Executive Summary

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

(January 2023)

Author – Jackie Dadd

Date completed – November 2023

Family tributes to Sarah

My Mum

My mum was a beautiful woman. I'll always remember her that way.

To her, her looks were everything. She was stunning on the outside but with my mum she didn't just have a beautiful face her soul beamed with beauty, so when it came to reputation it was a big thing, she would always keep her problems to herself and always told me our business is no one else's.

She never wanted anyone to know that she was breaking. So, as my mum put this mask up of her life not allowing many people to pass it she would hide the trauma that she went through all her childhood. My mum was an independent woman. She didn't like to be told what to do because she was independent, she also dealt with her problems by herself, she's the strongest person I know but even mum couldn't handle it on her own which just shows the terrible things she's been through.

Sarah was my mum, my best friend, my hairdresser, my hero, she was a survivor. Too many things were against her which is shame because she felt the world was so against her she started to become against it herself fighting off any type of help. My mum loved yoga she did it every morning. She stopped for a while but always tell me how she needs to do her yoga she was amazing at it; it was a big part of her. She also loved doing hair as a kid she'd always want to do mine. I'm her only girl and fortunately for her I have very long hair, I hated her doing my hair because at the time I was more of a "Tom boy" but now all I wish is for her to be here doing my hair. She didn't deserve anything that happened to her, she lived a life where no matter how hard she tried everything seemed to be against her, she fought so hard I don't blame her for the way she reacted to us sometimes, many people would hear my story and feel bad for me for the way my mum would have treated us at times but they would have a very different approach if they heard my mums.

My mum was an amazing mum, time was just against me and her.

My Mum

As her cackle echoes through my ears

I remember the nights

Our conversations would go on for hours

Her beauty as Elegant as a flower

Yet her eyes held power

Because as much as my mum looked as an angel

If she had to protect us

The outcome would be fatal

Because my mums a survivor in an angels body

My mum is my hero

And always will be

My Dearest Sister, words will never be enough to explain what you truly meant to me. Not only were you my big sister but you were also my best friend. I feel so lost in this world without you but I find the strength through our children. My heart breaks that I couldn't save you but now I know you are at peace. So, rest now my beautiful girl and remember it's never a goodbye but an until we meet again. I love you a million bits of love. Fly high beautiful and shine xx

Mummy will forever keep you alive and tell me with a smile on her face that "when mummy said no, Auntie ALWAYS said yes". I miss your 'big fat kisses and squishes'. I love you so much – Your Niece xx

I will never be able to listen to certain songs and not think about the times you used to sing them to me before bed when I was younger. Love you forever and always – Your Nephew xx

The Domestic Homicide Review Panel and the members of the Cambridge Community Safety Partnership would like to offer their sincere condolences to the family of Sarah, 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

1.The Review process

1.1 This review is into the death of Sarah, a 44-year-old female, who was found, having taken her own life at her home in Cambridge, by her partner, Michael. The Police have investigated the circumstances and submitted a report to the Coroner with a finding that the death was non-suspicious and believed to be suicide by way of hanging.

Due to a recorded history of domestic abuse where Sarah was recorded as the victim on multiple occasions, Cambridgeshire Police referred the matter to Cambridge CSP for consideration of a DHR.

1.2 A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1a. Fatal pressure on neck

There were no injuries or trauma to the deceased indicating or suggesting any third-party involvement in the death. Toxicology tests show significant high levels of alcohol were present in the blood and urine, cocaine was also present. Therefore, the deceased was under the influence of alcohol and cocaine at the time of death.

The coroner has suspended the coronial investigation pending the outcome of this review.

1.3 A decision was made by the Cambridge CSP and partners including voluntary and non-voluntary sector, to undertake a Domestic Homicide Review as it was found that the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.4 In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Sarah's death).

Sarah – A 44-year-old white British female.

Leon – Estranged husband of Sarah. A 43-year-old white British male.

Daniel – Eldest son of Sarah and Leon. A 21-year-old white British male. Suffers from epilepsy and Cerebral Palsy.

Anton – Son of Sarah and Leon. A 19-year-old white British male.

Sophie – Daughter of Sarah and Leon. A 13-year-old white British female.

Lucas – Youngest son of Sarah and Leon. A 7-year-old white British child.

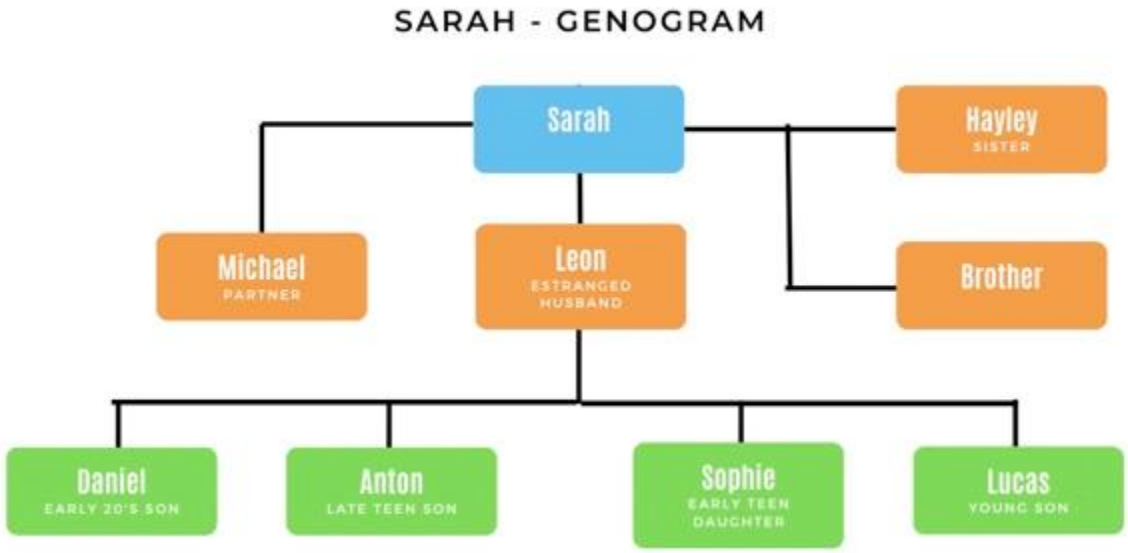
Hayley – Younger sister of Sarah.

Debbie – Close friend of Sarah.

Michael – Partner of Sarah. A 41-year-old white British male.

Address – Name of area provided as Cambridge

All pseudonyms were chosen by the author at random and verified by Hayley and Leon, as was their preference.



1.5 Hayley and Leon both attended the second panel meeting via teams with advocacy present. They have both received a copy of the report and had the opportunity to review the content. They are happy that it portrays Sarah's life and the multi-complex needs that she and their family faced. They are pleased with the conclusion and the recommendations. There are certain parts of reports from agencies that they do not believe are accurate accounts of what took place in their opinion.

1.6 IMRs were requested from the agencies who had significant communication with Sarah, Leon or their children or held significant and relevant information about them. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including the safeguarding of children and child to parent abuse. This was to assist in analysing the depth of knowledge and support already in existence and being required in the Cambridge area.

2. 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.

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT)	IMR, Panel member

Cambridge Community Safety Partnership	Oversight
Cambridgeshire County Council IDVA Service	Summary report, Panel member
Cambridge and Peterborough MARAC	Summary report, Panel member
Cambridgeshire Public Health	Panel member
NW Anglia NHS Foundation Trust	Panel member
East of England Ambulance service NHS trust	Panel member
Cambridgeshire and Peterborough DASV Partnership	Co-ordination, Panel member
NHS Cambs and Peterborough Primary Care Integrated Care Board	Summary report, Panel member
Cambridgeshire Women's Aid	Scoping, Panel member
Change Grow Live - CGL	IMR, Panel member
Cambridgeshire Children's Social Care - CSC	IMR, Panel member
Cambridgeshire Adult Social Care - ASC	IMR, Panel member
Department of Works and Pensions - DWP	Scoping, Panel member
Cambridgeshire Education	Information from schools
Cambridge City Council	Scoping, Panel member

3. 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 Lead	Cambridgeshire Police
Angie Stewart	Chief Executive Officer	Cambridge Women's Aid
Emma Foley	Peterborough City Hospital – Adult Safeguarding Practitioner	NW Anglian NHS Foundation Trust
Linda Coultrup	GP practice representative. Named Nurse Safeguarding Adults Primary Care	Cambridgeshire & Peterborough Integrated Care Board (ICB)
Keryn Jalli	Community Safety Manager	Cambridge City Council
Rachel Robertson	Advanced Practitioner Safeguarding and Domestic Abuse Lead/AMHP	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Deirdre Reed	Operational Manager/MARAC Chair	Cambridgeshire County Council
Lisa Barraclough	Advanced Customer Support Senior Leader	Department of Works and Pensions (DWP)

Rebecca D'Cruze	Ambulance service strategic safeguarding specialist	East of England Ambulance service NHS trust
Jim Bambridge (2nd panel meeting onwards)	MCU Review officer	Cambridgeshire Police
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Claire Saggiorato	Designated Nurse Safeguarding Children	NHS Cambridgeshire and Peterborough Integrated Care Board

3.2 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. Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred with the providing of information, particularly with CPFT due to capacity issues and the wealth of information held by agencies requiring research. There was also a delay to ensure the family were content with the report prior to submission and changes were made to accommodate this.

The completed report was handed to the Cambridge Community Safety Partnership on 2ND November 2023.

4. Chair and Author of the review

4.1 - 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 since January 2021, 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 DHRs 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.

5. Terms of Reference

5.1 - Terms of reference were discussed and agreed upon during the first panel meeting on 31st March 2023.

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

1) Domestic abuse in any form had been the causation or a contributory factor to Sarah taking her own life
2) The effectiveness and response of agencies in a collaborative approach to supporting those with multi-complex needs that include DA
3) The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home
4) Services and agencies provisions to suicide and those contemplating taking their own life within the Cambridgeshire area

It was agreed by the panel that the scoping dates would take place from January 2017 until the date of Sarah's death. This would maintain focus on the factors involved in Sarah's life and pressures she may have faced leading up to this time.

5.2 - The full Terms of Reference are below:

- The date parameters under consideration are from January 2017 up to the date of death of Sarah.
- 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 Sarah.
- 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, including voice of the child.
- Where we know children are victims of domestic abuse, what protections and support are provided to those children?
- How effectively do agencies listen to the voice of the child?
- What are the provisions and support in the event of a parental suicide due to DA?
- Do agencies have a domestic abuse policy which includes MARAC? Were agency policies abided by in this case?
- How effective was MARAC in increasing safety for Sarah and her children?
- Do services consider people holistically rather than just address what that agency provides? Did agencies consider Sarah's other needs whilst working with her?
- How effective are agencies within Cambridgeshire on a collaborative approach to supporting those who are vulnerable and require safeguarding, particularly with multi-complex needs including:
    - Fostering relationships
    - Utilising existing multi-agency meetings for planning
    - Improving communication between agencies
- Establish accessibility of services for those contemplating suicide and whether training for professionals has been received in relation to the effects DA may have towards this.
- How effective was the Criminal Justice system in responding to domestic abuse for this family?
- Where families are experiencing children causing harm to parents, what services are in place to support them? Are there additional support carers where this behaviour

occurs? Were these services offered/provided in the case of Sarah and were her multi-complex needs and vulnerability taken into consideration.

- Did agency intervention identify or consider Sarah's protected characteristics. Were any of the other protected characteristics relevant in this case?
- Was Sarah assessed as vulnerable in her own right?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review

6. Summary chronology

6.1 Sarah was one of three siblings. During her childhood years, she witnessed domestic abuse and violence on her mother from several partners and her mother's alcoholism. She suffered abuse from her stepdad with her windows being nailed shut and left out on the doorstep in the rain after school. Her mum would leave him and then go back to him time and again. When Sarah was twelve years old, she suffered sexual abuse from her older cousin who used to come and stay at weekends. She protected her younger sister, Hayley, by making her mum send her to stay with her Dad but this did not afford any protection to herself.

When Sarah was 20 years old. She met Leon and they married on her 21st birthday. She fell pregnant in 2001 and had a son, Daniel, who was diagnosed with Cerebral Palsy. Sarah is described by Leon as an amazing, loving mother who gave up her hairdressing job to look after him. Anton was born a couple of years later and although there was concern of Daniel's health, there were no issues and had a good marriage according to both Leon and Hayley.

6.2 Daniel had his first seizure when he was about 8 or 9 years old and Sarah and Leon had a break in their marriage after their daughter, Sophie was born. After they had reconciled, they had another son, Lucas in 2015. Sarah seemed happy for a while as she loved being a mum again but then started to have affairs. She had not self-harmed in a long time or had any suicidal tendencies.

Children's services first became involved with the family in 2013 with Early Help. In 2017, they made a home visit as Anton was not at school and was found to be looking after Lucas at 14 years old. A family worker was allocated as they informed them of the difficulties that they were having with the behaviour and demands of Daniel. Later that year, Sarah lost her mother through suicide by an overdose of beta blockers and took it really badly, not being able to accept it. Her mental health began to deteriorate and she was drinking a lot more and would be horrible to all her family members apart from the two youngest children when she was drunk. She started to cut herself which Hayley knew was a cry for help as she couldn't cope.

2019 - Sarah was referred to the Liaison Psychiatry Service following an overdose. Referrals were made to CGL and CSC for the family to be assessed for respite. Sarah spoke wit them and outlined her main issue was support for her son. She declined a routine assessment by the Cambs North assessment team.

CPFT received eleven third party referrals regarding Damage caused by Daniel and concern for neglect of the children due to Sarah's overdose.

A domestic incident occurred between Leon and Sarah whilst three of the children were in the home. Police were contacted but no action taken as Leon went to stay elsewhere for 24hours.

Daniel was referred to the Physical Disability team but there were significant delays in a social care assessment being completed. Daniel was eventually seen in the October where a plan was put in place for a further carers conversation and assessment. During the visit, Daniel became increasingly angry and following the SW leaving, Daniel became violent causing damage and had a seizure prior to police arrival.

Further incidents at home involving Daniel were attended and recorded by the Police. Daniel was arrested on one occasion for criminal damage and assault on Lucas but no further action was taken as Sarah would not support a prosecution as she did not want him criminalised. No Child safeguarding referrals were submitted.

Sarah had self-referred to CGL for support with reducing her alcohol but after a few months, felt that she no longer required support and withdrew.

2020 - A number of attendances by the Police were recorded and, in the August, it was noted that there had been 15 incidents of DA in the past twelve months including three in the past 90 days. The majority of these were in relation to Daniel either damaging or assaulting someone in the household. They continued after this and although he was arrested in the October, no further action was taken as it was deemed it would not be in the public interest to proceed due to his medical condition although expert medical advice on this had not been sought.

Daniel was admitted to hospital for his seizure and then discharged back to Sarah.

Sarah's SW changed back to Daniel's SW as it was deemed no longer appropriate to have a separate one. Daniel was not taking his medication and a conversation took place over the phone with Sarah over the risk Daniel poses and what support he needed. A formal carers assessment took place over the phone during which she stated that she did not really wish to speak to Talking Therapies. She agreed to be put in touch with Caring Together.

Daniel and Leon moved out and were eventually provided with temporary accommodation. Sarah disclosed that she was finding things overwhelming and took an overdose in the July.

Daniel's case was closed and re-opened as he had injured Leon and continued to visit Sarah's address where the police were called.

2021 - Shortly after the New year, in the middle of the night, Sarah self-harmed, cutting her neck and Leon was called by Anton to come and help. Sophie rang the police and was comforting Lucas. On police arrival, Sarah agreed to go to the hospital voluntarily as she was making suicidal comments and was intoxicated but following her attempting to strike Leon and then striking a police officer in the chest twice with an open palm, she was arrested. Whilst in custody, she was seen by LaDS. An Out of Court Disposal to attend CGL was given.

Sarah had two more incidents where she self-harmed and took an overdose during that year. A MARAC referral was made by the police in relation to the incident between Leon and Sarah and the accumulation of incidents at the address. However, the MARAC was ineffective in discussing the incidents surrounding Daniel. In the June, Daniel was again arrested following a common assault on Leon and the CPS requested further actions that the Police did not complete prior to closing the investigation.

Near to the end of the year, a strategy meeting was held in relation to Sophie and Lucas in which the outcome was single agency s.47 for Social Care. This was due to the alcohol abuse and self-harming by Sarah that was being witnessed by them and the behaviour of Daniel still posing a risk. CSC were informed of an incident where Daniel had locked Lucas in the house with him, making threats and horrifying him.

Daniel had been referred to the GP by both parents but there was no progress.

An Initial Child Protection Conference was held in which Sarah was to get support from mental health and CGL but reported some months later that she had still not heard anything.

CGL initially worked with Sarah from May that year and she managed to reduce her alcohol intake but began to miss appointments and self-harmed in the August.

Sarah was taken to hospital in November following her self-harming and CPFT were made aware but Sarah had stated that she did not want help from the mental health team.

Sophie began receiving support from the Acorn Project.

2022 - At the beginning of the year, Daniel and Anton were living with Leon and Sophie and Lucas were living with Sarah. Anton would stay at Sarah's occasionally.

In April, Anton called the emergency services as Sarah was drunk and suicidal. She had razor blades and a broken glass had been taken from her. Lucas was at home as this was the middle of the night.

A strategy meeting took place and it was agreed that Anton and Daniel would not stay over as they had been causing damage. Leon reported to CSC that Sarah had a number of boyfriends at the house and was frequently intoxicated with the children upstairs. Sarah admitted self-harming but also showed that she was black and blue from her boyfriend (identity not known). It was decided that unannounced visits would take place by CSC.

The family were aware that Sarah was having a relationship with Michael in the August. During this month, Sarah self-harmed. A Social Worker completed an unannounced visit but did not take Michael's details or discuss any concerns at the request of Sarah.

In October, the Police were called following a serious assault on Sarah by Michael in which Sarah was hospitalised and Lucas, who had been treated badly by Michael was taken by the Police for his own safety.

Following this, an ICPC determined that the children should live with Leon.

No further action was taken with Michael following his arrest as Sarah did not wish to pursue the complaint.

A welfare check was conducted by Police at the request of CGL in November as they could not contact Sarah and she was at home with Michael and stated her phone had been broken.

2023 - The Police were called by Leon at the start of the year as Sarah had been outside of his address upset having not seen the children over Christmas and due to comments made to him, he was concerned about her when she left the location. The Police attended her home address where they spoke to Sarah who was tearful and making suicidal comments but they left the location when she politely asked them to.

Later the same day, Sarah was found at her home address by Michael where she had hung herself and pronounced deceased by attending paramedics.

6.3 Voice of the Child

Leon kindly gave permission for both Sophie and Lucas to provide their thoughts on what had happened, so that the voice of the child could be heard within this review.

6.4 Words of Sophie

When my mum was little, she went through what I went through. Like what I have but a lot worse, her mum was an alcoholic and died when I was 8. She went through a lot, her babysitters were bad to her, she was traumatised when she was very little. She told me she had no help, she dealt with all of her demons and problems on her own. I think she started self-harming and drinking after my nan passed.

When I was younger something had happened to mum, she had hurt herself, and the police and ambulance came. The ambulance took her off, but the police were still there. It had happened before, the police never seemed to want to help my mum and the ambulance would just come and sometimes take mum to hospital but then she'd be let go when she said she was "fine". They never listened to my dad about how bad my mum was.
They, the police, spoke to me and Lucas in my bedroom and asked me if there 'was anything they could do to help me?', I asked them for help and someone to talk to, and they said yes that will be no problem, but they never did anything. I was 10 or 11 then and nothing happened they didn't help me. It took a lot of courage for me to speak up as I had started to realise how bad things were getting. This has affected me even now as I don't want to speak

to anyone. A lot of people are focused on getting me someone to talk to but it's too late, it happened. I dealt with it on my own, no one got me the support when I needed the help.

I think that not all kids will ask for help as they are scared and even if parents say the kid is fine, kids should have someone to talk to. The police should offer a chance for kids to talk to someone without kids having to ask. I understand that it is tricky when the police and ambulance come into a house, and you have a male and female telling you different stories, but they always steer towards the female if she's distraught. The kids are not going to speak the truth at that time as they do not want to take sides, but I feel the police should investigate more before they make any decisions and just leave.

Experience:
I think Michael should be arrested as he hit my mum - he hit my mum in front of Lucas and that alone is child endangerment. I think that a 7-year-old boy at the time shouldn't have seen that and for my brother to then see Michael back after all the things he saw him do is almost like it's normal for a man to beat a woman. My brother has been traumatised by Michael and has panic attacks when he sees people in hi vis work clothes and he also has nightmares.

I had to defend my mum to Michael, I was 13 years old and no one would listen. I had to tell him to get out of our house and he kept saying 'Sophie, let me in, your mums crazy'. He tried to make out that my mum had lost it. He's a bad man, he's just a bad man. He shouted at mum a lot. I don't want him to be near me or my family again. I don't want to see him ever again. He does drugs and he did it in my house.

Michael would go through my mum's phone all the time but never let mum go through his phone. If mum ever said no, Michael would start an argument with mum and call her names or say she is hiding something. He wasn't helpful, he played with her mind a lot knew she was vulnerable depressed and suicidal. Michael would say 'no one is here for you, your family are here for you only me', so mum would rely on him.
Michael would tell my mum he didn't like mums' friend, so this stopped mum seeing them. Michael made mum believe my auntie didn't like her, this impacted on mums' relationship with everyone and attending my little cousins party, which she wouldn't have missed before! They were very close, she used to do everything with her but then just stopped. I have pictures of my mum and cousin together, so when she grows up, I can tell her all about my mum and all the memories of them together!

Michael used to do things to make mum believe she was going crazy like hide the house keys in shoes so that we couldn't go out, but mum knew she hadn't put them there, but he made mum believe she had. One time mums phone went missing and me, my mum and Lucas looked everywhere for it but it definitely was not in the house. Then when we came home the next day it was in mum's bedroom on the side, like it had always been there, but it hadn't!

One time mum and Michael were arguing, and mum asked him to leave but he refused to so mum throw his wallet outside in the bush. Michael got really mad and made mum go and look for it but she couldn't find it. I was sat on the stairs while they were outside with the door open, and I could hear Michael shouting at mum and mum was crying. Then she came running in the house screaming that Michael had just grabbed her neck to push her.

Michael used to not like mum drinking red wine as she would defend herself against him and he would tell her he was going to leave. If he ever disrespected her and she had drunk red wine, she was able to stick up for herself and had more confidence to kick him out. She would turn on a lot of people when she had red wine, including me and my aunty, but he mostly didn't like it when she turned on him and stood up to him, so he made mum stop drinking red wine as she wouldn't defend herself when he was horrible to her and made her drink white wine because then she wouldn't stick up for herself. White wine wouldn't make her drunk. If she didn't drink, she said her head would be too loud and drinking stops this but then if she did, she would get too drunk and self-harm. I don't think he wanted to help her, if he wanted to, he would have helped her stop drinking in general and not give her some other wine.

Mum said if we were taken away, she would have fought everything in her power to have us back, to have me back. I know full well that she would. But Michael, he would say 'no one else likes you' and I think he would have said to her I didn't want to be there and told her things like 'why do you think they were taken away from you in the first place'. Because she was very protective of me, I think she sided with Michael because I feel Michael would question her if she didn't. Mum used to text me saying 'you are in a better place at dads', and when I went to see her near Christmas, she said 'no one else is ever here for me, everyone else has left me'. When I asked her about my aunt, she said she was angry at her. A lot of the things she said you could tell came from him.

6.5 Experiences with Agencies:
Mum told me once said she was going to go into a detox (I thought she meant Botox!), but that she had to be tested to see if she needed one, to see if her liver was bad. I was happy with this as I thought she was going to finally get better and stop drinking. I kept asking her everyday had the tests come back and when they did, they said her liver was fine – but I had seen her drinking 2 or 3 bottles a night. I was gutted as I really thought she was going to get help to stop drinking and everything was going to be alright, more normal, and mum wouldn't be drinking every night. They didn't offer anything else; I was frustrated as my mum needed the help. I don't know who it was through, but she did it and asked for help and mum never liked asking for help!

- To the Social services, police and ambulance: I didn't want to get taken away from my mum obviously but there were so many signs that my mum needed help. Like my mum got taken to the hospital like 15-16 times and I don't think anyone did anything about it.

- To the Hospital: If someone is getting brought to the hospital for the same reasons time and time again someone should have done something. I wouldn't want my mum to get taken away and locked in the hospital but if it would have made her better than she maybe would have been happy now and not where she is. There were so many signs and no one listened or took it serious like they should have.
- To Everyone involved: I just want them to know there were a lot of things they could do better. I know I keep repeating it but they could have done more to help my mum. I don't want them to feel bad because obviously there was other problems in the house. But if someone is going to hospital that many times they should investigate more and see there is problems and help. No child should have to see scars on their mum like it's normal or their house covered in blood and no one help us!

6.6 - To Social services:
We had social services involved and every time something would happen and my mum would go to hospital they would come a few days after ask us a few questions involving "how are you" "how's school" and "what do you think about mums drinking" which are all questions obviously I'm not gonna be able to answer and you're asking me after my mums just nearly ended her life 'how am I' and I have to answer "oh yeah I'm fine" I'm a little girl who's scared confused and just wants her mum to get better and they didn't help me or my mum at all, they also looked for the wrong things with my mum one day Lucas had a bruise on his knee and one social worker asked "have you been a naughty boy and mummy have to discipline you" inferring that my mum abuses Lucas when she's never laid a hand on us. They knew why they were there because my mum was poorly and needed help, and so did we, and they didn't help my mum, and if you're not helping my mum, you're not helping me. They ignored all the signs they needed to listen to and when it came to something that wasn't even do to with the case such as a bruise on Lucas's knee when they should have been focusing on why my mum is going into hospital so much what's causing this and how can we help this family.

We had lots of different social workers. It always felt like they couldn't be bothered, I sometimes didn't speak to the social worker's whenever they came because they were useless and asked pointless questions like, 'am I ok?', of course I am going to say 'yes', what else could I say? and I knew they would just go away and do nothing as usual anyway. They never really knew what was happening. They were meant to know why they were there, but they never did anything. It felt like they didn't know anything about us. At the end of each visit with the social worker they would say 'don't worry we are going to help your mum' but I never saw that. I wanted to see physical change, if I don't see anything done then I'm not going to believe it.

When I did speak with one social worker, I can't remember their name I told them things that were not really bad things, and they went and told mum straight away and then mum got mad at me and told me not to say things but what I had said was not bad, so the social worker didn't need to tell my mum. (*The social never advised Sophie that it would need to be discussed if the social worker thought it was important/relevant).* I think social workers, before they say anything, they should explain what confidential things can be, no one said to me that it was going to be spread, I didn't know that I could tell them why I wanted to keep it between us.

A few times they said they would come (*to visit*) and never did, they said they would come and see me in school, which I have wanted them to do, they never did and they never explained why not. They sometimes came at bad times; we would be busy and I remember mum asking for them to change the time but they didn't say why not.
I hated having to come home to speak with them. Like if I had had a bad day, if I knew they were coming after school and I remembered they were coming, I dreaded it and it felt like a chore, as nothing would change. It was something I didn't want to do but I had to. It got to the point where I ended up 'just putting up with them' but I was always polite but felt bored with the visits and gave blank sort responses so they would leave. I feel mum felt the same she said 'I don't enjoy it either' but we had to. I never knew what they said to mum, but sometimes we would have to find the light of the visits and make jokes, I remember telling her about a visit with one social worker and how he took everything out of context and that

they ended up just being necessary. They never explained why they changed so much; some would say 'this was my last time seeing you' while others just left. Then you would start again.

Now I don't like social services, due to everything, since I was little, since they betrayed my trust. I've thought that 'they were bad people' in my head and always felt that way. Always felt they weren't helping my mum and focusing on taking me away. What annoyed me the most was having the same visit over and over again. They would take me up to my room and say, 'how are you feeling, what do you think about mums drinking and how was school'.

Recently, I got on more with F most because she came off more as friendly than as just a social worker. Instead of asking those questions she asked more personal questions about me and Lucas before asking about mum.

Views:
Mum was always protective of me when it came to men and stuff like that and she always told me that no matter what she would always believe me, if I ever was in a situation where someone (a man/boy) had hurt me or you know?
I don't want a man to do what he did to my mum and it to happen to another woman like it did my mum because of him. I know physically Michael didn't kill my mum but mentally he killed my mum. She's dead because of him.

Michael got very aggressive to mum and they all failed my mum. They failed her. I do believe my mum would be alive if people like the police and ambulance took the signs seriously and did something about it. Thats why people should be given support at a young age before it gets too bad that they start refusing help because of the trauma they went through as a kid.

I struggle to go out now, I used to be outgoing and always out and outgoing, but now I'm struggling with depression and anxiety. It just gets mentally exhausting. When my mum passed it was kinda like wanting to stay away from everyone and lock yourself away from reality. Then when you hear that your asked to speak to this person or that person, I want to do something for mum to help but sometimes, It doesn't feel real to hear back what I've shared, hearing it back its hard to hear as it feels it happened to someone else and you feel bad for that person, then it hits me that this is me and what I've been though.

6.7 Words of Lucas

Experience:
I saw it, Sophie didn't. I think it was school holidays as I had to spend a long time away from school. I saw Michael punch mummy in the face, we were at his house, and I was upstairs in Michael's room. I heard swearing from Michael, mummy was just shouting, like screams. Then Michael called my name, I went downstairs to see what was happening, Mummy was outside then, kicking his door to get in. Then I remember we went to mummy's friend's house as she put a plaster on mummy before we were going back home to mummy's house, then we went to mummy other friends house where the police came. I spoke to the police there and they asked me what happened. We went back to mummy house to get a coat, then they (police

officer) took me to the police office, I got to sit upfront and press the siren! I slept there for the whole night before dad picked me up.

I would hear Michael swears at mummy a lot. Heard arguments about Mummy getting some money from Michael, he would shout at her a lot and swear at her saying 'give me my f-ing money'. I was scared to talk about this before as I didn't want mummy to get in trouble for having the money and because I didn't understand what they were taking about.

There was other stuff, but I don't remember it all. Sophie does, I know she saw lots too.

Experience with Agencies:
To Social Services - The social workers would come to see us at mummy's house. When we were younger, I think we had a little time with them but when we were older, we had a few weeks with them. The one I remember before was call G and my recent one F. F was amazing. She would take us out to McDonalds and KFC, she took us places instead of just meeting us at the house, she actually played with Rosie (our dog), she would ask me questions about me, but I was ok to answer them.

The other ones just asked 'what do you think about that' it was always at home in the living room, it always took a long time and they never had anything to play with or do, it was very boring. I still don't know why they had to visit and I had to talk to them. They always said they were going to come to see me at school, but they never did, I told the chairperson when I met her once *(from the CP conference*) but they still didn't come.

It was normally dad who told me we had a new social worker; F was the only one who told me she was leaving. I was the last person to know what was happening which annoys me at times.

6.8 To School –
I have teachers at school and the room (*pastoral team*) to go to, they don't make me talk which I really like. I can do what I want and talk if I want and they have things to keep me busy! I talk better when I am busier. I feel safe there and have told them things before which made me sad or worried and they made sure I was ok. Mummy used to come into school too and talk to someone too.
I feel they were middle with helpful. I've had Bluesmile since year two. I didn't get told right away, mummy just said that 'there was a really nice lady coming to see you today'. R was really nice; I was happy to go and I still go now. I say she is my favourite teacher but I know now she is a therapist. I don't use her as a therapist but as a playtime friend, she has loads of cool stuff.

To Police –
The police boss was very nice, they brought my Nintendo switch with me when I had to go with them for me to play with. I waited there for hours and hours until dad came. I was ok though, I felt comfortable.

I asked what happened after once, no one told me what was happening, because I was little, so I didn't know after what happened. I wanted to know, for the police to come again and talk to me …… I don't know if I know what to ask them but I didn't see them again.

Views:
I remember how things were with my family, being happy and playing games with mummy. She was the best at winning games after me! We play games now about what mummy did and did not like and I joke to Sophie about me being her favourite. I have mums' funeral heart in my bedroom so its close. I have people I talk to but don't always remember, but I like knowing why they want to talk now, I can tell my dad things.

7. Key issues arising from the review

7.1 The effectiveness and response of collaborative working and communication when supporting a person with multi-complex needs.

Sarah had issues with her alcohol intake and self-harming from an early age but managed this during the pregnancy and early childhood of Daniel. These only manifested themselves as there became problems within her marriage and Daniels behaviour became progressively worse and difficult to manage. On each occasion that Sarah called the Police, she stressed to them that she could not cope and the reasons why yet no referrals were made in relation to substance abuse support at any time. Although consent is required, it does not appear that the question was asked in relation to mental health or alcohol referrals.

Daniel is the named suspect/offender in respect of 48 criminal allegations made against him by either Sarah or Leon and although a DASH was completed on the majority of incidents, none were graded high and a MARAC referral was only made after a supervisor reviewed the fact that there were 21 incidents over a short space of time and the incident that triggered the referral was one of self-harm. No referrals were made from any of these 21 incidents for domestic abuse support and there is no record of signposting. This impacted on the MARAC meeting where they did not consider the child to parent abuse. Also, awaiting 21 incidents is not compliant with the Safelives guidance of referrals.

Sarah asked for help and support with Daniel on numerous occasions and made it clear to CSC and CPFT that this caused her stress and she then resorted to alcohol abuse and self-harming as a coping mechanism. Daniel was a victim of being of the age where he was about to become an adult in relation to his age and records show that he fell within the gap of Children's services not progressing a long-term plan because of this and Adult Services would not begin a plan as he was not of age. Focus was on Sarah and Daniel's response, not the actual cause.

7.2 Lack of oversight of plans and actions that are implemented in multi-agency meetings for safeguarding

CPFT notes in November 2021 show a s47 single agency for the school nurse to consider a health assessment for Sophie and Lucas. Ten months on there was no evidence of a health assessment within Lucas or Sophies notes.

Lucas and Sophie were placed on a child protection plan in December 2021 for emotional harm and this was continued throughout the year 2022 with provisions and processes in place to safeguard them. The focus of attention was to be on reducing the risk to the children. However, these processes were not followed and an opportunity to risk assess Michael during an unannounced visit was missed due them not being followed and lack of supervisory oversight led to poor recording and no follow-up.

The drift of the Core Group and a lack of engagement during the latter stages of involvement due to worker turnover meant that there was little change to the perceived needs or meaningful exploration as to whether these changed over time.

During an Initial Child Protection conference (ICPC) in November 2021, it was agreed that Sarah would get MH support and support from CGL for her alcohol intake. Referrals were to be made. Sarah had not heard about either when she spoke to a social worker in May 2022 and they stated they would chase the referrals up.

CSC's response to all the information being received from the police was not robust enough to effect change earlier or more effectively. CSC did not appear to fully investigate who was living in the home with the children when it started to become clear that a partner (Michael) was living there, and a police check (which should be routine for adults living in a home with children on a CP plan) may have revealed a better indication of the potential risk Michael posed.

7.3 Services responses to those with Mental Health difficulties or contemplating suicide who are victims of domestic abuse

The Police were called to Sarah's home address on nine separate occasions in relation to Sarah's mental health. The ambulance service attended a number of these following self-harm and a big frustration for Leon was that when Sarah spoke to professionals, she was lucid and articulate, blaming her behaviour on alcohol when Leon had seen an 'out of control' person minutes earlier. Leon would be told that Sarah had capacity and as an adult, could choose whether to attend hospital, but the word capacity and the limitations of police powers within this area were not explained sufficiently and led to stress and the feeling that no-one was prepared to help.

Sarah had on-going mental health problems that were exacerbated by alcohol abuse. This area was focussed on with referrals to CGL and there does not appear to have been consideration by any agency as to whether the self-harming and alcohol abuse were due to

the core of the issue being domestic abuse and addressing assistance and support in this area to reduce the subsequent repercussions.

With over ten contacts with one of the CPFT provisions for mental health in a three-year period, Sarah was always discharged when medically fit with little follow-up and no long-term plan made. Guidance points to alcohol moderation before talking therapies can be undertaken is advised but both at times overshadow the domestic abuse which could be the cause of either and this was not explored.

Following the serious assault on Sarah in October 2022 by Michael where she sustained a head injury, Sarah had self-harm injuries which were not noticed by the staff at the hospital. Her sister Hayley rang the ward and voiced her concerns as she realised that this incident may be a trigger to suicidal tendencies as the children had been taken to Leon's, yet she was not spoken to by the mental health team prior to her being discharged.

8. Conclusions

8.1 Sarah grew up as a child witnessing violence and emotional abuse towards her mum from various partners through the years. She saw her mum turn to alcohol as a way to cope. Sarah was subjected to sexual abuse both in her early teens and shortly after her marriage. These adverse child experiences went on to affect Sarah's response to stress throughout her life when she felt unable to cope. Her sister, Hayley, tells how her body meant nothing to her and thought that sex would mean she was loved and their upbringing led to Sarah being needy and not strong.

Friends and family speak of her as funny, loving and a person who has great humility. She showed protectiveness of others throughout her life, over her sibling when she was younger and then over her children, constantly trying to prevent Daniel from a criminal conviction even though this would be to her detriment with continued abuse.

As Daniel grew older and his behaviour became more demanding, Sarah turned to alcohol as a coping mechanism as she had done in her early years before he was born. Sarah asked for help from Children's Services, CPFT, The Police and CGL with them having full knowledge of incidents in the home involving Daniel and although a DASH was completed by the Police on most occasions, no agency specifically recognised this as abuse from a child turning adult to their parent and the only MARAC referral by any agency was made by the Police after 21 incidents had occurred. No Dash, despite the accumulation of incidents was graded as a high and Safelives guidance in relation to referring to MARAC for repeat incidents was disregarded. Daniel's behaviour was violent in that he would cause damage around the house, cause fear in those present, including his younger siblings and there was an occasion that Sarah discloses where he had thrown hot water towards her.

8.2 Although no physical abuse occurred, the emotional abuse had a detrimental effect on Sarah. There is a direct correlation between the incidents attended by the Police increasing and then the re-occurrence of self-harming and hospital attendances by Sarah who

admitted her actions were due to the stress she was under from Daniel's abuse and that she couldn't cope. However, the domestic abuse was not addressed. This was not seen by any agency as the core issue that caused Sarah to have to utilise coping mechanisms. Had domestic abuse been addressed, supported and adequately safeguarded, then this could have reduced her stress and potentially minimised her mental health issues and alcohol abuse.

Communication between agencies was poor at times with Daniel falling into a gap between CSC and ASC due to his age, which meant that neither he, nor his parents received the support that they should have. Records were made in his name with no separate file to identify the needs of Sarah or Leon. They were not recognised as carers and therefore did not have additional support for this area and would not then have had the additional risks identified that carers have in relation to caring for someone, whether that be their child or not.

CGL showed good communication with other agencies and good follow up welfare checks when an appointment was not made and were the only agency to build any kind of rapport with Sarah, even though help was rejected frequently as with other agencies. Other agencies did not utilise the rapport with the CGL to foster their own relationship. An example of this was when Sarah eventually built-up the courage to self-refer to PWS, a CPFT primary care provision and received a letter in response informing her they were not appropriate to assist her as her needs were too complex and to refer herself to CGL when this could have been done on her behalf, as there was a risk that she may not have had the strength to do this herself.

Agencies had short periods of involvement with Sarah before closing their files, meaning that there tended to be a short-term pattern of involvement and closure which tended to offer the same solutions to what appear to be the same issues, so less opportunity for understanding the family in depth and in particular why Sarah continued on the cycle of drinking and self-harm and seemed unable to engage with the support identified with and for her.

Sophie and Lucas were placed on a Child Protection Plan for emotional harm to reduce this risk, however, the family's needs as a whole were not considered and there was not a holistic approach by multiple agencies towards this. Anton is not mentioned on any records as having been considered, the MARAC meeting that took place was ineffective with only two actions and the core group for the child protection plan lacked pace and progression.

The schools of both Sophie and Lucas provided good support and assistance for both the children and gained the trust of the parents so that they had a good insight into the situation at home and made appropriate referrals and shared information when necessary.

Following an incident where Sarah had self-harmed and then disclosed that she had been assaulted by Leon, who had been restraining her at the request of Anton, CPFT correctly referred her based on her disclosure to the hospital IDVA. However, this was only completed on one occasion following a reported physical assault.

CSC's response to all the information being received from the police was not robust enough to effect change earlier or more effectively. CSC did not fully investigate who was living in the home with the children when it started to become clear that a partner (Michael) was living there, and a police check (which should be routine for adults living in a home with children on a CP plan) may have revealed a better indication of the potential risk Michael posed.

It is known that Sophie and Lucas witnessed a number of incidents of domestic abuse by their elder brother, self-harm by their mother and both saw and received abuse from Michael with Sophie ringing the Police in the middle of the night whilst her mum was self-harming. Lucas has hid in the wardrobe and also been thrown out of the house by Michael with no shoes on. Anton argued with Sarah's male friends who attended the house and even rang the Police to ask for advise which is an example of how this affected him.

8.3 Michael immediately started isolating Sarah from her family and friends from the beginning of their relationship. He was controlling and coercive over her, tracking her movements, making her take drugs for the purpose of sexually abusing her and gas-lighting her, calling her names, putting her down and behaviour witnessed and recognised by Sophie as gaslighting by hiding her keys and making her question herself. Sarah's self-confidence was fragile throughout her life and Michael exploited that as a means of control, telling her that her family did not love her and she wouldn't get her children back.

Following the violent assault on Sarah from Michael, she was referred to the MARAC even though the DASH was still not graded as high. Although this is good practice, again, this is an example of the identification and action following violence and physical abuse but causes concern over the identification, recognition and response to emotional and psychological abuse.

It is accepted that Sarah self-harmed at different stages of her life but her family state that these were cries for help and not attempts to take her own life as you could tell by her response on one occasion when she knew she had gone too far and hurt herself severely. Sarah also re-iterated throughout those last years that she would never leave her children the way her own mum did.

Hayley makes a poignant remark that the emotional abuse was far more damaging to Sarah than the physical abuse and the isolation from her family and friends that Michael caused and initiated, the children moving to Leon's and Michael's constant torment of Sarah that she would never get her children back and that her family did not love her, knowing that to be loved and have her children were the most important things to her, will have caused irreparable psychological damage and shows a sinister exploitation of her vulnerability.

It is accepted that when Sarah had been drinking alcohol, she could be a different person and records show that Sarah withdrew from CGL support over the Christmas of 2022 which

would have been an emotional time for her and Michael utilised both the alcohol and drugs to maintain that control and isolation with friends not asking anything poignant about her relationship over text or phone in order to minimise her risk as they were aware he monitored her phone, iPad and social media, which eradicated an avenue of support that Sarah had leaned on previously.

Hayley, Debbie and Sophie all state that they believe the abuse by Michael on Sarah was the cause of her finally taking her own life. Hayley summed this up by saying that "Sarah always had the gun but Michael provided the bullets" and feels that Michael's abuse of Sarah was 'the final nail in the coffin.'

The panel concur with this sentiment and conclude that domestic abuse was a contributory factor in Sarah sadly taking her own life.

9. Lessons to be learnt

9.1 Lack of continuity in assigned Social Worker causes additional stress and frustration

The Head of Safeguarding from Sophie's school commented on the fact that they had recorded six different social workers in a calendar year assigned to Sarah's family and the fact that this led them to losing their trust in the service as they didn't feel valued. It prevents relationship building, rapport and trust and doesn't provide consistency and in-depth knowledge of the whole situation.

CSC have acknowledged that due to the lack of permanent staff, they have to utilise agency staff and have a high turnover of personnel which has caused issues in a lack of knowledge of the history when they visit the family. Poor recording of information has been identified in this review which prevents an informed risk assessment and comparison and raises a question into the adequacy/process of supervision and oversight.

The comments by Sophie in relation to Voice of the child also evidence a lack of trust in speaking open and honestly with a social worker when they have only just met them and know there will be a different one on the next occasion.

9.2 The identification of child to parent abuse and the collaborative working that is required

This review outlines the number of incidents attended at the home address of Sarah where Daniel had either damaged property or was being aggressive and the number of times that Sarah asked for help and told professionals that she was afraid of him. There were a number of times when positive action was not taken and no specific MARAC referrals relating to this particular abuse. When mentioned at the MARAC, it was not discussed. A Dash risk assessment was completed for the majority of incidents but the mash did not identify this as an issue on secondary review.

When Sarah asked Children's Services for help with Daniel as she couldn't cope, she was informed that there was no time for an assessment as he was four months away from becoming an adult yet wouldn't be able to be assessed as an adult until he reached that age. Sarah was initially provided with a different Social worker but was still not assessed as an adult needing help in her own right. Communication between Children's Services and Adult Services was poor and improved working together could have assisted the transition of the ages to obtain the support that was required.

Also, the domestic abuse was not recognised by Children's Services as it was overshadowed by Daniel's medical condition on which they focussed their response.

9.3 The recognition of the Voice of the child in domestic abuse cases

The Voice of the child is known by all agencies but it is not clear whether all practitioners understand the extent of the considerations that they should take into account.

The Police response was inconsistent when attending incidents in both speaking with the children present and the subsequent referrals thereafter. When they were omitted, these were not identified by the MASH which is the secondary review of the DASH forms which were completed and would have identified children in the home.

Although it is recorded by Children's Services that there was a risk to Sophie and Lucas with Daniel in the home, it was not recognised as domestic abuse and any specific support they may require in direct relation to this, nor was this considered at the MARAC.

CPFT received notifications of the incidents and also Sarah directly informed them of the fact that her stress levels and mental health difficulties were due to the abuse she received from Daniel, but this was not always responded to and the children within the home were not taken into account, even though at least two complex factors had been identified.

There is currently an ongoing programme of work by Cambridgeshire Public Health regarding support for Children and Young Persons who have been bereaved by suicide with one strand being a booklet containing information and pathways for support. Consideration is being made to disseminating this widely with all schools. This is good practice and has been encouraged by the DHR panel.

11.Recommendations

National

There were no National recommendations from this review.

Local

1. **CSC to implement a staffing strategy to ensure those with multi-complex needs are allocated a permanent member of staff.**
   This will provide consistency for families and a historical footprint of knowledge to provide a holistic understanding of their needs, building trust in the relationship to be more effective in support.

2. **DASV within Cambridgeshire to commission Safelives to complete an independent review of MARAC processes, policies and working practices in line with their guidance.**
   This will identify good practice and also areas that may need change or gaps that require addressing to ensure it provides representation from all relevant agencies, decision making and actions are applicable and accountable and it ensures that sufficient safeguarding measures have been met for the victim.

3. **In all cases of suicide reported to Cambridgeshire Constabulary, a Detective Inspector (DI) will be responsible for updating families and being their Single Point of Contact (SPOC), this will ordinarily be the DI who is the Sudden Death SPOC for North or South of the county respectively.**
   This will ensure that families are kept up to date following the death of a loved one in the case of DHRs including suicides when an FLO may have not been assigned. This is in direct response to observations from not just Sarah's family, but also found in previous DHRs.

4. **Cambridgeshire Police to conduct a review of the processes within the Out of Court Disposal Team to ensure effectiveness and accuracy including:**
   - **Recording processes.**
   - **Additional scrutiny prior to closure**
   - **Communication with Liaison and Diversionary Service (LADs)**
   - **Obtaining specialist advice when dealing with Domestic Abuse**

   This will ensure improved recording and a review process on occasions when the conditions are not complied with and eradicate omissions. It will provide accuracy to PNC records.

5. **The refreshed DA strategy for CSC to be signed off and circulated to all staff, with a communication package with a focus on the role of MARAC, IDVAs and the agreed practice around child to parent violence.**
   This will provide renewed guidance and training input on the areas identified within this report that provided learning and reflective points from this review.

6. **CSC to ensure that policies for supervision and management oversight for both individual cases and members of staff are adhered to.**
   This will ensure timely recognition of any omissions within recording, regular reviews of cases and safeguarding measures to ensure they are appropriate and current and identify any good practice or learning in staff performance.

7. **Adult Social Care and Children's Social Care to promote collaborated working in cases of child to parent abuse when the person who is alleged to be causing harm also has care and support needs.**
   This will provide a holistic approach and ensure all individuals within the family's needs are met and supported, particularly in those cases where the child is approaching adult age.

8. **CSC to give consideration on open cases as to what support parents might need in the event of a child being removed (either through court proceedings or by a parent with care exercising their PR) and for families when a parent takes their life.**
   This will ensure the whole family's needs are met and supported and prevent solitary focus on the initial core reason for referral, providing a holistic approach.

9. **CSC to refresh practice guidance around assessments, ensuring workers gather evidence and exercise professional curiosity around parental self-reporting.**
   This will ensure that an accurate picture of the family's needs can be gained and the right levels of support be put in place.

10. **DASV Strategic board to review funding streams and a possible trial of an IDVA attending repeat domestic Abuse locations alongside the Police and the feasibility.**
    This would provide advocacy and an opportunity to build a rapport from the outset of Police attendance when it is identified that there is a repeat victim and they may not respond to authorities in the same relationship trust manner.

11. **ASC to undertake a s42 enquiry with discretionary powers when it is identified that there is significant ongoing risk to either a carer or someone being cared for and they are not engaging with services.**
    This is to increase the identification of carers within a family unit and ensure that the risk assessment considers all facets of the family's stresses and risks. This will also provide additional support where needed which may not have been available otherwise.

12. **Cambridgeshire Police to implement the process that all officers delivering a sympathetic message are aware of the Lifecraft service and are able to refer onward with consent. Material is to be left with the family on all occasions outlining the service and support.**

    This will assist families who may not be in the right frame of mind to either take in information at that time or are not in the right place to receive

13. **Ensure frontline professionals responding to incidents involving vulnerable people are aware of the continuing risk of suicide in those who have previously attempted suicide, self-harmed, or spoken of suicide.**

    There were several comments in the IMRs that although Sarah had previously attempted suicide or was currently speaking of suicide, she was deemed to not be at immediate risk. However, research shows that a previous suicide attempt is a significant risk factor for future suicide attempts, even after several years. In addition, there can sometimes be a mistaken belief that those who talk about wanting to end their life are doing so to seek help or attention and won't go on to take their life – this is not the case and every mention of suicidal behaviour should be taken seriously.

14. **All professionals are able to access training and to be aware of resources available to support those subjected to Child to Parent Abuse, regardless of the age of their "child", with any local agency domestic abuse policies to include the issue of child to parent abuse.**

    This has been identified as an area in which Adult Social Care need to be more informed in order to respond and support appropriately.

15. **Signposting Support: Where a person is seen by a CPFT service and they are then signposted to self-refer to another service within or external to CPFT, support should be offered to assist in making that new self-referral to ensure the person has the support and encouragement they need.**

    This will improve the likelihood of the person self-referring for appropriate treatment and support and improve overall outcomes for the person.

16. **Assessment documentation: Where a person is assessed or triaged by CPFT, the assessment documentation should include sufficient prompts and plans for safeguarding adults, children and young people and domestic abuse.**

    This will ensure improved identification of domestic abuse and safeguarding and ensure referrals to safeguarding and/or domestic abuse services feature more explicitly within health plans

17. **Referrals to MARAC for numerous incidents of DA: CPFT will include in their DA Policy and Standard Operating Procedures that where a DASH has been completed by CPFT staff but scores below the MARAC threshold of 17 and above, but there have been 3 incidents of DA in 12 months or less, and there is imminent and significant risk, an automatic referral to MARAC should be made on professional judgement.**

    This will ensure that cases such as Sarah's are heard at MARAC sooner, information is appropriately shared and safety planning and support is discussed.

18. **CPFT staff working in general hospitals: CPFT will amend the Standard Operating Procedures (SOP) for CPFT staff on Honorary Contracts and staff working on an 'on-call' basis working within general hospitals to ensure greater clarity of responsibilities, recording systems and referrals in relation to safeguarding adults, safeguarding children and young people, and domestic abuse.**

    This will ensure greater consistency and best practice in response to safeguarding and domestic abuse.

Appendix A

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CSP: Community Safety Partnership

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

EH: Early Help

GP: General Practitioner

ICB: Integrated Care Board

ICPC: Initial Child Protection Conference

IDVA: Independent Domestic Violence Advisor

IMHT: Integrated Mental Health Team (Police)

IMR: Individual Management Review

MCU: Major Crime Unit

NFA: No Further Action

MASH: Multi Agency Safeguarding Hub

OOCD: Out of Court Disposal