Executive Summary

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

(February 2022)

Author – Jackie Dadd

Date completed – September 2022

Family tribute

Mum was someone who wore her heart on her sleeve. When she was happy, I felt that I got the real her; I could feel her joy for life and we could connect as mother and daughter should. Throughout her life, mum had hobbies and passions that brought her peace and happiness. When I think of her, I remember her in one of her gardens. Her garden would always be the most colourful and well-kept in the street, no matter where she lived. It was a point of pride for her. It allowed her to express herself in ways she couldn't with words; it was the place where she was able to be creative and find peace.

And this was important to her, finding peace. Mum had her demons. They were intrinsically a part of her, so I can't help but remember them. She fought hard to be well but the illness always ate away at her, and even the strongest rock is eventually worn away by the tide; this is when she was most vulnerable to herself and others. In the weeks leading up to her death she told me that she didn't want to die, and it breaks my heart to think that she must have been so vulnerable at the end.

This is why I want her to be remembered where she was well: in her gardens, surrounded by her beloved pets, or walking her dogs along the beautiful, hidden paths near where she lived that she always had a knack for finding. This is where she would be at peace, and we could talk and laugh, and we would be Mother and Daughter.

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

Contents

The review process

This review is into the death of Emily, a 62yr old female, who was found deceased in February 2022 by Cambridgeshire Police at her home address. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review and the Pre-Inquest review hearing has been set for 12/10/22.

Cambridgeshire Police made a referral to Fenland Community Safety Partnership on 10th March 2022 due to a history of domestic related incidents involving Emily on their records.

A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1) Death by unnatural causes due to hanging

At the time of her death toxicological analysis has shown that the deceased was intoxicated with alcohol. Her blood ethanol level was 203mg/100ml. Depending on her tolerance to alcohol this level of ethanol can be associated with coma. She was also found to have a high therapeutic concentration of the antidepressant Citalopram and a low therapeutic amount of the anxiolytic Diazepam. No other drugs were detected.

The only recent injuries found were those of ligature marks around the neck.

Fenland Community Safety Partnership, in accordance with the December 2016 Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review on 14th March 2022. The Home Office were notified of the decision in writing on the same day.

Two subsequent parallel reviews have taken place.

Cambridgeshire and Peterborough NHS Foundation Trust Serious Incident - CPFT SI

This review has been conducted to investigate the care provided to Emily by Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) in the year leading up to her death in February 2022.

The report received the Serious Incident Group approval on 18/07/2022 and was submitted to the commissioner on 26/07/2022. It reflects both good practice and areas for development which are captured in recommendations and an action plan which are referred to throughout this report where relevant.

Independent Office for Police Conduct - IOPC

A referral by Cambridgeshire Police was made to the IOPC in February 2022. A parallel investigation is in progress regarding Cambridgeshire Constabulary's response and open investigation of a domestic related incident that occurred on 1st December 2021. A decision has been made for this to be reviewed internally and any learning to be implemented by the Learning and development inspector who will take account of this review.

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

Emily - Deceased, who was a 62-year-old female at the time of her death.

Pauline – Ex-Partner of Emily, a 62-year-old female at the time of Emily's death

Susan – Daughter of Emily. Only child.

Daniel – Ex partner of Emily and Father to Susan.

Address – Name of area referred to as Fenland

In Cambridgeshire, since May 2018, nine suicides relating to domestic abuse have been considered as requiring a DHR. This is the first one involving a same sex relationship. In 2018, a quarter of the total of 6507 deaths by suicide registered in the UK were by females. (ONS, Suicides in the UK, 2018 registrations). Domestic Abuse is a factor in around 12.5% of female suicide attempts.

IMR's were requested from the agencies who had significant communication with Emily or held significant information. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including age, suicide and same sex relationships. This was to assist in analysing the depth of knowledge and support already in existence and being required in these areas in the Fenland district.

Review Panel members

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

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection	Cambridgeshire Police
Emma Foley	Peterborough City Hospital – Adult Safeguarding Practitioner	NW Anglian NHS Foundation Trust
Julia Cullum	Domestic Abuse and Sexual Violence partnership manager – IDVA Service	Cambridgeshire County Council
Rebecca Cooke	GP Practice Representative. Deputy Designated Nurse for Safeguarding people	NHS Cambs and Peterborough Primary Care ICB

Alan Boughen	Community Safety & Partnership Officer	Fenland District Council and representing the Fenland 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
Martina Palmer	Senior Operations Manager	Refuge
Lauren Mason	Domestic Abuse Champion Lead	Clarion Housing
Aimee Elener	Quality Lead	Change Grow Live (CGL) - Cambridgeshire
Pushpa Guild	MCU Review officer	Cambridgeshire Police
Donna Glover	Assistant Head – Adult Safeguarding	Adult Social Care

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

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

Contributors to the review

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

- East of England Ambulance Service NHS Trust (EEAST)
- Cambridgeshire Constabulary
- NHS Cambridgeshire and Peterborough Integrated Care Board (ICB) – on behalf of involved GP Practice
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Cambridgeshire Women's Aid
- Cambridgeshire County Council Domestic Abuse and Sexual Violence partnership (DASV)
- Clarion Housing
- Fenland District Council
- Change Grow Live Cambridgeshire (CGL)
- NW Anglia NHS Foundation trust
- Public Health department – Cambridgeshire County Council
- Refuge
- Cambridgeshire Adult Social Care

Author of the overview report and Chair

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

Terms of Reference

Terms of reference were discussed and agreed upon during the first panel meeting on 9th May 2022.

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

1) Domestic abuse in any form had been the causation or a contributory factor to Emily taking her own life
2) The availability and effectiveness of service and agency provisions for domestic abuse within the Fenland area, specifically for LGBTQ+, Older persons and vulnerable persons
3) The availability and effectiveness of services and agencies provisions for suicide and those contemplating taking their own life within the Fenland area
4) Establish the response to Emily's mental health and information sharing processes in relation to this

It was agreed by the panel that the review and research dates would take place from 2009 as this was the known year that the relationship issues became known to multiple agencies, but any relevant information held prior to that should be included until the date of her death.

The full Terms of Reference are below:

- The date parameters under consideration are from January 2015 until 30/10/21.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of RS.
- 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 RS?
  a) Communication and information sharing between services.
  b) Information sharing between services with regard to the safeguarding of adults and their carers.
  c) Communication within services.
  d) Communication to the community and non-specialist services about the provisions of available specialist services.
  e) Identifying the vulnerability of carers to being either the abuser or subject to domestic abuse due to their role within the relationship and are adequate safeguarding measures and recording processes implemented in these situations.
- Establish if agencies have sufficient training and knowledge to identify signs of domestic abuse and how to appropriately refer and record this, specifically including both psychological and economic abuse and coercive and controlling behaviour.
- Establish accessibility of services for those contemplating suicide and bespoke training in relation to the effects DA may have towards this.
- Identify and highlight good practice for wider sharing
- Is there sufficient support available locally for male and elderly victims of domestic abuse and how accessible are they?
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and his wife? Was consideration for vulnerability and disability evident? Were any of the other protected characteristics considered in this case?

Summary Chronology

Emily was adopted by her parents in her early years, had severe dyslexia and moved house frequently. She was abused by her mother throughout her childhood because she was 'not girly'. Emily never opened up to anyone about the extent and explicit details of the abuse but both her daughter, Susan and Susan's father, Daniel believe it to have been mainly emotional abuse with some physical abuse. The abuse then caused Emily to be rebellious.

This treatment of her at a young age would impact the rest of her life as she never moved on from this, not having a good relationship with her mother and a strained relationship with her father as she felt resentment that he never did anything to stop the abuse.

During her mid 20's, Emily became an au pair in Holland. The first significant occasion Emily manifested signs of any mental health issues when she was 28 years old. Whilst on a holiday in Spain, Emily had a breakdown and her mother had to fly out to bring her back. Emily was immediately hospitalised.

A year later, Emily met Daniel whilst having a drink one evening and they went on to have a relationship. Emily was never violent towards Daniel and they never really had any

altercations. Emily had alcohol issues caused by her frustration and upset with her illness and when she had been drinking, she would ring her parents and verbally abuse them down the phone.

Emily and Daniel had a daughter, Susan when they had been together about two years and Emily was 31 years old. Their relationship was already strained by this point and after the birth, Emily suffered post-natal depression and was in and out of hospital. They continued to live in the same house for four years but Daniel was raising Susan as the primary carer. Emily struggled with the fact that the relationship was over but they remained on good terms.

Around 2001, when Susan was in primary school, Emily announced that she was gay as she had met Pauline and wanted to live with her. Pauline also had a history of alcohol misuse and mental health issues. This was the start of a downward spiral in Emily's mental health. Susan used to go and stay overnight each week, which had to be carefully monitored by Daniel as they lived in a one-bedroom flat, were both always drinking and then arguing. Pauline would always blame Emily although a lot of the time she would start it or they were both at fault.

Susan recalls times spent with her mum and Pauline as full of drunken arguments and described the relationship as toxic. There were issues with Pauline getting them into debt by overspending and is described as manipulative with a hold over Emily.

Pauline and Emily had six recorded domestic related incidents with the Police between 2004 and 2010 in which both were recorded as suspects on differing occasions and mental health and alcohol were comparable factors. These included violence towards each other with alcohol having been consumed on most occasions.

In October 2009, Pauline entered a refuge stating that Emily had barged into the bedroom, threw herself on top of her and started punching her. When Pauline reached for the phone to ring for help, Emily hit her on the head with the phone. Pauline fled and was accepted in the refuge where she remained living in for the next eighteen months.

Contact continued for a short while with Police involvement, but Emily moved on with her life and had other relationships that were 'normal' although her mental health issues continued.

In 2017, Emily's mother died. This left her father living on his own. He was frail and struggling. Emily moved to the same street as her father in order to look after him. This also happened to be the same street that Pauline lived in and had done so since 2011.

Emily found the caring for her father very stressful and her mental health deteriorated further. Between the end of 2018 and June 2021, Emily made calls or had face to face contact with Fenland Mental Health services on at least 210 occasions.

In 2019, Emily was so overwhelmed at caring for her father that she tried to hang herself. She would tell her housing officer and health professionals how caring for him affected her mental health. She self-referred to Change Grow Live alcohol service to get support and

assistance with her drinking. Her father passed away in 2020. Emily and Pauline were in contact during these years.

On 1st December 2021, Emily and Pauline were drinking together with another friend when they had an argument. Emily alleged that Pauline had punched her. Emily had no visible injury. Pauline alleged that Emily had punched her and then grabbed her. Pauline had a red mark on her neck. Neither were willing to pursue a complaint against the other or provide a statement. Emily was removed from Pauline's home and returned to her own address.

An ongoing police investigation saw contact with both Emily and Pauline over the next two months with additional allegations and counter allegations. Emily was recorded as the perpetrator due to the injuries to Pauline. Over the Christmas period, Emily did not have access to medication due to an error in the Doctors repeat prescription system and Emily took an overdose at New Year.

At the end of January, mistakenly thinking that she was going to be arrested by the police, Emily rang the First Response Service (FRS- mental health services) on several occasions stating that she wanted to kill herself and had the pills and rope to do so saying

'If no one helps me I will do it whenever'.

In February 2022, a mental health services team member (unqualified) visited Emily's address for a pre-arranged appointment. Upon her arrival, there was no response from Emily, which gave rise to concerns for her welfare. Upon Police entering the property, via a partially open rear door, which was blocked by an obstruction, they located Emily slouched on her knees in between the door and a cupboard with a noose (white rope) around her neck tied to a coat hook on the side of the wall. Emily was freezing to touch; rigor mortis had set in and there was no sign of life. No attempts were made to resuscitate.

Emily left a note to her daughter which said,

'My Dear Susan, I so sorry that I have to do this but Pauline is making my life hell again. I love you more than anything but my life is always hell and I cannot stand it anymore.

I do hope and pray you will xxx I've been feeling very ill for a long time and this has just past me over again. Please forgive me. You have always been my life but I just cannot do this anymore my darling.

Love you so much. Please forgive me. Wish you a very happy life. Love you dearly

Mum xxxx

Pauline will have to have live with this for the rest of her life. She made my life a misery, what she did to me.'

There were no signs of third-party involvement or criminality. This incident was treated as a sudden and unexplained adult death, indicative of a suicide.

Key issues arising from the review

Response to LGBTQ+ community needs

There are no support groups within the Fenland area for the LGBTQ+ community. However, many of the local support groups available within Fenland would sign post people to organisations that deal primarily with the LGBTQ+ community which are based within the more populated locations such as Cambridge, Peterborough and Norwich.

Safeguarding and DA training within the agencies does not include LGBTQ+ and therefore, there may be barriers to identifying needs, a lack of understanding and missed opportunities to signpost to support services.

Throughout this review process, it has not been clear how the victim or perpetrator identified themselves from police records, in terms of sexual orientation, gender or any other protected characteristics. Records from CPFT show Emily to be heterosexual on the health electronic record keeping system. When this was probed, it was revealed that they were aware that Emily identified as a lesbian but staff did not know how to change it on the new systems. (Recommendations refer)

Housing issues with informed risk assessing

When Emily requested a move so that she could be near to her father who was in ill health in order to care for him, she was not asked any questions on her application form that may alert Clarion Housing to any potential risks associated with the location that they subsequently placed her. However, had they done so, it would still have been reliant on disclosure from Emily in relation to her association with Pauline and the domestic abuse in the past making it inappropriate to house them in the same street. Also, Clarion Housing have no means to search any database that would alert them to any safeguarding risks when placing applicants into properties. (Recommendations refer)

Communication between organisations to share information

On comparing the three separate records on Emily held by CGL, the Doctors practice and FALT, it is apparent that there has been good evidence of information sharing at times. It is also apparent that each record holds different narrative at times provided by Emily as she would partially tell them parts of her life each so none of them held the full picture as these were not shared amongst them. There are some barriers that prevent a full flow of information between the three organisations. CGL had consent from Emily to inform the Doctor that they were supporting her and ensured that they linked in with the doctor as often as possible. However, they did have to rely on what Emily was telling them to a large extent as information was not shared with them by FALT and in some cases, the Doctors surgery. They did have a good relationship with Emily as she had the same caseworker throughout her time with them and frequently had the same doctor as well who knew her history and had built a relationship of understanding. However, FALT strategically chose to respond to her with different caseworkers on each occasion as they felt she built up a

reliance on one single person. Her relationship with FALT was fragmented as can be gauged by comments that she made to others.

When in crisis, Emily could often contact all three organisations on the same day with differing parts of disclosure. As this would not be shared amongst the three, this could have the potential of conflicting advice or Emily continuing to contact until her need was met to her own satisfaction. (Recommendations refer)

Delays preventing supply of medication

Emily's mental health deteriorated over Christmas 2021 which coincided with a technical fault which prevented Emily obtaining her medication. Her mood became so low that she took an overdose on New Year's Day. The understanding as to why the technical fault occurred remains unknown as 'something that occasionally happens' and it cannot be identified on the medical records. There was a further delay when eventually prescribed as it was in a waiting list for an electronic signature and the GP was struggling with capacity at the time. (Recommendation refers)

Conclusions

Emily was adopted as a child and although the full details are not known, she experienced forms of emotional and physical abuse from her mother which affected her for the rest of her life alongside the anger she felt towards her father for not intervening. This appears to be the catalyst for her mental health issues.

Emily clearly loved her daughter very much as is shown in the note she left and her comments to her care workers. Her relationship with Pauline caused her issues with alcohol consumption and her mental health from the outset. The relationship is described as toxic by Susan who witnessed a number of altercations and it is difficult to differentiate between who was the main aggressor. However, although both had their own mental health issues, Pauline does disclose to care workers and doctors of how this affects her both before and after the relationship showing a vulnerability on this matter. The Police must ensure that their recording mechanisms of who may be a perpetrator are not influenced by any previous incidents and treat each further incident with an open mind, whilst taking history into consideration for the wider picture.

Emily had a chronic history of suicidal ideation during times of heightened stress and to help manage these feelings she would often use alcohol as a coping mechanism however this would often intensify the feelings leading to her attempting to end her life. Emily had consumed alcohol prior to taking her life as referenced in the post-mortem report. Emily expressed ongoing concerns of feeling isolated and having no friends but appeared to be making steps to address these issues.

She had expressed ongoing physical health concerns which were being investigated by her GP. She also found being discharged from services difficult as she described feeling alone and isolated. The CPFT SI investigation found that there were no direct acts or omissions by

CPFT services that was a root cause. However, there were service factors that contributed such as there was not a smooth discharge from FALT due to a delay in completion of documentation, and Emily was not provided with an up-to-date relevant crisis/safety plan. Emily's difficulties with discharge such as feeling like she was being abandoned was highlighted but key services such as GP and FRS were not made aware and directed to a Safety Plan individual to her needs. Communication between service was not always documented/uploaded and risk by removal of means was not always discussed.

Her mental health needs overshadowed the identification or response to her disclosures about her personal relationship and consideration of domestic abuse when dealing with both her Doctor and FALT and there were missed opportunities to refer and to provide advice of pathways to support her for this.

Emily's sexuality did not directly affect the way in which she was dealt with by professionals but the lack of recording of her sexuality, lack of provisions in the area and lack of training within organisations about the LGBTQ+ communities needs is an area to be addressed to ensure that intervention to be able to provide specialist needs in this area is available and recognised.

Both Emily's records and from her daughters' observations, it was clear that Emily did show a marked improvement when she was not with Pauline, albeit not eradicated. Therefore, the placing of Emily into accommodation in the same street as Pauline can be seen as a catalyst and risk to both her mental health and confrontations between the two whether in a relationship or just friends. Housing was not aware, but the records show that Emily was and at present, there is no database or process that would allow housing departments/associations to identify risk based on recorded data.

The most recent DA investigation by the police undoubtedly had a detrimental impact on Emily's mental health, along with the grief from losing her father, her lack of medication over Christmas, her anxiety about wanting to see her daughter and the confusion over what her relationship was with Pauline. All of these clearly contributed towards her taking her own life. Emily specifically refers to Pauline in the note she left for her daughter but given the number of attempts to die by suicide previously and the history of her mental health issues, the conclusion is that although DA was a factor in Emily's death, it was not the sole causation.

Lessons to be learned

Pressures of being a carer

The additional pressures of Emily caring for her father in his last years of life were disclosed and documented to both the GP and CPFT. Emily frequently disclosed how this additional responsibility had a detrimental effect on er mental health. Although CPFT offered Emily a carer's assessment which was declined, there were no referrals or advice provided as to where specific support could be obtained. (Caring Together offer this service in the area).

Recommendations in relation to carers have been made to Cambridgeshire County Council Carers strategy refresh Board in another DHR involving an older person caring for a relative so will not be duplicated within this report.

Effects of Covid

Medical notes from the Dr's practice, CGL and FALT, all comment on disclosures from Emily as to how isolated she felt during Covid 19 lockdown and the lack of face-to-face consultation available had a detrimental effect on her as telephone conversations do not always fulfil her need. Their records show a vast dialogue of contact with Emily and reflect how different she leaves the consultation when she has actually seen someone.

This is a wider issue to review separately, but worthy of note that it was identified by panel members and was the period of time when her mental health has then reached a low point directly before ending her life.

CPFT SI

The CPFT SI investigation found that there were no direct acts or omissions by CPFT services that was a root cause TO Emily's death. However, there were service factors that contributed such as there was not a smooth discharge from FALT due to a delay in completion of documentation, and Emily was not provided with an up-to-date relevant crisis/safety plan. Emily's difficulties with discharge such as feeling like she was being abandoned was highlighted but key services such as GP and FRS were not made aware and directed to a Safety Plan individual to her needs. Communication between service was not always documented/uploaded and risk by removal of means was not always discussed.

There are nine recommendations made in the CPFT SI report relating to:

- Procedures of continuity of staff and discharging of patients
- Recording of information accurately and appropriately
- Communication between differing departments within the health authority
- Appropriate response to someone making contact with suicidal ideations

As they are already being addressed, this report will not duplicate these recommendations. However, the panel concur with the recommendations as these were issues that were independently identified and discussed during the panel meetings.

Recommendations

National

1. **A database for research on safeguarding matters in order for Housing departments and associations to ably risk assess suitability of accommodation for applicant to be explored for feasibility.**
   As housing issues are now an intrinsic part of the Domestic Abuse bill, this will allow both the local council housing departments and housing associations who are

commissioned to accommodate on their behalf, the ability to have access to information for informed decision-making taking regards of vulnerability and risk.

Local

2. **Victims and perpetrators should be asked directly to self-define their sexual orientation and how they identify themselves, for the purpose of signposting them to the appropriate additional support services, and this should be recorded appropriately and accurately.**
   This will increase referrals and specialist support that can be provided and will ensure the correct recording is made to identify any specific needs and responses.

3. **The Fenland Community Safety Partnership to ensure the promotion and wider publicity of LGBTQ+ support services within Cambridgeshire to provide awareness for professionals to signpost and utilise these services. Other CSP's in the area are to consider this.**
   There are no support services for the LGBTQ+ within the fenland district and a lack of knowledge of the support services available within Cambridgeshire and the surrounding areas. It is important that professionals know where to signpost those requiring the specialist support.

4. **Cambridgeshire Police and Adult Social Care to ensure compliance of the process for Supervisors, Gatekeepers, Managers and MASH staff to ensure all DASH risk assessments and any referrals pertinent to any subjects, have been:**
   - **Physically seen and endorsed accordingly**
   - **Reviewed and revisited alongside any significant developments or changes in the investigation for accuracy and recording purposes**
   - **Submitted to the relevant specialists and agencies for action**
   - **Decisions and amendments to the grading of STANDARD/MEDIUM/HIGH to reflect the circumstances of the victim at that time, and recorded on the investigation log**

   This will provide a robust scrutiny of the recording of assessments and the review of these for accurate risk assessing and appropriate referrals.

5. **Cambridgeshire Constabulary to speak with Public Health for an adaptation of their training programmes for suitability of the Constabulary's needs.**
   This will increase knowledge and awareness amongst their workforce and assist them in identifying suicide indicators: interpretation and identification of risks to individuals at the earliest opportunity and enable effective interventions to be considered at the earliest stage.

6. **Cambridgeshire Police Reinforcement of the DASH and DVPN/DVPO policies, particularly in cases of counter allegations, expectations, and standards across the**

workforce, to ensure consistency of practice and early intervention support services, for vulnerable victims and perpetrators of domestic abuse.
This will increase the use of such tools provided by legislation to address domestic abuse and provide safeguarding in such cases where a victim may not wish to support a prosecution and therefore, a criminal prosecution is not viable.

7. **Clarion Housing to revise the Homelink housing application to include the applicant to comment on 'You or a member of your household needs to move away from another area to escape violence or harm'.**
This will then reflect the Fenland Housing application form and identify if there are 'risk' issues that need to be explored further before deciding on the suitability of where to re-locate.

8. **CGL Cambridgeshire will upskill staff to ensure they are aware of how consensual information sharing can support a service user throughout their treatment journey. Staff will feel confident in explaining and exploring consent with service users, particularly in relation to a change in their risk or circumstances.**

   CGL staff will increase their information sharing where relevant to improve the quality of service and support they can offer from a wider understanding. This will ensure that the issue of consent is reviewed periodically in each case to provide confidence that the information held is current and reflects the wish of the subject and also, that staff are aware of the requirements of when to share information without consent.

9. **Domestic Abuse training must include reference to the needs of the LGBTQ+ community**.
This will provide knowledge in this area, identification of needs, appropriate recording and increase referrals for specialist support where required.

10. **Stronger working relationships and communication channels are required between the GPs and pharmacists to prevent any delay in the administering of prescriptions with an escalation process or safety plan to address issues when a technical error occurs and is identified.**
This will address the technical issue that the GP surgery is already aware of and how to prevent any delays in a person not receiving medication because it has not been identified that the prescription has not been transferred to the Pharmacy.

11. **A robust process to be established to prevent any delay in the signing of prescriptions and where a capacity concern is identified, there needs to be an escalation process to be able to re-act in a timely manner.**
This will prevent unnecessary delay in someone receiving medication as the prescription had not been signed due to capacity issues.

12. **Cambridgeshire Public Health to progress and advance its data collation into suspected suicides of the LGBTQ+ community.**
    This data will identify any patterns or increases to provide a clearer and informed understanding as to whether the current support provisions are suitable and can be utilised to determine whether any immediate response is required within this community at any given time.