Overview report

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

(October 2021)

Author – Mrs Jackie Dadd

Date – September 2022

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

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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 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.

Section 1 - Introduction

1.1 The commissioning of the review

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

The Police initially referred this case to the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board to consider a Safeguarding Adult Review (SAR). The subcommittee met and unanimously agreed that there was no evidence of care and support needs so the case did not meet the SAR criteria but agreed it should be referred for consideration of a DHR to South Cambs CSP.

Following a meeting held on 17TH March 2022 with representatives from local authorities and voluntary sector, 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
South Cambs District Council	Panel member
Cambridgeshire County Council	Panel member and summary report
Cambridgeshire Police	Panel member
NHS Cambs and Peterborough ICB	IMR, Panel member
Lifecraft	Panel member
Caring Together	Summary report, panel member
Cambridgeshire and Peterborough Adult Social Care	IMR, Panel member
Cambridgeshire Public Health	Summary report and panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT)	IMR, Panel member
Multicare Community Services Ltd (MCCS)	IMR
Cambridge Community Services	Panel member
Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership	Oversight and Panel member
Cambridge Women's Aid	Panel member

1.2.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports, chronology, and discussion. Individual Management Reviews (IMRs) have been requested and supplied:

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

All members of the panel and authors of the IMR's have complete independence from any subject in this review. Following careful consideration by the Review Chair and the Panel, 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.

1.2.4 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 independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been

involved in the DHR process since its inception in 2011. She has undertaken a number of DHR's having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

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.

DHR's 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 Jack has been recorded by the Coroner as suicide by 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 Jack.

1.3 Timescales

1.3.1 Cambridgeshire Police made a referral to the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board to consider a Safeguarding Adult Review (SAR) on 28th October 2021.

At a sub- committee on 25th January 2022, it was unanimously agreed that the case did not meet the SAR criteria but due to DA elements, referred it to South Cambs Community Safety Partnership, who, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review.

The decision to hold a DHR was taken on 17th March 2022. The Home Office were notified of the decision in writing on the same day.

Mrs Jackie Dadd was commissioned to provide an independent chair and author for this DHR on 23rd March 2022. Three separate panel meetings then took place. The completed report was handed to the South Cambs Community Safety Partnership on 16th September 2022.

1.3.2

22/10/21	Jack was found deceased in his garage at his home address
28/10/21	Cambridgeshire Police send a referral to the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board for consideration of an SAR
25/01/22	Decision that it did not meet SAR criteria
01/02/22	Referred to South Cambs CSP for DHR decision
17/03/22	Decision to commission a DHR made by South Cambs CSP and HO notified
23/03/22	Mrs Jackie Dadd commissioned as Author and Chair
13/04/22	First panel meeting
16/06/22	Second panel meeting
02/09/22	Third panel meeting
16/09/22	Completed report handed to South Cambs CSP by Author

Home Office guidance states that the review should be completed within six months of the initial decision to establish one.

1.4 Terms of reference

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 13th April 2022.

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

a) Domestic abuse (DA) in any form had been the causation or a contributory factor to Jack taking his own life
b) Services and agencies provisions to domestic abuse within South Cambs, specifically for carers, elderly, and male victims
c) Services and agencies provisions to suicide and those contemplating taking their own life within the Cambridgeshire area
d) Are recording processes and the sharing of information sufficient between agencies when a situation arises where the risk assessment and concern are for a person associated/related to the person being cared for?

It was agreed by the panel that the scoping dates would take place from when Jack first stated he had suicidal thoughts in 2015 until the date of his death. This was because although there is information provided by the family of ongoing abuse throughout the marriage, initial scoping showed that 2015 was the poignant year that other organisations became aware outside of the family unit.

1.5 Subjects of the review/Family and friends' perspective

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

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

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

Emma – Only daughter and eldest child of Jack and Helen

Simon – Second child and son of Jack and Helen.

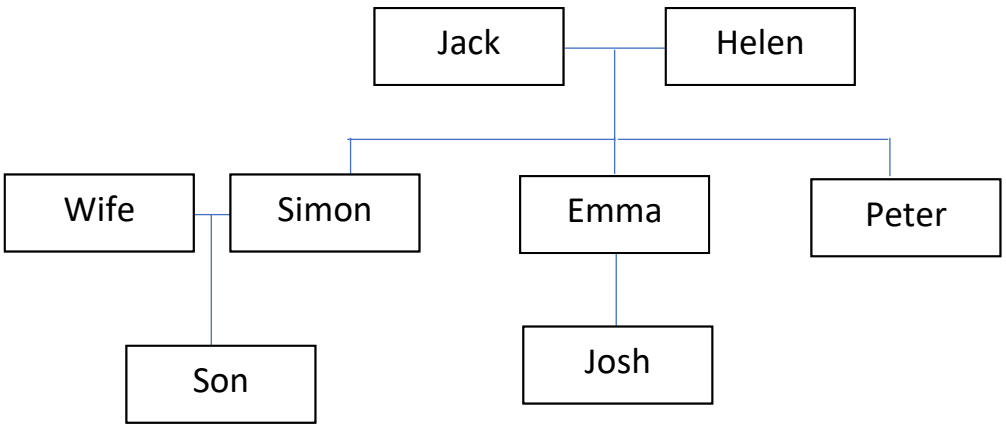
Peter – Youngest child and son of Jack and Helen

Josh – Son of Emma, Grandson of Jack and Helen

Address – Name of City provided as Cambridgeshire

1.5.2 The family of Jack, represented by his daughter and youngest son, wished to be fully engaged with the review and the author would like to express their gratitude for the significant contribution and assistance provided throughout. The pseudonyms used in this report were agreed by Emma and Peter as they did not wish to choose any themselves.

Genogram



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

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

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

1.6 Parallel reviews

1.6.1 Coronial process

The Coronial process has taken place prior to this review.

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

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

1.6.2 Safeguarding Adult Review (SAR)

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

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

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. All concerned are defined as white British. The relevant legislation that provided the context for the panel was The Care Act 2014, The Disability Act 2016 and The Equality Act 2010.

Key considerations for the panel were whether age, sex, health conditions (dementia) and limited mobility influenced how the various agencies dealt with Jack and Helen and influenced the support that they were offered.

It was considered that Jack's sex was relevant to the review as it took into consideration the lack of support provisions within the area available to him as a male and the fact that although he did disclose to his doctor, he was not treated as a victim or in need of safeguarding and was offered inappropriate advice in the manner of couples counselling.

1.7.2 The same points relate to that of age as being over 60 years old, Jack is classed as an older person. In addition to the points made in the previous paragraph, Jack's age was not taken into consideration in relation to his capabilities of being a carer of a person who is immobile and no assistance or risk assessment offered as age can produce additional specific challenges.

Academia in this area indicates that older people are not being represented in domestic abuse services, for a wide variety of societal and attitudinal reasons, with very few cases being considered at Multi Agency Risk assessment Conferences. (Safe Later Lives. Older People and Domestic Abuse 2016).

Disability is relevant to this review due to:

a) The physical condition of Helen, which had a bearing on the dynamics of their relationship as Jack became a carer for Helen, having lived his life not being allowed to do anything for her or for their home/garden and

b) That of the subject of dementia. This relevance is prevalent in both the mental impact the constant accusation Jack endured over many years from Helen of him being diagnosed with dementia when his cognitive tests proved otherwise and the lack of either consideration or identification of dementia in Helen's behaviour as she has now been recently diagnosed with this but there is nothing on her medical records known to this panel (CPFT have not provided an IMR of Helens medical history) that dementia was ever considered or recognised as having dementia prior to Jacks death.

1.7.3 Although not listed within the Equality Act 2010 as a 'protected characteristic,' questions have to be asked in relation to the role of Jack as a carer as he was not recognised as such by any authority and as he wasn't a direct patient of CPFT, ICT or MCCS, his concerns and risks were not recorded under his name or in his own right, even by ASC when the referral raised concern for him.

Equality is about ensuring everybody has an equal opportunity and is not treated differently 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.

1.8 Dissemination

Recipients who received copies of this report prior to publication:

Panel Members (listed in 1.1)

Peter and Emma received a copy of this report. A copy was offered to Simon but he declined.

Confidentiality has been practised throughout this review.

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 within the Cambridgeshire and Peterborough combined unitary authority and has a population of 156,000 of which 77,100 are male. It is estimated that in 2021, 25% of the overall population in this area were over 65yrs of age and this figure will continue to increase. (Source: CCCRG mid-2009 population forecast).

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

When domestic abuse is referred to in the elderly, this relates to those who are 60 years of age and older and is referred to as an older person. Domestic abuse on an older person is not to be categorised as elder abuse as the latter relates to any form of abuse against the elderly, as this is a relationship of an abuse of trust due to a form of vulnerability whereby domestic abuse is specifically defined.

1.9.2 The term 'carer' relates to both those who are in a paid profession and those who care for relatives or friends due to circumstance. This report will ensure it is clear when the term is used as to who it refers to.

- Almost 1 in 10 people aged 85+ provide unpaid care.
- Most carers over age 80 spend more than 50 hours per week caring. (A huge task for people whose own health may be deteriorating and whose caring role often goes unnoticed and unsupported.)
  (Ref: Caring together provided information and statistics in the area of older persons and carers)

The Care Act 2014 put in place significant new rights for carers in England including:

- A focus on promoting wellbeing
- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

1.9.3 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.

In Cambridgeshire, since May 2018, nine suicides relating to domestic abuse have been considered as requiring a DHR of which two were older persons. Between January 2019 and July 2022, suspected suicides of men over the age of 60 make up 15% of all male suspected suicides, 10% of all suspected suicides and 57% of suicides in over 60's. The number of men over 60 dying by suicide has increased each year since 2019. (Ref - Cambridgeshire and Peterborough Real-Time Suicide Surveillance – please note this uses suspected suicide data and is subject to change following the outcome of a coroner's inquest).

1.9.4 The DASV worked alongside Public Health to review the correlation of suicide and domestic abuse in which the outcomes form part of the Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025, due to be published in Autumn/Winter (awaiting sign-off).

Research showed:

1. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
2. Domestic Abuse victims are 8x 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
4. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible" Williams (2001)

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. (ONS, Suicides in the UK, 2018 registrations). Also, the suicide rate for males aged 75 years and over was 32% higher than in 2017 just a year later. (ONS, Suicides in the UK, 2018 registrations).

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%.

Section 2 – The Facts

2.1 Background information

2.1.1 The following information has been provided by Peter and Emma, either by what they have observed or what they have been told by either their father, mother or their brother, Simon. Comments and observations are their own words.

Jack was born in 1938, just three weeks before his future wife, Helen, who was known to him from the age of seven. Jack left school at 15yrs old, following his father's trade as a slaughterman, and began working for him. A year later, he started 'going out' with Helen, who he married three years later in 1957 at 19 years of age whilst completing his National Service.

Having resumed his trade once National Service was completed, he would remain in this demanding, physical role for the next twenty years, maintaining excellent fitness and strength. During this time, whilst living in Essex, Jack and Helen had three children, with Helen totally family focussed on raising their two sons and their daughter and they had no financial stress.

By the age of 40, the sheer physical nature of his job was taking its toll on Jack and so, in 1978, they moved their family to Hopton, Suffolk where they had bought a house with a butcher's shop. Helen was not happy with the move and this unhappiness was set to fester

and grow, playing a key part in their future relationship. They lived in Hopton for the next twenty years until 1998, having the opportunity for very few holidays due to the shop demands and specialist nature of the work. Jack has been referred to by his son, Peter as hardworking, loyal, and committed when he looks back at how his Dad worked six days a week to provide for his family.

2.1.2 Helen had a distaste for the property and a ten-year struggle over land access and planning permission on their additional acre of land took its toll on her, in addition to the children becoming adults and leaving home. The time in Hopton was not good for Jack and Helen's relationship in which Helen would regularly ridicule him in front of the children and Helen began to say that she had wasted twenty years of her life and that she hated all her time there. She was very resentful towards Jack and directly blamed him for her unhappiness.

In 1998, when the children were all in their 30's or close to, they sold the house and shop in Hopton and realised a long-held ambition of building their own house in Caston, Norfolk. For the first two years, whilst they were busy creating this together, they appeared happy, but this was to be the last period of happiness together. Helen's complaining and unhappiness began to creep in again. It appeared that Jack felt she would never be happy, or at least, he could never make her happy.

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

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

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

Neither Helen or Jack were big drinkers and almost tee total, so when Helen noticed a bottle of alcohol missing from the cupboard in 2015 and Jack informed her it was in the garage and

he was going to drink it before hanging himself, Helen told all three children, who were now clearly adults in their own right and the three of them decided to turn up unannounced which was out of the ordinary, to talk to their parents. This was following Emma contacting the doctor and being given this advice as she knew her 'mum would flip' if she knew she'd discussed it with the Doctor and that neither parent would attend the doctors.

When the subject of Jack's intention was brought up, Helen instantly responded with something along the lines of, "Oh no, we don't need to talk about this," before turning to Jack and saying, "We're all right aren't we?", to which he replied, "Yes", with a very strained and awkward look on his face. They persisted with the conversation, even though it was very uncomfortable for everyone, but Helen just kept putting up blocks to every suggestion made. It was stressed to them both that they needed to live apart to get out of this constant cycle of misery and Helen responded that there wasn't enough money to be able to do this, although their assets at that time would have been between £600,000 and £700,000.

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

In the coming months, there were to be several disagreements between Helen and the three children as they wanted to show their Dad some support and eventually, this led to Emma telling Helen some 'home truths' about how she treated Jack and would eventually lead to a total breakdown in their mother/daughter relationship.

Jack and Helen had separate bedrooms for over twenty years and Helen used to barricade herself in at night as she stated she was in fear but it is unclear what the fear was based on.

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

Emma continued to contact the doctor with concerns for her Dad and Jack underwent at least two mini-mental state examinations which he scored highly on and the Doctor had no concerns that he had dementia although this continued to be an obsession with Helen, even after the Doctor had shared this information with her (with consent).

In 2016, Peter used a connection to get his dad a small job in a local joinery which would provide Jack a couple of days in the company of others which he seemed to thrive on. When his children sorted him out a bank account of his own to have a small amount of money in, he bought himself a mobile phone and a watch and they all felt his mental health had improved as he had gained back his first bit of independence in years and was making friends. Helen went to the Caribbean in first class on holiday on three separate occasions and insisted each time that Jack did not stay in their home whilst she was away so he went

to stay with either Emma or Peter and got to spend some quality time with them and 'opened up' to them as he had the chance to talk freely.

2.1.5 Helen had begun to cook convenience foods for Jack and would bake a rhubarb crumble which was one of his favourites and not let him have any. Jack noticeably began to lose weight. In August 2021, Helen wanted to send an email on her mobile to her estranged brother but couldn't and said it hadn't been set up right. Trying to help, Jack contacted Simon who confirmed the emails were on the phone so Jack researched how to send one and offered to help Helen. When he got out of the shower that evening, he found that his room had been 'trashed' and the cushions had been pulled off the sofa in the lounge. Helen screamed in his face in anger saying,

'How dare you contact Simon about my phone, I don't want your help, I hate you'

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

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

2.1.6 Helen returned home in early October 2021 with a care plan and a health company providing care for her. On the Saturday before Jack died, Peter received a phone call from him and when he asked how things were, he replied,

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

2.2 Circumstances of the death of Jack

2.2.1 The week following his conversation with Peter, a member of staff from Multicare Services (MCCS) was at their home address preparing lunch as part of Helen's care plan when they realised that Jack was very agitated saying that he did not have dementia and hadn't been diagnosed. He was holding a bottle of whisky and rope, threatening to end his life. Contact was immediately made with the MCCS assessor and the Intermediate Care

Team (ICT) who commission MCCS were informed. The emergency services and the family were contacted later in the day.

The assessor attended the address with the initial carer having left prior to her arrival. Helen informed her that she was scared he would hang himself when she least expects it and was afraid of her own wellbeing as she relied on him to help her. Helen and Jack got into an argument in front of the assessor and Jack said that Helen needs 'sending back to where she was' as he could not help her anymore which the assessor thought may be a cry for help from him. Jack left to go to work and at the time was calmer but very nervous about leaving, back chatting his wife as he left the premises.

The assessor updated ICT who in turn, updated the emergency services who when conducting a further risk assessment, cancelled their attendance. MCCS completed a referral to Adult Social Care with their concerns.

(The following information has been provided by Emma)

2.2.2 A couple of days later, Peter took fish and chips over for tea. Helen dominated the conversation but he managed to speak to his dad, who seemed more confident and happier as he was now taking care of food and dished up dessert and made a cup of tea. The incident a few days earlier was not mentioned, leaving Peter unaware. He left later that evening with his dad watching a carpentry programme in the kitchen as he wouldn't 'be allowed' to watch it on the big television as Helen wasn't interested in it.

The next day, Jack was dressed for work when he and Helen had an argument over food. With this, Jack threw his wallet onto the table and said,

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

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

She sent the following two texts to Peter:

14:10 - You have to come here dad isn't at work I have just phoned. I think he is in the garage.

14:22 He told me he would do it the day I came home from hospital. I should tell Emma but I don't have any number could you call her to come over.

The text she sent Simon read:

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

2.2.3 Helen was quite immobile. The garage was near to the house at the back. She rang her grandson, Josh, who managed to get hold of his uncle Peter at 15.48hrs and informed him that Granny had told him that Grandad had hung himself. On arriving at the house, Helen was crying and simply said to Peter,

'He's in the garage'

The garage was initially locked with the key hanging in the bungalow in its usual place. Peter entered the garage to find his Dad hanging from a beam with a blue rope around his neck. His face was grey and he looked calm and peaceful but was unresponsive. Peter contacted the emergency services.

At 16.42hrs, the same day, the Police and Ambulance arrived. No resuscitation took place and Jack was pronounced deceased. Jack had left a note alongside his mobile phone which said,

'There is a recording message on my tablet, the PIN no is ***** to unlock it, Dad xx.'

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

2.2.4 The death was not deemed suspicious. Helen informed officers attending that her relationship with Jack had deteriorated over many years and that he was nasty to her.

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

2.3 Individual management reviews (IMR's) inc: Good practice

2.3.1 Due to agencies initially preparing scoping documents for the SAR which were all subsequently forwarded as part of the DHR referral, they were utilised for the first panel meeting to be diligent and expeditious as the statutory guidance for both reviews outline safeguarding and learning for the future.

Jack had very little contact with any agencies. Helen's contact was predominantly in relation to her health and that of her reporting concerns over Jack which were recorded under her name. Neither party were known to the Police. IMR's were requested from the following organisations due to the contact they had with either party over the areas considered in the terms of reference.

2.3.2 NHS Cambridgeshire and Peterborough ICB (GP)

Jack

Medical note entries

Apr 2013 - Records indicate that Helen was worried about Jack's memory. A Cognitive assessment was undertaken with no concerns.

Aug 2015 - Helen contacted the surgery with concerns about her Jack's memory and felt it was deteriorating. She stated he was very aggressive in his attitude towards her and refused to discuss his problems but would bring him for his flu jab so it can be discussed with him at the time. She requested he was not told of her concerns.

Sept 2015 – Helen was concerned that Jack was getting dementia and said he sometimes says that he wants to kill himself. She was worried that it was due to arguments with her. An appointment was made but Jack refused to go as he had seen another clinician for a pain relief injection earlier today.

A telephone call was made to Jack and he said the injection had helped. When asked about looking tired and to come back to the surgery for a chat, Jack declined.

Helen attended without Jack. Helen was worried about Jack's memory and admits that 2 of their 3 children disagree with her and told her that he has no problem. The children were not in attendance. A decision was made to assess him when he was next in the surgery as refused to come for a memory check.

July 2016 - Jack attended the surgery for a medication review. He was well in himself but was experiencing bowel pains. Jack stated he was forgetful, with poor focus and concentration and recalled that the other day he went to St. Ives instead of Cambridge. Jack reported it does not affect his daily life and not a worry. Jack did not want an official memory test. Mini-mental state examination scored 10/10.

July 2020 – The surgery received an email from Emma expressing her concerns about Jack and Helen's relationship which was followed by a telephone call between GP and Emma. Helen has been saying for 20 years that Jack has memory problems but no other family member has concerns. Jack is active and recently measured and fitted a new garage door. Emma feels her mother has always been controlling and does not give him freedom, including his money as they have a joint account. Emma would like the GP to reassure Jack that he is fine and has no mental health problems. An appointment was booked with Jack 2 days later.

Jack visited the surgery. Jack was aware that his daughter had contacted the GP surgery with her concerns. The GPs overview was that Helen has been saying for years he has dementia, no one else in the family has any concerns, 2 sons and a daughter all feel he is fine. Jack reports his bank card has been confiscated by his wife and has no access to money. He is not allowed to do things in the kitchen or garden although he is very capable. Helen becomes very anxious. Jack has thought about divorce.

GP discussed with him about abuse and adult safeguarding, but Jack did not wish to go down this route at the time. GP discussed couple's counselling, but Jack did not feel Helen will agree. He agreed to a cognition assessment cognition and gave permission to speak to Helen following this. There were no concerns or signs of cognitive impairment or mental health problems.

Sept 2021 - Telephone call from Trauma Centre. Helen had been admitted and she had concerns about her husband, Jack, who has dementia and was at home. A request for a welfare visit was made and a telephone call was made to Jack. Jack was lucid and orientated; he was just on his way to the bus stop to visit Helen in hospital. No need was identified for a welfare visit. It was recorded that other family members do not have concerns over his cognitive issues.

2.3.3 – Helen medical reports redacted.

2.3.4 Good practice/Reflective considerations:

Jack and Helen had been registered at Willingham Medical Practice for many years. The records indicate that both attended the GP surgery for a number of age-related concerns at the majority of which, no concerns were identified. The records indicate that overall, Jack's physical health was good. Helen received regular diabetes and pain management reviews.

The entries in the chronology identify the contacts within the records which sit within the terms of reference. These are primarily in relation to Helen's concerns about Jack's mental health and memory.

In 2015, Helen regularly begins to contact the practice to explain that she is worried about Jack's memory. The records indicate that the practice listen and take seriously Helen's concerns as one would expect and attempt to invite Jack into the surgery for review. Between August 2015 and July 2016, Helen makes four contacts to raise concerns about Jack's memory and their daughter makes one, concerned about Helen's fixation on Jack's memory.

There is good practice identified in which the practice attempt to follow up Helen's concerns without success. It is likely from the records that Jack was reluctant to attend the practice to discuss his memory and so there is little the practice could have done to change this. It is not uncommon in primary care for a spouse to have concerns for their partner's memory, only for the partner to brush off those concerns like the records in this case show. Jack did visit the practice for a review in July 2016 in which a mini-mental examination was completed.

The same can be said for the disclosure in Sep 2015 from Helen that Jack has said he wants to kill himself. The GP made an appointment for Jack that day but he declined to visit. The records do not give an indication as to the risks and as far as we are aware Jack did not attempt to take his own life. A follow up contact following his refusal to visit the practice may have been an appropriate opportunity for a further mental health review and risk assessment.

In a consultation, Helen did state that Jack is aggressive in his attitude towards her and threatening at times. Unfortunately, there is little detail in the records to indicate what is meant by this. In hindsight, it may have been helpful to explore this phrase in a little more detail to evidence what was meant and understand the context, it may have highlighted whether further support or risk management was needed. Additionally, terms like "long chat" and "discussed options" are used when it would be helpful to have the details of these discussions to enable greater understanding.

Jack had a review in which he raised concerns about his memory but a mini-mental state examination identified no concerns. There was potentially a missed opportunity to explore the relationship with Helen and why she thinks he has memory problems given her persistent claims he had dementia.

Between 2016 and 2019 there continue to be a number of references from Helen about Jack having dementia. Helen states this was having an impact on her "stress" and mental health. The IMR indicates that there were efforts made to engage with both Jack and Helen during this time with little success.

In July 2020, their daughter contacts the GP surgery once again with concerns for her parents' relationship, namely Helen's controlling behaviour, in which the practice responded promptly inviting Jack into the surgery. At the same time, Helen had a contact with the practice stating that she feels threatened and the GP states they "discussed options" but unfortunately does not go into detail. This may have been a missed opportunity to consider domestic abuse but unfortunately the details of the conversation are unknown.

There is evidence of good practice within the follow up contact with Jack in which Helen's behaviour is framed as abuse and they discuss adult safeguarding. It would be unlikely that Jack would have met the criteria for adult safeguarding given his lack of care and support needs, but it is unclear if alternative support was offered such as domestic abuse services. Couple's therapy was offered to both; however, this is not recommended for couples where there are allegations of abuse. The records did demonstrate good practice to complete a further memory assessment but did not contact Helen to explain the outcome in an attempt to alleviate her concerns. It may have been helpful for practice staff to have not only considered his memory but to also review his mental health in light of the allegations continually being raised by his wife. We do not get a sense of the impact this was having on him.

Helen was identified to have mental health problems, namely anxiety, poor sleep, and panic attacks, which she contributes to Jack's behaviour. Helen was offered medication for this which after initial refusal, she did accept in July 2020.

Whilst there is no indication to suggest the outcomes would have been different at any of the contacts. It may have been helpful to complete a DASH risk assessment with both Jack, who wasn't recognised as a victim of domestic abuse and Helen at different points of disclosure, however from the records it would be unlikely to score as high risk. Yet, it may have helped Jack recognise the behaviour as abuse and may have encouraged him to accept support.

2.3.5 Multi-Care Community Services Ltd (MCCS)

Multi-Care Community Services Ltd is a privately owned company providing nursing and domiciliary care with Intermediate Care Team (ICT) and NHS clients/service users across Cambridgeshire and the Isle of Ely. They offer care and support to a range of people who are getting older and a little frailer including 24hour support. They provide a short-term rehabilitation service following discharge.

Some of their services include:
- Assisting with bathing and dressing
- Assisting with meals and drinks
- Assisting with incontinence care
- Assisting with morning/wake up or bedtime support
- Collecting prescriptions
- Companionship and conversation
- Monitoring diet and eating.

MCCS were commissioned by ICT to provide services for Helen as from 5th October 2021 when she was discharged from North Cambs Hospital (NCH), Trafford ward following a fall. They were to make four single calls to the home address for morning, lunch, tea and bed calls to assist with preparation of meals and general welfare.

Helen immediately cancelled three of the visits, maintaining the lunch call for general welfare and to make sure she was alright. The single lunch visit began on 7th October and ICT were informed of the reduction of the POC (package of Care).

On 17th October 2021, Helen reported that her mobility was declining and she could not feel her right leg. MCCS referred the service user to ICT and PT (physiotherapist) for equipment as well as the GP for pain management. This was again stressed with ICT the following day during an MDT (Multi-disciplinary team) meeting.

On 19th October 2021, MCCS staff visited the service user and observed that Jack was very agitated saying that he was diagnosed with dementia which he does not believe. (This may be a misunderstanding by the carer of what Jack actually said). Jack was holding a bottle of whisky and a rope, threatening to end his life. Helen was very upset.

MCCS called 999 requesting Police and Ambulance services and reported this to ICT. The assessor from MCCS attended the home address and below is a time chronology of the emails that followed outlining the change in information from what had initially been disclosed from Helen at the home address until the son, Simon had been consulted:

19/10/21 @ 13.23hrs from assessor to internal MCCS staff.

'Straight away this is a safeguarding concern as the atmosphere in the home of the above service user was awful and I witnessed the slight aggression in the husbands' voice whilst trying to calm both of them down.

Background story is that the husband was diagnosed with dementia but I feel this is worse than that some form of mental health that gets him to suicide point of which from the day

after service user came home from hospital 05/10/21 he said to her I have the drink and the rope so when I have had enough I will hang myself , she has had to lock her bedroom door in the past months in case he hurts her and he has been abusive towards her by nudging her and threatening that if he hits her she will know about it, her family do not believe her so she has tried to deal with this on her own they feel there is nothing wrong with the husband and she is making it up , I have tried to ring son on mobile and house phone to report this to him as given permission from Helen as she feels the family need to know just how bad it is getting, she is scared he will hang himself when she least expects it and obviously is afraid of her wellbeing as she relies on him to help her but they got into an argument whilst I was there and he said she needs sending back to where she was I cannot help her anymore, maybe a cry for help from him also. When I left, he had gone to a small job he has locally and was calmer but very nervous about leaving but back chatting his wife as he left the premises. The concern is what happens when he returns home later '

15.04hrs – From assessor to internal MCCS staff

'I have just had a returned call from the son and he says that the service users husband has never been diagnosed as having dementia and the thought of his dad wanting to commit suicide was a surprise to him at present although he threatened it a few years ago he feels that his dad has got depression of some kind due to the fact the service user is always nagging as such and irritating him (which I may agree to some level) , I explained this was being reported for safeguarding as we are not fully aware of the full length of concern here and this required someone to intervene with both parties to resolve or help at present he agreed that this should happen and get to find out what is truly going of possible control of one and lowering the moods of the other to the point that they have had enough. He is not going to ring the GP as he says the GP already knows about it'

15.07hrs – Further email to ICT

'We have contacted the son and mentioned the issue that we had this afternoon. According to the son, Jack doesn't have Dementia, but it might be a sign of depression. The son also mentioned that the GP of Jack has been made aware regarding the ongoing threats.

We believe that the service user is not safe with this situation, and we would like to raise it as a safeguarding issue. Kindly let us know it that is fine on your side.'

20/10/21 @ 14.33hrs - From assessor to internal MCCS staff

'I have just spoken to ICT to chat about the latest concern of the above service user she asks that we do a MASH referral for the service user noting recent concern which will then be noted about the husband, also she will do a daytex email in regards to this and also stated that the recent Mental capacity check of the service user was at a level unknown of cognitive impairment showing up so she seems to think this could be a contribution to what's going on but she will speak to her team therapist to pay a visit to look into this
I said to her that I have spoken to the husband and all emails are what has happened to confirm this and he has stated he had a recent check and was given the 'all clear' from GP'

NB. All emails sent internally were immediately sent to ICT to keep them informed. These emails are a direct copy to evidence decision making and processes followed.

20/10/21 – MCCS complete a Safeguarding referral to MASH.

21/10/21 – MCCS attempt to contact son due to Helen ringing and stating that Jack had stopped eating.

The services for care for Helen ceased on 3rd November 2022 as per the commissioning of one month.

All staff at MCCS receive training on domestic abuse as part of the mandatory safeguarding training. This includes awareness of the reporting process and is in line with the company's Domestic Abuse Policy and Procedure.

2.3.6 Good practice/Reflective considerations:
MCCS staff acted immediately on the concern for Jack, following their processes and escalating it immediately to the assessor who personally attended the address, whilst keeping ICT informed throughout. Emergency services were requested and the Next of Kin (Son) contacted, spoken to, and listened to. There was a clear ongoing risk assessment taking into consideration developing information.
A safeguarding referral was completed the following day.
The initial carer at the address who spoke to Jack, left the premises five minutes prior to the assessors' arrival, leaving Jack alone in the house with Helen. This was due to having an appointment with another client, knowing that Jane was only five minutes away and that the emergency services had been called.

2.3.7 Adult Social Care (ASC)

Adult Social Care were not involved with Jack but he is referenced on Helen's file.

Jack

20/10/21 - Referral made to adult social care by MCCS. Safeguarding report is as follows:

On the 18/10/21 the service user made our carer aware of her concerns about her husband having dementia and he was going to hang himself and drink alcohol , our carer rang through to our office and we rang for emergency services , I myself went to visit at the same time due to the concern and found the husband was okay but quite upset and angry I spoke to the mentioned service user and she expressed her safety as he was and always has been aggressive nudging her and threatening behaviour and that he wanted to hang himself and she was scared of him, I calmed situation down as they started to argue and the husband stated he wanted her sent back, all was okay when I left as the husband went to his local job. I also spoke to the son who says a different story that it is the service user who is controlling and this has made the father depressed to the point that a few years ago he wanted to commit suicide.

I have recently spoke to Jack and he expresses that his wife, the service user has been controlling and labelling him as a dementia sufferer for years and this irritates him that it has sent him into depression and he has had enough. He even gave me permission to contact his GP from his last test of mental capacity that he was clear and nothing wrong with him.

Our concern here is there is an underlying concern that some form of aggression or suicide thoughts will proceed if this carries on as the husband says his wife totally hates him.

This referral was on Helen and filed under her name but the information relates to Jack. Concern was received by the contact centre 20/10/21 at 16.25hrs. It was sent to MASH graded as info gathering and triaged on 21/10/21 as a high priority. This was subsequently allocated on 25/10/21 when they were informed by police that Jack had passed away. This was during the pandemic when referral rates were increased.

2.3.8 Helen (To be redacted for publication but included to provide context of medical and emotional impact on both Helen and Jack).

05/10/22 - Referral from EEAS Transporting Pt (patient) back home from hospital. Direct copy. Helen disclosed the following:

Patient husband had dementia; he is making threats of violence towards her. Pt(patient) is also very concerned how she is going to be fed or looked after due to her reduced mobility. If her husband does not feed her, she will not be fed.

He has made remarks like "your weak now, I could hurt you and nobody would know"

Pt has to lock herself in her bedroom so husband cannot get to her. He was sweeping up and hit Pt with broom.

07/10/22 - MASH practitioner called Helen. Discussed referral with Helen. She said that her husband has been diagnosed with dementia but is struggling to accept the diagnosis. She said that he has never hit her but does make threats. She said she is able to talk him down when he gets aggressive. Helen said that her husband looks after her. He cooks all the meals. Helen has carers twice a day and is well supported by her G.P. Helen said she didn't need any further support at this time.

Information gathering closed with the following summary. Risk level 1. Concerns that husband was being aggressive towards his wife.

Spoken to Helen who said that her husband can be verbally aggressive but she can manage him. Helen has carers twice a day and is well supported by her G.P.

Helen declined any further support and there was no further action for MASH. Case was closed.

20/10/22 – Same entry as above as per Jack entry on this date.

The first information to social care has come from Helen who disclosed DV on herself citing her husband's recent diagnosis of dementia as a factor. When this was discussed with Helen by MASH the extent of the abuse being disclosed was much lower than what was told to the

ambulance crew. There would be no reason why the MASH practitioner would question the validity of the information around Jack having dementia. From the perspective of Helen being subjected to DV there were protective factors of having carers twice a day. There was nothing to indicate that there were any concerns around Helen's capacity and under the care act principle of making safeguarding personal her outcome was that she did not want any further support. The further referral on the 20th also stated that Helen was the victim even though concerns are expressed for Jack's wellbeing. In context in October MASH was experiencing a high volume of referrals with turnaround times being around five days. Based on the information contained within the referral, it was not felt that there was an immediate risk of harm as the worker describes the situation as calm on leaving. The incident was dated 18th of October but was not submitted until the 20th. The second referral contained information that indicated Jack may be the victim rather than Helen.

This should have also been submitted on Jack and gives insight into the couple's relationship. There was not an opportunity to explore this further with Helen and would not have happened without Jack's knowledge and consent given the information in the second referral.

2.3.9 Good practice/Reflective considerations:

The MASH practitioner followed good practice principles in consulting the alleged victim and seeking her views and ensuring that the areas of risk reported by the ambulance crew had been discussed and based on the information known at the time the risk was assessed as being low with Helen stating that she did not feel to be at risk.

The referral from the care agency clearly captures the voice of Jack in terms of his relationship with his wife and how this is impacting on him. The care was privately commissioned and the referral shows that the agency understood safeguarding. It also gives context and highlights that abuse may have been happening to Jack over a number of years with evidence of the son being consulted around the allegations made by Helen. It provided enough information to enable the MASH practitioner to explore further. It would have been better if the referral had been on Jack in his own right.

2.3.10 CPFT - Cambridge and Peterborough NHS Foundation Trust

CPFT do not specifically hold information under the name of Jack but hold information relating to him on the file of his wife, Helen. At the request of an IMR, CPFT's assessment was that the release of Helen's confidential health information, without her consent, did not meet the threshold and would breach GPDR and data protection laws.

The information below has been obtained from the initial scoping document which was provided to the SAR by CPFT to enable future safeguarding and learning. CPFT has a duty to breach confidentiality and share confidential information with the SAR under requirements of section 45 Care Act 2014.This was forwarded by the SAR chair as part of the referral documentation for consideration by the DHR to again, enable future safeguarding and learning.

14/10/21 - Phone call to Helen which was answered by Jack. The Dietician asked to speak to Helen and Jack stated, “surely she doesn’t want to speak to a dietician”. When a call back was offered, he stated “please stop bothering me”. The dietician noted Helen had a mobile number & planned to call her on that number.

Inpatient at North Cambs Hospital (NCH), Trafford ward:

15/09/21 - Helen informed patient transport that Jack was violent & abusive to her. Helen stated she ties her bedroom door closed at night so he cannot get in. Helen said GP were aware & CUH had raised a “SOVA”. Helen worried about returning home.

19/09/21 - Helen reports husband pushes her with his body. Fears she will not be quick enough to move from him if she needs to get to her bedroom. Lock advised on door instead of string. Helen describes husband as big & mobile. Helen moves objects for her safety.

22/09/21 - DASH offered. Consent gained. Staff member felt that Helen had discrepancies in her descriptions. Son fed back to staff member that his parents do not get on with each other. There is no loving relationship. Helen dominates husband. She is convinced he has dementia. Son feels there are no issues with husband’s cognition.

29/09/21 - Cognition score for Helen 16/30 (normal score is 26 and above). Intermediate Care Team ICT: Helen now at home.

20/10/21 - Visit by MCCS (commissioned by ICT). Staff member had to calm Helen & Jack down, atmosphere described as “awful”. Jack displaying suicidal ideation & aggression in voice, & Helen feeling scared.

20/10/21 - Conversation with CPFT Named Nurse Adult Safeguarding. Previous events described (tying door shut, husband pushing her, suicide ideation) Advice given by CPFT Named Nurse Adult Safeguarding: MCCS Care Agency to seek advice from their safeguarding lead MCCS will need to refer to the MASH as they witnessed event Advise DASH Monitor situation at next visit Complete Datix. If there is a risk to life & limb police will need to be called. ICT contacted MCCS & discussed situation. MCCS to refer to MASH.

CPFT state that they must have consent from the patient in order to speak to any family members and disclose information on the care plan. It is not known whether Helen declined for Jack to be spoken to or not but CPFT accept that they can have a general conversation with him in regard to his own welfare. There is no record that this was completed.

CPFT have provided the below information in relation to the terms of reference:

In September 2021, CPFT employed a full time equivalent dedicated domestic abuse lead (management banding) to take forwards the Trust’s Domestic Abuse Strategy which includes:

- Launch the Trust wide domestic abuse strategy
- Increase staff awareness and skills in recognising and responding to domestic abuse,
- Ensure there are Trust policies and procedures on domestic abuse in place

- Ensure the Trust has mechanisms for counting numbers of patients and staff who experience domestic abuse
- Provide representative at DHR's.

1. Trust-wide Launch of DA Strategy
   The Trust's domestic abuse strategy was launched in November 2021 by the Chief Exec. In addition to the Chief Exec's promotional session to all staff, the DA leads provided promotional sessions to individual teams across the Trust. Not all teams had the opportunity for a promotional session due to limited resources caused by covid and the Christmas period. CPFT recognises that individual teams' sessions are both a popular and effective method for increasing staff knowledge, skills and confidence in the area of DA and will resume these as and where resources permit. CPFT have some very motivated DA Champions within the Trust but again, resources have been very stretched leading to this area not expanding as hoped. CPFT supports DA Champions to attend DASV meetings and training sessions.
   New DA patient leaflets have been designed and circulated so patients are better informed where they can seek support and advice locally and nationally. We have been clear with our message that it is safe to disclose DA to our staff.
2. Staff Awareness of Domestic Abuse
   CPFT has produced and circulated a large quantity of staff awareness material. We have designed a framework to assist staff; CPFT's 5R's Domestic Abuse Process Model: Recognise and ask as Routine, Respond, Risk Assess, Refer, Record.
   CPFT have designed and circulated 5-minute guides on a number of DA topics for example the DASH, The 5 R's, Why Referring Perpetrators to Couples Counselling is Not Appropriate.
   Guidance tools have been designed and circulated for Safety Planning and an awareness poster has been circulated highlighting support for staff who experience DA. There are several other DA related staff short guides planned for the next 12 months.
   Links to in-house and external DASV and the SAB information is available to all staff on the Trust intranet DA pages.
   The CPFT eLearning platform has a safeguarding training package and within the safeguarding training package there are dedicated DA slides focusing on recognising and responding to DA. The Trusts DA staff intranet page also has links to both the Safeguarding Boards training and the DASV training. The Trust DA training package is currently under review.
   In addition, the Trust promotes Bright Sky.
3. Trust DA Policies and Procedures.
   These have been updated and are in the Trust's ratification process
4. Trust DA Data Collection
   The Trust now has dedicated templates and read codes on System 1 (electronic record system) to ensure data collection on patients who disclose DA, and the range

of responses taken can be counted. This will take some time to accurately reflect all that we do.

5. DHR's.
   There are 2 dedicated DA Leads who provide representation on behalf of the Trust on DHR's.

2.3.11 Good practice/Reflective considerations:

The CPFT have recognised the importance of their response to DA issues and have invested in dedicated staff. They are in the early stages of a review of all processes, policies and procedures and have implemented a domestic abuse strategy. However, they are still awaiting sign off having been with the executives for some months.

Training has begun to all staff in relation to domestic abuse but was interrupted due to covid so there is a lot more work to complete in this area.

2.4 Summary reports

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

2.4.1 Cambridgeshire County Council and DASV

At present, Cambridgeshire has no support provisions specifically for older persons who are victims of domestic abuse. On completing a research project, they identified gaps for identifying risks specific to the older persons within domestic abuse which included carers and those reliant on financial support. They created a DASH to be used by professionals when dealing with DA victims who are older persons that asks questions to ascertain the risks that have been identified as relevant to their age. These replace certain questions such as pregnancy to replicate the same questions on a DASH and therefore provide the accurate level of risk. The questions also include those around suicide and carers.

The initial three-month pilot was for Adult Social Care but was then expanded to all authorities apart from the Police who did not have capacity. The year-long pilot comes to an end in July 2022 having been well publicised on the website, incorporated within training inputs and heads of authorities being aware.

The DASV partnership have also disseminated recognised guidance in relation to Domestic abuse in the elderly to all professional organisations within Cambridgeshire based on the Dewis Choice project but have made it more relevant to the Cambridgeshire area. The DASV lead on the elderly currently sits on the Home Office Safer Care at Home Review project group which is due to report in November 2022.

DASV partnership commission health IDVA's within the IDVA service to specifically offer support and assistance in this area. Health IDVAs provide a specialist service working with all community, hospital-based and midwifery services across Cambridgeshire and

Peterborough. They accept referrals, from professionals only, at all risk levels. Referral is via a short form and the referrer does not have to include a DASH Risk Assessment Checklist, although it is useful, but the health IDVA can undertake the relevant DASH with the victim. The health IDVA can also provide advice and information to professionals who may be concerned about someone experiencing domestic abuse. The health IDVA's also accept referrals where the adult does not appear to have care or support needs.

Cambridgeshire DASV are working with the local Alzheimer's Society to develop an awareness presentation on the issue of domestic abuse and dementia which has been presented at the DASV Champions Network in July 2022. It is planned to roll this presentation out to partners including Cambridgeshire Constabulary over the next six months as well as any other organisations that are interested.

The Cambridgeshire County Council carer strategy is currently under revision and does not currently address domestic abuse.

There are effectively no provisions for male victims within Cambridgeshire. Although the Cambridge Women's Aid would accept referrals for males and this is publicised on their website, they have supported less than five previously, so it is not common practice.

2.4.2 Cambridgeshire Public Health

Suicide training has been delivered to all specialist domestic abuse workers within the past 18 months by CPSL MIND and in the spring of 2022, was also delivered to Peterborough Samaritans and Lifecraft (who run a mental health helpline).

Cambridgeshire Public Health signpost suicide mitigation training to Zero Suicide Alliance training, which is available to non-health professionals, private health carers and anyone in contact with vulnerable people. It is online training and free of charge. They also commission a 'Stop suicide' workshop run by CPSL-MIND.

A four-year plan until 2024 and a Suicide Prevention strategy is due to be published for Cambridgeshire and Peterborough, following approval by the Health and Wellbeing Board, which addresses a vast array of subject matters connected with mental health. It does not specifically address groups for elderly or carers as it is led by data. Scrutiny in these areas would become more focussed if an increase is seen. The new strategy proposes that we take a collaborative approach to preventing suicide, with the mental health system and community being partners in ensuring that everyone in Cambridgeshire and Peterborough has access to the right care and support to ensure that they do not die by suicide.

2.4.3 Caring Together

Services that Caring Together provides:

- Information and advice on rights and entitlements of carers.
- Training for carers to help them with their role such as safe moving and handling.
- Someone to talk to – from a listening ear to counselling.

- Emergency planning in case a carer needs to attend their own health appointments or is experiencing breakdown.
- A carer break – providing replacement care so that the carer can enjoy time away doing what they want to do or to join one of our outings or trips.
- Carer hubs based in local communities so that carers can meet other carers for social time together and peer support.
- Awareness raising sessions for professionals in health, education, or community settings.
- A quarterly carers magazine full of useful tips, information and details of local events across Cambridgeshire that might be of value to carers.

There is general recognition that some carers can be harder to reach, or perhaps easier to overlook and less likely to access services. Very often this can be because barriers exist in the structure and accessibility of services for some groups of carers or because carers do not expect to receive or actively seek support.

Many carers simply do not realise they are a carer – they may simply think of themselves as someone's wife, brother, son, partner, friend, neighbour. However, unless carers are identified, it is difficult to get support to them until they reach crisis point.

It is vital that those working in a wide range of community-based services including primary care are equipped to recognise carers and proactively help them to access appropriate information, advice and support. Referring carers to local carers organisations, can be the first step in helping someone to realise they are a carer and begin to get the support they need. Particular attention may be required to recognise and involve carers who are less likely to approach services or speak out themselves. Older people may be more reluctant than other carers to ask for or accept help and less likely to reveal their caring status or to identify themselves as a carer. This could be for a range of reasons including a sense that asking for or accepting help is a failure on their part. They may also be fearful of someone else taking over or even removing the person they care for from them, or the person with care needs may be adamant that they will not accept care from anyone else. Additionally, there is often a sense of dignity in remaining independent. It may therefore be that services need a particularly skilled and sensitive approach to older carers to address their concerns and this may be a process rather than a one-off intervention.

However, older carers are likely to be accessing primary care services such as their GP and community pharmacies with a range of health or other needs for themselves or the person they care for, so these are important places to identify older carers. Health and care staff undertaking home visits are also in a key position to identify carers.

Caring Together runs awareness sessions for professionals in health, education and communities' settings.

2.4.4 Cambridgeshire Police

Cambridgeshire Police reviewed the incident created on their system in relation to MCCS contacting emergency services on 19/10/22 in relation to Jack's comments of suicide at his home address. They are satisfied with the risk assessment that was conducted which led to no attendance being required and are satisfied that policy and procedure were followed. They follow the College of Policing guidelines that the FCR (Force Control Room) assess THRIVE throughout the call, initially at the beginning of the incident to determine the level of risk and therefore the response level and then throughout the incident to establish if that response level should change.

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Written by College of Policing
Vulnerability-related risks

About these guidelines

Our approach to recognising vulnerability-related risk is based on the concept that vulnerabilities are features of individuals, and that harm – or the risk of harm – occurs when relevant vulnerabilities interact with the individual's situation. For example, an individual with a learning disability may not be at risk of harm if they receive suitable support and protection that helps to prevent them from being exploited or abused.

We have adopted the THRIVE (threat, harm, risk, investigation, vulnerability, and engagement) definition of vulnerability. This states that a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation.

Applying this approach requires the following four steps:

1. Identify an individual's vulnerability or vulnerabilities.
2. Understand how these vulnerabilities interact with the situation to create harm or risk of harm.
3. Assess the level of harm or risk of harm.
4. Take appropriate and proportionate action if required, involving partners where they have the relevant skills and resources.

Over the last decade, responders have been reliant on checklists and risk tools to identify and assess risk. The review of the research evidence undertaken in developing these guidelines identified a lack of evidence associated with the effectiveness of these checklists and tools. Most people who need help will be vulnerable in more than one way, and a single tool is unlikely to address all vulnerabilities.
This does not mean, however, that checklists and tools have no value. They can inform and guide a responder on the nature and origin of risks. However, decisions about the level of risk and what action to take rely on responders using professional judgement.

2.4.5 Employment

Jack worked a couple of days a week at a local joinery, sweeping up and doing odd jobs which gave him social engagement and time away from the house. He was very happy when he was there. It is a small family run business who reported to Emma shortly after Jack's passing that they were shocked and had no idea he had any issues he was having to cope with. His employers have not been contacted for the purpose of this review at the request of the family as they do not feel they could add insight and to maintain the memory of Jack that they hold.

Section 3 - Analysis

3.1 Family involvement and perspective

Jack and Helen have three children who are all adults. Contact was made with all three of whom the daughter, Emma and the youngest son, Peter chose to be involved in the review and have provided a large portion of the information included throughout the report in relation to background information, context of the family unit and Jacks personality. Both have very similar recollections and opinions of the relationship between their parents.

Both Emma and Peter are certain that the reason that their Dad took his own life was due to the abuse he received from their mother over the years and that he just couldn't take it anymore. They are adamant that he did not have mental health problems as he never displayed any signs of this apart from frustration and unhappiness in his relationship, to the extent that Peter wrote a 10,000-word letter to the coroner outlining their parents' relationship through the years, interactions they had witnessed and Jacks own words that he had confided to them. Peter's words in the letter are captured throughout the report.

Both speak from having had a good relationship with their mother in their early years but then noticing more of her personality traits as they grew older. Emma's relationship with Helen broke down after she 'dared' to stand up to her on behalf of Jack due to the way she saw her treating him. Helen 'cut her off'.

Emma feels that the GP surgery failed Jack in their duty of care. This is partially down to the lack of face-to-face contact with patients and the differing doctors seen, so the relationship and trust is not built for a man of the age of Jack to feel comfortable to speak. Emma initially contacted the surgery when she first learnt of her Dad's suicidal thoughts but was only offered advice of a family meeting or him going into the surgery with Helen. No support services were provided and the family felt they were left to deal with it on their own.

It is Emma and Peter's description of Jack and his personality that provides the narrative of his male pride and generational traits although once he had admitted the situation and his feelings to them, he would have been more inclined to speak to professionals, given the opportunity as he did with the GP on the one occasion. It was never spoken about outside of the family unit. Emma stated, 'no one knew, only us three' (referring to her and her two brothers).

Both Emma and Peter comment on Helen's controlling behaviour of not just Jack, but the whole family unit, even in adulthood and many decisions were made based on the reaction Helen would give.

Helen was diagnosed with dementia early in 2022 and the symptoms developed rapidly. She is now a resident in a care home in Cambridgeshire. The author has not spoken to her in relation to this review as it would be inappropriate due to the rapid decline in her health. There is no Power of Attorney in place at this time.

3.2 Terms of reference areas

3.2.1 Has domestic abuse in any form been the causation or a contributory factor to Jack taking his own life?

Statutory agency files in Helen's name, record that Helen has reported that she is a victim of domestic abuse on more than one occasion to more than one authority although not the Police. If read in isolation, this would be believed without question. However, Jack and Helen did not have many other people involved in their lives who saw them together apart from their children and they report the complete opposite.

Jack is described by his family as always having been a strong, hardworking man who showed commitment, strength of mind and loyalty to both his work and his family. He had known his wife Helen since childhood and married her at nineteen years of age. The two children who have contributed to this report both separately remember their childhood and the personalities of both their mother and Jack in very similar ways and although now older and more reflective, whilst 'growing up' they just accepted their mother's controlling behaviour as 'the norm' as they knew no different and did not realise that they themselves were subject to this as well as their Dad.

Throughout their marriage, Helen never appeared happy or satisfied, openly ridiculing Jack in front of the children during their younger years and blaming Jack for her unhappiness during the twenty years living in Hopton. Jack never argued back or defended himself. Helen controlled the family finances which grew substantially at this time.

Around the year 2000, two significant things happened in the relationship. Jack spoke about leaving the marriage for the first time with the family becoming involved and the realisation of Helens dominance over the family unit, as it was now noticed how she never let Jack speak or give an opinion. Also, that Helen began to tell people including the family that Jack had dementia. This was never to be proven and medical records show quite the opposite but this constant narrative by Helen to all was to be the main source of frustration to Jack. Was this a way of Helen undermining Jack to ensure she maintained control as this was the first time he had alluded to gaining some independence? As the years past, did it become a 'prod to poke him with' as she was aware how much it bothered him that she was telling people something that wasn't true? However, since Jack's death, Helen has been diagnosed with Alzheimer's herself, so was her behaviour one of fear that she felt she may have the

onset of this awful illness and deflect it on to Jack as a self-coping mechanism. Medical records do not reflect this and it does not appear to have even been a consideration leaving one to consider whether that was because it wasn't an issue prior or that those medically treating Helen had missed any signs.

Emma describes her mother as having an unhealthy attitude and obsession about money. This manifested itself in later years as Jack had his bank card confiscated from him by Helen and wasn't allowed any money from the joint account. Although the children did intervene in later years and get him his own account with some of the money he had earned deposited in it, providing some independence, they had to pay for the internet to keep in touch with him rather than insisting the cost came out of the joint account which shows reluctance to challenge their mother. This is clear evidence of economic abuse which Jack disclosed to his GP.

Reviewing the comments made by Helen to the ambulance crew, she is alleging that she is now very vulnerable and Jack is exploiting this. Gaslighting seems to be a feature and this is evidenced in how Helen describes Jack to not only family, but professionals too, including the safeguarding team.

Helen accuses Jack of being nasty to her to health officials and having to lock herself in her bedroom, yet the family never witnessed any behaviour of this kind from Jack and state this was indicative of Helens behaviour towards him. They do acknowledge she would barricade herself in her room each night but it was put down to her erratic behaviour. The only mention of physical violence was when Jack told his daughter how Helen had once threatened him with a pair of scissors and hit him twice due to him pruning a plant in the garden as he was not allowed to.

Jack did disclose domestic abuse to his GP and to his family during the latter years, although it is not clear whether he recognised Helen's treatment of him as domestic abuse. This was an incredibly significant step by Jack as he was a male from a generation where 'these things' were not discussed and was a proud man. The message he left his children outlined the fact that he could no longer live like he was as he was so unhappy and did not feel things could change, only showing signs of happiness when Helen was not with him and he had some independence.

3.2.2 How effective are services and agencies provisions to domestic abuse within South Cambs, specifically for carers, elderly and male victims?

One of the barriers in obtaining help and support for carers is the lack of identification from professionals in realising the family member has that responsibility and the fact that there is an assumption they will take on the role, not considering the responsibility this placed on them.

Potential opportunities were missed in either identifying Jack as the carer for Helen or failing to provide information of pathways for support. The GP records reflect the deteriorating physical condition of Helen. It is accepted that it is difficult to identify the point where those living together look after each other when at home to when they actually

become a carer. There was no wider consideration as to what may be causing Helen's fixation or holistic thinking in the knowledge of the issues this was causing Jack or the family. The whole situation from Emma's email through to Helen being informed of the results appears to be dealt with in isolation with no follow up and records of 'long chat' do not outline what issues were discussed and if any advice was provided. This would have been an opportunity to put her mind at rest and prevent her any cause for concern. When Helen was in hospital, she informed CPFT that she was the victim of domestic abuse and that Jack had dementia. Although CPFT completed a referral to Adult Safeguarding in relation to domestic abuse, CPFT did not act on either of these facts in regard to discharging her back home to his care. They did not conduct any safeguarding for Helen in relation to DA, no contact was made with the GP to ascertain if Jack did have dementia and Jack wasn't spoken to, yet Helen was discharged immobile, back into his care with some additional assistance commissioned to help with meals and bedtime. (Recommendations refer)

Assessments are not routinely conducted on those who are either to become carers or who are already carers. One of the blockers can be the fear of having to disclose financial means making the carer reluctant to complete it, although this was not the case with Jack. As CPFT did not identify Jack as a carer and didn't form part of their statutory duty, Jack was not offered a risk assessment prior to Helen being discharged into his care. A carers needs assessment was not conducted at any time for Jack by anyone who received information on him. Had a carer needs assessment/open conversation with him been completed, this may have identified his suicidal tendencies, the cause of these and a care plan implemented for Helen that would address both her needs and those of Jack. (Recommendation refers)

Consent is an issue when referring those identified who may be at risk. Consideration was given to ASC referring all referrals of carers to Caring Together for triage but this cannot be done if consent has not been given. Those who do not meet the care and support criteria but give consent are referred to the Health IDVA for support. Following a recommendation from a previous recent DHR within the area, in cases where there is a high risk identified, the ASC will follow the s.42 principles for safeguarding to adhere to their duty under the Care Act.

There is a lack of support provision within South Cambs and the surrounding areas for either male or older person victims. Jack was a proud man and from a generation where he wouldn't speak about domestic abuse (information from family) and opportunities were missed when in direct conversation with him to provide pathways of support to national helplines or Caring Together that he could have self-referred to. GP notes on the conversation are inadequate to be able to review the content of the conversation and what services were offered. (Recommendations refer)

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, due to the lack of identifying Jack was a victim of domestic abuse with no referrals or advice and the fact that Jack himself may not have identified this as part of domestic abuse, he would 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 Jack is

male and had been the main 'breadwinner' throughout their marriage may provide unconscious bias by authorities. The ManKind initiative report 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%

(ref: ManKind Initiative with UCLan. Male victims of coercive control 2021)

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

3.2.3 How effective are services and agencies provisions to suicide and those contemplating taking their own life within Cambridgeshire?

A dedicated piece of work has been ongoing by a large number of partners, led by Public Health in Cambridgeshire and Peterborough to publish a suicide prevention strategy and Four-year plan around one basic principle: 'Suicide is preventable'

Their ambition is –

Every person in Cambridgeshire and Peterborough has access to the right care and support, from both the mental health system and their communities, to ensure that they do not die by suicide

During this project, it has been rightly identified and confirmed that there are links between domestic abuse and suicide as the statistics outlined in 1.6 of this report. Due to this research, the DASV Partnership Manager is now a member of the Suicide Prevention Group and they work together to examine how future deaths may be prevented. Also, the Public Health Lead for suicide will be invited to sit on all DHR Panels examining suicide.

Support services including Samaritans and Lifecraft have received training and awareness of the effect of domestic abuse, however, this review highlights opportunities missed where Jack or his children, who expressed concern to the GP, could have been provided

information about services that could assist them as they were aware of the realness of his suicidal tendencies for some years yet did not receive support as there was an issue with consent from Jack. This causes a dilemma for professionals as without all of the relevant information, they are unable to ascertain the overall risk. Although they can act upon information that they have received without fear of breaching GDPR if it is felt there are safeguarding concerns or significant risk to self or others, there is a gap between an individual asking for help and the identification of significant risk whereby without consent, referrals can't be made. However, there is still the opportunity to provide them with information of support services as a safety net. (Recommendation refers)

In this case, it is noted from records that the GP was informed of specific information of Jack's mental state in 2015 and the family state they reiterated this in 2020, when they said how he was being treated and the effect this had on him. However, on the occasion they had a face to face with Jack, they did not ask any questions in relation to his suicidal tendencies, complete any risk assessment asking questions of his capabilities and the effect his home circumstances had on him or make the correlation between that and the domestic abuse. (Recommendation refers)

3.2.4 Are recording processes and the sharing of information sufficient between agencies when a situation arises where the risk assessment and concern are for a person associated/related to the person being cared for?

The only authority to hold a record of 83-year-old Jack under his name was his GP Surgery.

Two separate referrals were made to ASC from two different agencies. The first referral came from CPFT who sent it in the name of Helen as she was an in-patient at hospital. The practitioner did not identify that Jack may be in a caring role. The risk in this referral was centred at Helen. No record was opened for Jack.

The second referral was from MCCS, who were a private company commissioned for the care of Helen and was again referred in her name. It focused on the needs of Helen but also included concerns for the risk of Jack which needed to be reviewed and addressed. Again, no individual record was opened in Jack's name.

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

There is a potential to improve how information is gathered about all involved parties, and links across made, when more than one person appears to have care and support needs. This was a safeguarding situation for both Jack and Helen but was viewed just through the

lens of Helen as the referrals came in under her name and ASC would not then have created a file in Jacks name.

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

For the second referral, there was a two-day delay in the agency referring and a five-day (three working days) delay in the MASH team allocating the concern. By this time, Jack had taken his own life. In context of what was happening at the time there was an increase in referrals being received in MASH and at the time was linked to the pandemic. However, it cannot now be known as to whether intervention could have been made if the referral had been addressed immediately.

It can be anticipated what action would have been taken by MASH had there been an opportunity to explore the concern further. Adult social care now has written practice guidance around carers who may be at higher risk of abuse due to their caring responsibilities but more work may be needed to help identify male victims at an earlier stage. Jack was not an adult at risk so he would not have met the criteria for safeguarding but had he been referred prior to Helen having care needs he could have been signposted to the IDVA service. Sex may be a factor as may age. ASC may wish to review what information is readily available to support people in Jack's situation to recognise what is happening to them and how to seek support. (Recommendations refer)

Section 4 – Conclusions and Recommendations

4.1 Conclusions

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

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

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

The accusation of dementia was utilised in the **controlling and coercive behaviour** by Helen, keeping Jack isolated from family and friends, even when the family were present or called

on the phone, by not allowing him to participate or voice an opinion. Jack had no independence through **economic abuse**, with Helen not providing him access to their money by confiscating his bank card and access to the joint account, declaring his dementia as the reason why. This prevented him from buying himself essentials such as underwear whilst Helen bought herself any items she required. Emma speaks of how happier he seemed once he had demanded his wages back and had a little to spend on himself during his last months.

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

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

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

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

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

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

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

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

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

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

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

4.2 Recommendations

National

1. Policy and protocol to reflect that an individual should not be left alone until further assistance has arrived when high risk/immediate safeguarding

needs are identified and this should be built into the commissioning of homecare providers.

Having stated that he was going to kill himself and it being perceived as a 'real' threat, the carer then left Jack and the premises prior to an assessor from the company arriving, to go and attend to a patient at a different location. This will prevent this situation occurring in the future, whether the person identified as high risk is the specified patient or not.

Local

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

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

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

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

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

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

5. **Caring Together and Lifecraft to increase promotion of their services to enhance awareness amongst the public and professionals of what services are available.**
   This would highlight the provisions available and increase referrals for both carers and those who are suffering from mental health issues and have suicidal ideation as the panel discussions highlighted limited knowledge amongst professionals.

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

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

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

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

10. **CPFT to ensure that their procedure and protocol for discharge includes a discharge plan that incorporates 'think family' and that consultation with the family takes place as well as the patient to identify any issues or needs the discharge into their care may cause.**
    CPFT Carers policy states that carers should be offered a carers assessment as per their statutory duty. Jack was not offered a carers assessment or spoken to prior to Helen's discharge. If they had considered this approach, they may

have identified him as a carer and an older person and assess whether he would have had the capabilities of additional responsibility and stress, already knowing that there were issues within the relationship.

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

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

Appendices

Appendix A

Terms of reference

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

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

ICT: Intermediate Care Team

IDVA: Independent Domestic Violence Advisor

IMR: Individual Management Review

MASH: Multi-Agency Safeguarding Hub

SAR: Safeguarding Adult Review