. It is not known whether Richard contacted the domestic abuse lines on the day of his death due to the behaviour received from his wife or that of his mother-in-law or both. (Recommendation refers)

Prior to the Global pandemic, Cambridgeshire and Peterborough DASV Partnership had distributed literature on domestic abuse and support provisions in the area in the forms of leaflets and posters to places of Public access such as GP Surgeries, Libraries and the Accident and Emergency Department of local hospitals. It is not known whether these are still available and accessible. These continue to be distributed and posted around key venues in the district of South Cambs by CSP officers. Late 2022, there was a significant distribution of leaflets and posters to GP Surgeries, gyms, libraries, health clubs, hairdressers, solicitors and other venues. One of the posters distributed featured a man as a victim.

The internet does not refer to either domestic or familial abuse if you utilise the search facility surrounding wording of being treated badly by your mother-in-law or suchlike.

What training have professionals received in relation to recognising signs of DA, in particular, familial abuse and are sufficient opportunities provided for disclosure?

All organisations on the panel have received domestic abuse training and in particular, training on familial abuse. Bespoke domestic abuse policies are also in place in each agency.

There was specific debate and review in relation to the processes in place at North Middlesex University Hospital in relation to procedures during pregnancy and Antenatal appointments. They have a clear domestic abuse policy that provides guidance on the identification of domestic abuse and processes such as seeing the patient on their own and making a routine enquiry in relation to domestic abuse. There is no record of disclosure of domestic abuse from Geetika who was seen on her own on more than one occasion, however, it does not record if she was asked. No attention was given to Geetika attending appointments with her mother as this is common practice as fathers do not always attend. It is not recorded as to whether it was asked why he was not present. Seeing Geetika on her own presented the opportunity to voice any concerns over her mother's treatment of either her or Richard and she did not do this although it is only recorded on one occasion that she was asked.

In September 2021, Richard attended his GP and records show that he refers to family stress when speaking with the doctor. There is no record of any questions being asked in relation to this or the opportunity for disclosure even though this would have been relevant to the fertility tests he was attending for. A number of GP's now state that they can only discuss one medical issue per appointment to ensure they remain within the allocated timeslot. This raises concern that safeguarding issues including domestic abuse might not be addressed or recorded appropriately due to the time pressure on a GP. (Recommendation refers)

What provisions are available within Cambridgeshire for males suffering from Domestic Abuse and mental health issues.

Up until October 2022, provisions for male victims within Cambridgeshire were scarce and restricted. The IDVAS have always worked with men and women but self-referrals to local outreach services in the area were limited to women which deterred males from either recognising abuse or actively seeking support.

This was recognised through previous DHRs and recommendations and the DASV commissioned IMPAKT Housing and Support to provide all victims of domestic abuse with support. They believe that all survivors of domestic abuse should be able to get the support they need to feel safe and move on from the impact of the abuse they have experienced. IMPAKT were also included on the DHR panel particularly to provide the male victim balance and stance within this DHR.

Their website has clear direction to the segment on domestic abuse and does not mention male or female but refers to 'people' and 'all', being inclusive. IMPAKT also state that they work holistically with other agencies which ensures all support is utilised and not isolated to one provision.

Domestic abuse support services assist with economic abuse and advice along with the other strands of domestic abuse as it is not feasible to have separate support services for each. However, it is unknown as to whether Richard identified this as a form of domestic abuse so he may not have been able to identify who to contact for support and assistance. Economic abuse is an area that is not always identified and the fact that Richard is male and males have historically been viewed as the main 'breadwinner' in marriages, this may provide unconscious bias by authorities. The ManKind initiative report[8] that economic abuse forms part of the cycle of controlling and coercive behaviour with over half of male victims having their earnings controlled with statistics of the method of abuse showing as:

- Controlling money – 71%
- Refusing to share expenses – 75%
- Making it difficult to work or study – 87%

Richard's disclosures to his colleagues and the fact they felt they had to address them within the company to support him, shows the impact this had on him as Ishika's comments made him feel he was not sufficiently providing for his family.

There are a number of provisions for both medical treatment and support within Cambridgeshire for those suffering with their mental health or having suicidal ideations. The Cambridgeshire and Peterborough Foundation Trust (CPFT) provide mental health services within the area and are accessible through referrals from all agencies within the area and also self-referral. Lifecraft and the Samaritans run a mental health helpline and their websites are easily found when searched for, providing information and contact details.

[8] ref: ManKind Initiative with UCLan. Male victims of coercive control 2021

Section 4 – Conclusions and Recommendations

4.1 Conclusions

The panel were satisfied that the Cambridgeshire and Peterborough DASV had addressed the awareness and provisions for male victims of domestic abuse within the area sufficiently over the past few years. Richard accessed information and helplines available nationally for male victims on the morning of the day he died, evidencing he had managed to both identify that he was a victim of domestic abuse and obtain information on where he could speak to someone for support.

It is not known whether he had identified that he was a victim of domestic abuse from just his wife, Geetika, or from his mother-in-law, Ishika or both. It was clear that he knew the way he was treated and spoken to by Ishika was not acceptable due to the disclosures that he made to colleagues and the notes that he had written on an envelope that were found on his desk indicated that some of the points were directed at Geetika. His employers and colleagues responded to Richard's disclosures with empathy and support with no show of unconscious bias that he was a male and therefore any less of a victim. Their sentiments since his death in relation to the behaviour of his wife and mother-in-law towards him encompasses frustration that they could not have done more to help. They recognised that the way he was being spoken to and treated by Geetika was domestic abuse but did not realise the familial abuse from Ishika although they knew that her behaviour was not how a mother-in-law should behave towards a son-in-law. The company and staff have not received any training in relation to domestic abuse or suicide which they are open to and they should be commended for their support of Richard during his last few months. This does highlight the lack of recognition of familial abuse, not only by employers but by the public in general.

All panel members organisations in both Cambridgeshire and the Enfield Borough include familial abuse within their domestic abuse training, which is best practice, but this training is sometimes only delivered to those in specialist safeguarding positions so does not provide the understanding to the wider members of staff. The panel feels that both locally and nationally, familial abuse awareness and understanding is required amongst employers and in communities.

Richard's previous history of mental health, self-harm and suicidal ideations was manifested following his wedding by the emotional abuse initially from his mother-in-law and then from his wife and his vulnerabilities were exploited. He began to question and doubt himself due to being criticised for how he held his hands and being told his parents were at fault that he had autism as they had not brought him up properly. Ishika would then make him think he had misconstrued what she had said causing him additional confusion and emotional abuse. This was to the extent that he asked the doctor if he could be tested for a diagnosis as he had been convinced that he suffered from autism.

Controlling and coercive behaviour that would have a direct impact on his marriage begun almost immediately after the wedding with Richard not being able to leave any of his

belongings at the Enfield address and having to have the door open to the bedroom whilst he slept when he stayed there on a weekend. Ishika insisted on always being present when they were together including holidays and it was initially considered by the panel as to whether Geetika was also being controlled and may require safeguarding but due to information gathered during this review with opportunities to disclose to health professionals and no concerns noted when asked and then the disclosures Richard made to his colleagues of how his wife was treating him along with the comments he made on the envelope, it would appear she was abusing him both emotionally and financially and also controlling him to a degree.

There was a missed opportunity for Richard to be encouraged to disclose his abuse to a professional when he attended the GP Surgery in relation to him and his wife not being able to conceive and mentioned family stress which was not explored by the Doctor. It is also not recorded as to whether he was asked why he thought he may have autism which would have been a further opportunity for him to disclose the abuse he was receiving.

Richard showed deep concern as to how he was being forced to treat his parents, knowing that it would upset them and not knowing what to do as he was trying to appease his wife and mother-in-law who both dictated to him what to say.

The panel considered the fact that there may be aspects of Geetika and Ishika's behaviour that may be culturally influenced in regard to wanting him to earn more money to look after the family and the lack of privacy for his marriage, but without knowing their beliefs and culture, it would be remiss to speculate on the impact this may have had. However, there are examples of behaviour that would not be in the Indian culture such as Ishika threatening Richard with divorce and the panel felt that the behaviours of both Ishika and Geetika that were outlined were more controlling and coercive than cultural.

Richard told his colleagues how happy he was that he was going to become a father and had made steps to read books to prepare himself. However, a culmination of being told not to take his tablets for depression as he would not be able to hold his baby, fears that his marriage would end as disclosed to colleagues and being ridiculed over his mental health when he was already self-harming and in a vulnerable state would have added to Richard's turmoil over his situation with his parents and he would have felt very isolated.

On the day he took his life, he had been receiving calls from his mother-in-law from 3am and had a pressurised presentation that he would not have been comfortable completing but did so competently.

With no other known issues or stresses in his life and the happiness at the thought of becoming a father whilst taking into account his previous mental health history, the conclusion of the panel is that the domestic abuse Richard suffered was a cause or contributory factor to him taking his own life.

4.2 Recommendations

National

1) **A National campaign to highlight familial abuse to both the public and employers.**
   This will inform and educate people across the country about familial abuse and assist them to potentially identify this in others and themselves, leading to obtaining support and safeguarding if required.

Local

2) **Cambridgeshire and Peterborough DASV to hold a promotional campaign for the public and employers to highlight familial abuse and the provisions and pathways available to assist.**
   This will inform and educate those living and working in the area about familial abuse and assist them to potentially identify this in others and themselves, leading to obtaining support and safeguarding if required.

3) **Cambridgeshire Public Health to publicise 'Stop Suicide' to businesses within their jurisdiction and how to access this.**
   This will both inform and encourage employers within Cambridgeshire to educate themselves in this area as to how they can support their staff and what pathways are available in these circumstances.

4) **The Metropolitan Police, Enfield Borough to dip sample reports dealt with by the Domestic Abuse team for victim contact satisfaction.**
   This will identify whether the Code of Practice for Victims of Crime within this department is being adhered to on a regular basis and if not, then this can be addressed.

5) **The GP Surgery to implement a process where the opportunity for disclosure of domestic abuse is provided when a patient makes a negative comment in relation to their home or family circumstances.**
   This will ensure that the subject is explored and the opportunity provided whilst in a closed and safe environment with appropriate recording of the conversation thereafter. If domestic abuse is not disclosed, then mental health provisions can still be made available.

6) **Cambridgeshire Public Health to ensure ongoing suicide prevention activity is adapted to meet the needs of people with autism and learning disabilities, primarily by sharing suicide prevention resources and promote suicide prevention training to key organisations.**

This provides focussed information and advice specific to an area that has been identified as having a heightened risk and ensures availability to those who require it the most.

Appendices

Appendix A

Terms of reference

- The date parameters under consideration are from 2016 until present. However, if relevant information is held prior to this, can a summary be provided to provide context.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was the cause or a factor in the death of Richard.
- 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 what literature and training is available in relation to familial DA for both professionals and the public to recognise and understand it within the South Cambs and Enfield areas.
- Is there sufficient support available locally for male victims of domestic abuse and how accessible are they?
- Establish whether agencies have appropriate policies and procedures to identify and respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.
- Establish accessibility of services for those contemplating suicide and whether training has been received in relation to the effects DA may have towards this.
- Establish if there is sufficient professional curiosity and opportunity provided for disclosure of DA from professionals surrounding pregnancy, birth and fertility discussions.
- What information is available to professionals and employers within the areas of South Cambs and Enfield in regard to domestic abuse and suicide. What training have they had and what policies do they have in place to be able to respond to any disclosures from employees.
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and his wife? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

ASC: Adult Social Care

CSP: Community Safety Partnership

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASH: Domestic Abuse Stalking and Harassment risk assessment

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

GP: General Practitioner

ICB: Integrated Care Board

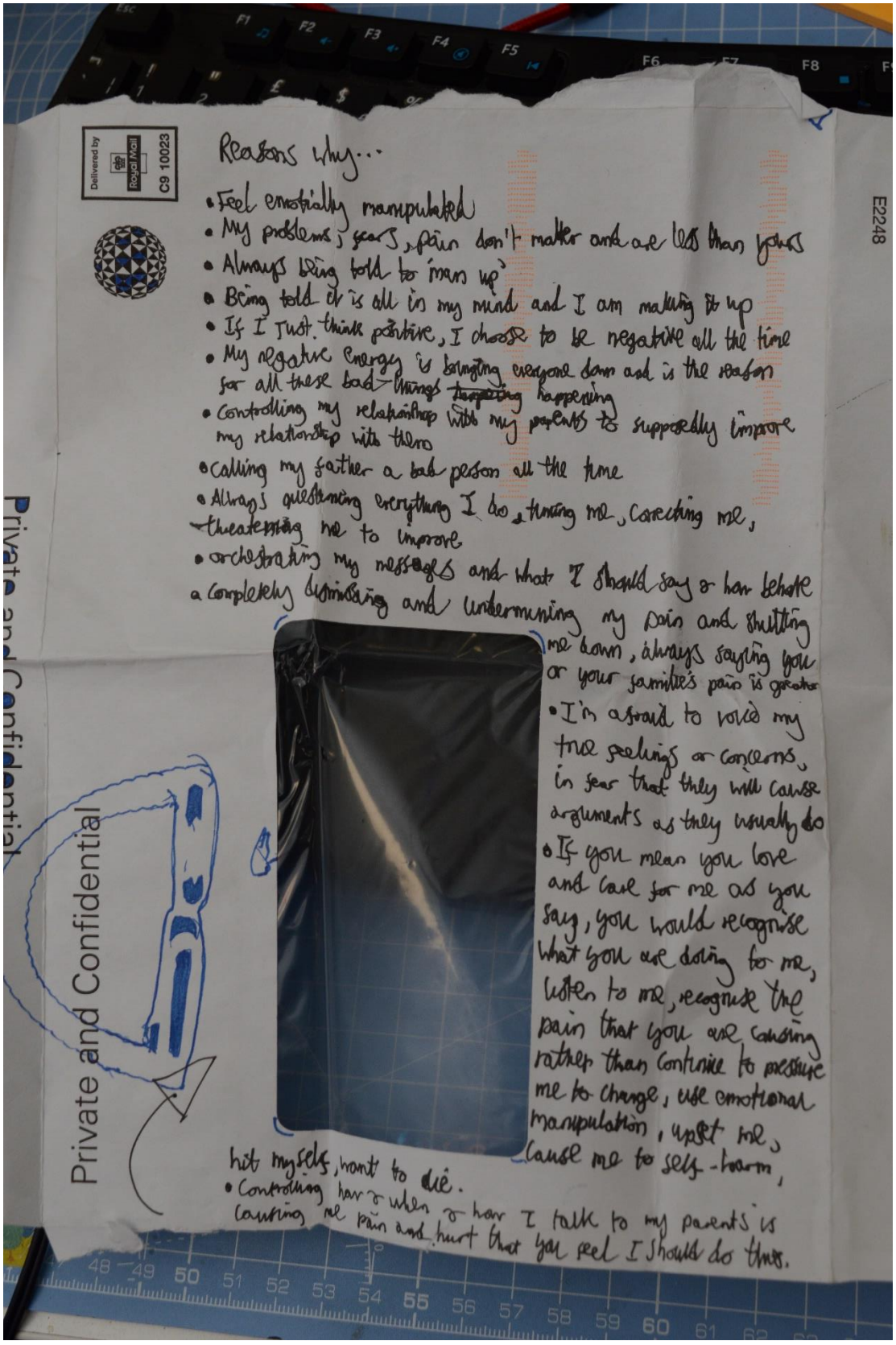
IDVA: Independent Domestic Violence Advisor

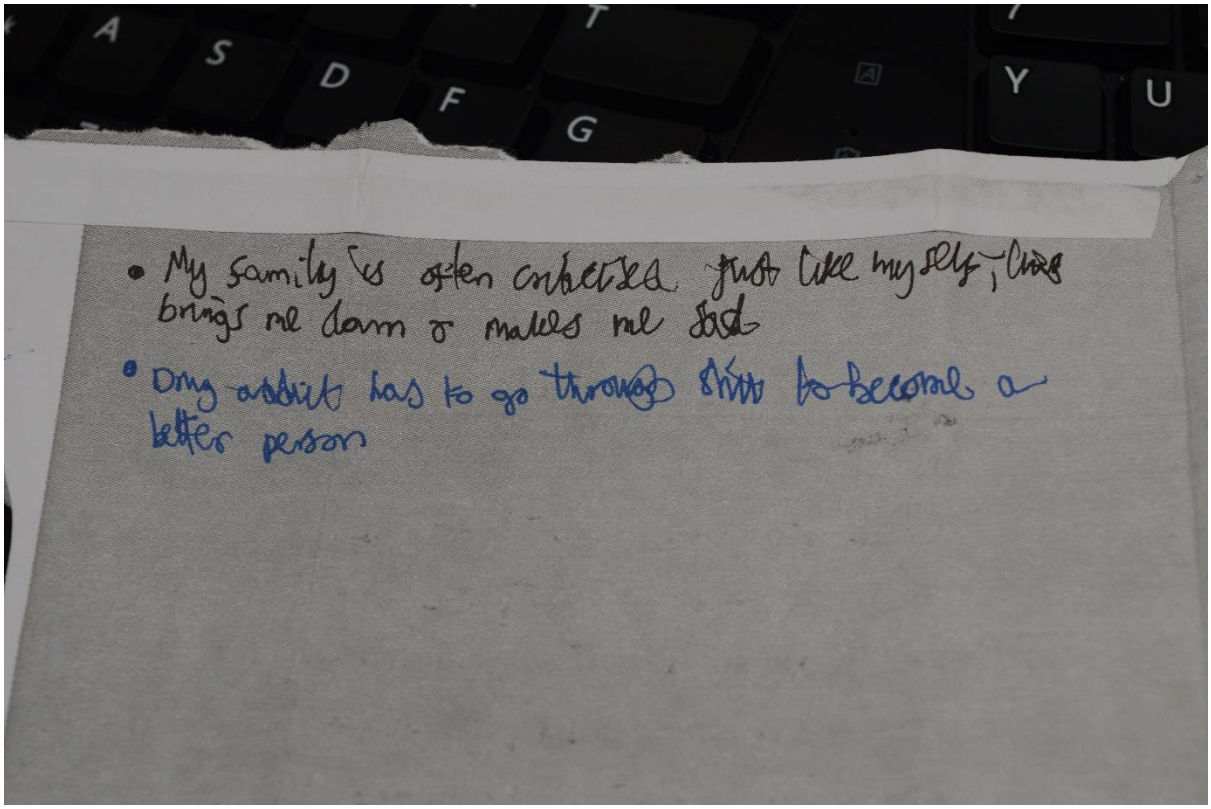
IMR: Individual Management Review

MASH: Multi-Agency Safeguarding Hub

Appendix C

A copy of the envelope found on Richard's desk following his death.




A
S
D
F
G
Y
U
• My family is often criticized just like myself, it brings me down & makes me sad
• Drug addict has to go through shit to become a better person