Executive Summary Report – Gloria

Cherryl Henry-Leach, Independent Chair

Date review completed 18th August 2025

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Contents

Family Tributes to Gloria

"Gloria had a wry sense of humour, and this came to the fore when she was happy.

"She was happiest when with him, and her marriage to him was a source of contentment for her.

"She was intelligent and enjoyed reading to enhance her knowledge. She found, in him, her intellectual counterpart.

"Gloria is missed."

1. Review Process

1.1 This summary outlines the process undertaken by the South Cambridgeshire Community Safety Partnership domestic homicide review panel in reviewing the homicide of Gloria, who was a resident in their area. The Review Panel and Community Safety partnership extend their sincerest condolences to Gloria's family and all who knew her.

1.2 The following pseudonyms have been in used in this review for the victim and perpetrator to protect their identities and those of their family members:

	Age at time of Gloria's death	Sex	Ethnicity
Gloria (deceased)	75	Female	White British
Marcus (the perpetrator)	81	Male	White British

1.3 Criminal proceedings were completed July 2023. Marcus pleaded guilty to manslaughter and was sentenced to two years imprisonment, which was suspended for two years.

1.4 The review process began with an initial meeting of the Community Safety Partnership on 23rd May 2023 when the decision to hold a domestic homicide review was agreed. All agencies that potentially had contact with Gloria and Marcus prior to the point of death were contacted and asked to confirm whether they had involvement with them. 15 agencies were contacted and asked to confirm what contact, if any, they had with Gloria and the perpetrator. Four agencies confirmed contact with the victim and/or perpetrator and were asked to secure their files.

2. Contributors to the Review

2.1 Individual Management Reviews IMRs were requested and received from:

- Cambridgeshire Constabulary (The Police)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- NHS Cambridgeshire & Peterborough Integrated Care Board on behalf of GP Primary Care (ICB)
- Cambridge University Hospitals – Addenbrookes (CUH)

2.2 One agency, the Ambulance Service had minimal involvement with the perpetrator, and this occurred after Gloria's death. The panel received a summary report from this agency.

2.3 The IMRs were reviewed in detail by the panel and a combined chronology of

events was established. Analysis of the professional involvement with Gloria and Marcus was undertaken, learning identified, and recommendations provided for future practice.

2.4 All IMR authors were independent of any direct contact with the subjects of this DHR and nor were they the immediate line managers of anyone who had had direct contact.

3. Review Panel Members

3.1 The Review Panel comprised of the following individuals:

Cherryl Henry-Leach	Independent Chair and Overview Report Author
Vickie Crompton	DASV Partnership Manager Cambridgeshire and Peterborough Domestic Abuse & Sexual Violence Partnership
Angie Stewart	CEO, Cambridge Women's Aid
DS Alicia Yorke	Cambridgeshire Constabulary
Kathryn Hawkes	Community Safety Partnership, South Cambs District Council
Rachel Robertson	Safeguarding and Domestic Abuse Lead, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
Linda Katte	NHS Cambridgeshire & Peterborough Integrated Care Board
Tracey Brown	Cambridge University Hospitals – Addenbrookes (CUH)

3.2 All panel members were independent of any direct contact with the subjects of this DHR nor were they the immediate line managers of anyone who had had direct contact.

3.3 The panel were also aided by the Chair's liaison with members of Gloria's family, and their contributions to this review.

4. Author of the Overview Report

4.1 The chair and author of this report is independent of all agencies involved in this review and had no prior contact with any family members. The chair has not worked in the Cambridgeshire area, in any capacity, nor has she been employed by any of the agencies who contributed to this review. She has undertaken the Home Office online training and having undertaken and successfully completed the accredited training for DHR Chairs. She holds the requisite skills as set out in the statutory guidance for the

undertaking of Domestic Homicide Reviews[1]. This includes her experience in relation to domestic violence and abuse, having been strategically and operationally active in this area of work for nearly three decades, including as a Subject Matter expert support supporting the delivery of Domestic Abuse national training. She holds two Judicial Office appointments and is also an Independent Chair for a Domestic Abuse Board in the North of England. During the course of this review, she was employed by two national domestic abuse charities[2].

5. Terms of Reference for the Review

5.1 The review considered agencies contact/involvement with Gloria and Marcus from 1st January 2020 up to the end of December 2022 which is the period of the relationship between Gloria and Marcus[3].

5.2 The Statutory Guidance for the Conduct of Domestic Homicide Reviews outlines the purpose of a DHR process is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- contribute to a better understanding of the nature of domestic violence and abuse; and
- highlight good practice.

5.3 In addition to these points the panel agreed that the case warranted consideration by IMR authors of specific points that were relevant to Gloria's circumstances.

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency have that could have identified Gloria as a victim of domestic abuse, and what was your response?
2. What assessments did your agency undertake in relation to Gloria and members of her family? What was the outcome and, if you provided services, were they fit for purpose?

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[1] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)
[2] AAFDA's Deputy CEO (Home - AAFDA) and become the CEO for Standing Together Against Domestic Abuse (Standing Together) in January 2024.
[3] This pseudonym has been chosen by agreement with the family of Gloria and is used interchangeably with Marcus as he has not consented to be named within this report.

3. What was your agency's knowledge of any barriers faced by Gloria that might have prevented her reporting domestic abuse, and what did it do to overcome them?
4. What knowledge did your agency have that indicated Gloria could be at risk of serious harm or homicide as a result of domestic abuse and any coercive and controlling behaviour?
5. What knowledge did your agency have of Gloria's physical and mental health needs, and those of her family members, and what services did you provide? Were these adequate and were appropriate referrals made?
6. Was appropriate consideration given to Gloria's needs and to the needs of members of her family providing care and support? Were carer's assessments appropriately considered and undertaken? What actions followed those assessments and were the actions appropriate, in line with policy?
7. What knowledge or concerns did Gloria's family, friends, colleagues, and wider community have about Gloria's circumstances and any victimisation, and did they know what to do with it?
8. What knowledge did your agency have that indicated Gloria's husband might be a perpetrator of domestic abuse, and what was the response – including any referrals to a Multi-Agency Risk Assessment Conference (MARAC)?
9. Were the subjects informed of options/choices to make informed decisions? Did they have the capacity to make informed decisions? Were they signposted to other agencies, and how accessible were these services to the subjects?
10. How did your agency take account of any racial, cultural, linguistic, faith or other diversity issues, including disability, when completing assessments and providing services to Gloria and members of her family?
11. Did your agency follow its domestic abuse policy and procedures, and the multi-agency ones, including information sharing protocols and safeguarding policies and processes?
12. Were there issues in relation to capacity or resources in your agency that impacted on its ability to provide services to Gloria and her family, or on your agency's ability to work effectively with other agencies?
13. What learning has emerged for your agency?
14. Are there any examples of outstanding or innovative practice arising from this case?
15. Does the learning in this review appear in other Domestic Homicide Reviews commissioned by South Cambridgeshire Community Safety Partnership?

5.4 In undertaking this review, the Panel and Chair produced a final overview report that addressed the key lines of enquiry and also considered:

a) If procedures were sensitive to Gloria's protected characteristics and those of the perpetrator, and if this included necessary consideration for vulnerability and disability?

b) Whether communication in relation to DA support is available and effective within Gloria's community?

c) How accessible were the services for Gloria and the perpetrator?

d) Whether agencies have appropriate policies and procedures to respond to domestic abuse and if the panel needed to recommend any changes following the review process?

e) Establish accessibility of services for those contemplating suicide.

f) Cross reference relevant recommendations of previous DHRs as to whether these were implemented and ascertain the current efficacy of those recommendations.

g) If the review identified and highlighted good practice for wider sharing and dissemination.

6. Summary Chronology

6.1 The panel also considered a combined chronology, which gave a comprehensive overview of agency involvement. This:

- Charted the relevant key events and contacts with Gloria and Marcus during the final years of Gloria's life.
- Documented occasions when Gloria's views and wishes were sought by or expressed to professionals and clinicians in contact with her.

6.2 Prior to the temporal scope of this review, Gloria received a diagnosis of Parkinsons Disease in 2018 and had been diagnosed with breast cancer, there was minimal agency involvement with her. Gloria was under regular review by the CPFT Parkinsons Specialist services and had recently been 'discharged' from breast cancer monitoring. Following Gloria's diagnosis of Parkinsons disease, she disclosed her experiencing depressive symptoms and anxiety and the Psychological Wellbeing Service (PWS) undertook assessments with her in relation to this. She was assessed as low risk of suicide on the basis that Gloria stated she had considered suicide, had some thoughts on how she would achieve her suicide but had not made plans to take her own life. She stated her family were the protective factors in relation to these suicidal thoughts and that 'it wasn't time yet'. She indicated that being a burden was a concern to her and would impact on her decision making around suicide in the future. Gloria responded well to treatment which included High Intensity Integrative Therapy. At the conclusion of these sessions, she was reassessed and stated she was much improved.

6.3 In the month before she died, Gloria fell at home and was admitted to hospital. Gloria was discharged with a full care package to support her daily living just before a holiday period. Prior to her fall in the home and admission to hospital, Gloria experienced relatively good health and independence.

6.4 During the holiday period, Gloria was found deceased at home. Gloria's death was originally reported to the Police by the Ambulance Service, following a call to the latter from the family home, which reported that Gloria had been found deceased. Police officers attended in response to this referral and commenced enquiries, and a senior detective attended the scene to oversee the investigation.

6.5 Officers spoke to the perpetrator, Marcus[4] and another family member who was staying at their home, and obtained a synopsis from the attending paramedics, including confirmation that Gloria had been declared deceased shortly after their arrival, but appeared to have been deceased for several hours as rigor mortis was present, and so CPR was not attempted.

6.6 Marcus stated that he was with Gloria the previous night, up until approximately 10.30pm when Marcus went upstairs to bed, by which time Adult 1 was already in bed. Adult 1 was awoken by Marcus at around 5am and was told that Gloria had passed away.

6.7 Marcus initially stated that he had awoken at around 2am, had gone downstairs and had discovered Gloria deceased but had no idea of what he should then do. He stated that he had waited for Adult 1 to wake up and when he did, he told him that his mother had passed away. Both then sat with Gloria until the arrival of the scheduled home carer at around 7am. Marcus told the carer, *"She has died. She has gone in the night."*

6.8 Three days later, Marcus was found in a semi-conscious state on the floor next to an armchair by a Pharmacy delivery driver who phoned for an ambulance to attend. Marcus survived this apparent serious attempt on his own life.

6.9 Whilst the full police report was in the process of being prepared for the coroner, Marcus attended his local police station in the company of his solicitor, where he made an admission, *"I've come here to tell you that I killed my wife."* He said he had disclosed this to his family, and he was encouraged by them to report himself to the police. During this admission, he stated that:

- He had taken an overdose in an attempt to end his life before coming to the police station.
- Gloria had begged him to kill her, after a period of illness.
- He smothered Gloria with cling film that he located in the kitchen of their home.

7. Key Findings

7.1 The panel noted that following changes have taken place since the death of Gloria:

- Cambridge and Peterborough Foundation Trust CPFT now have a revised policy to include when safe to do so, routinely asking about domestic abuse, routinely and more directly as part of practitioner's routine contacts.

7.2 The panel identified the following examples of good practice when undertaking this review:

- Gloria was provided with numerous opportunities to discuss her experiences, and her relationship, in a safe environment.
- Gloria was given 12 sessions of High Intensity Integrative Therapy in 2020 which reduced her anxiety and allowed her to stop her life-limiting behaviours and

[4] Pseudonym agreed with Gloria's family

enjoy travel with her husband and family.

- The GPs who had contact with Gloria and Marcus were, at the time of this report, up to date with mandatory Level 3 safeguarding training. The panel also commends the action taken by the GP practice to ensure its staff are appropriately trained in relation to domestic abuse and safeguarding, and that this includes immediate escalation of concerns when received.
- Safeguarding information and guides on reporting concerns are on display in shared working areas of the GP practice and in the shared folders for all staff to access.
- Information for patients on reporting abuse and obtaining help is on display in the GP practice.
- When Gloria's rehabilitation was slow to progress and Marcus could not be contacted, hospital staff considered her best interests to ensure that he was made aware of the need to contact them.
- Professionals managed to ensure there were no delays in discharge planning or support at home caused by general health and social care limited resource over the holiday period.

8. Conclusions

8.1 On the basis of the information presented to the panel, the panel concluded that:

- Prior to Gloria being killed by the perpetrator, Marcus, she did not experience domestic abuse in her relationship with him.
- Up to, and during, her last period of illness, Gloria was positive about her marriage, loved her life with him and was happiest in his company.
- During her time in hospital Gloria experienced low mood, depression, and intermittent lack of interest in her selfcare and therapy. She was seen by a multitude of professionals and had many reviews. Despite the context of Gloria expressing suicidal ideation to clinicians, prior to her death there is nothing to indicate Gloria attempted suicide or self-harmed.
- There were some indications that Gloria was concerned that Marcus was finding his increased caring responsibilities difficult, but this was not explored further with her.
- Professionals and family members did not identify any concerns in relation to Marcus' ability to care for Gloria, and so the need for a s.42 Care Act Assessment was not identified to be a need.
- Marcus had not been offered a Carer's assessment or had received signposting advice as to how to access one.
- Marcus' suicidal ideation was only recognised after his confession. Although Marcus had the opportunity to disclose to professionals his struggles as Gloria's carer, or Gloria's requests that he kill her, he did not do so until after he confessed to killing her.
- Beyond the medical evidence presented to the Sentencing Court, the panel could find no further explanation as to why Marcus did not share his struggles as a carer and so concluded the risk he posed to Gloria was not known to

professionals and that no agency was enabled to take action to mitigate this risk.

8.2 The panel extended its thanks to all who contributed to this review. It also extends its sincerest condolences to Gloria's family and all who knew her.

9. Lessons Identified

9.1 The panel identified the following learning whilst undertaking this review:

- We must "Think Family" when patients experience significant life events, and discuss, and record those discussions, and the impact of these changes on the patient and their families' lives with them to enable our consideration and assessment of support their carer's might need or be signposted to.

- We must ensure that our record keeping reflects a timely audit trail of discussions with patients and their families so when they become concerned about a patient's mental well-being, they are clear on how to raise those concerns with professionals. This must include the actions a family member can take if a patient expresses a desire to die and a family member or carer is asked to assist them to die.

- We must undertake routine enquiries about domestic abuse if it is safe to do so when patients present with health, including mental health, issues. If the patient is accompanied and it is unsafe to discuss domestic abuse, an opportunity should be made for the patient to be seen alone during the appointment or at another earliest appointment to enable the patient to safely discuss and/or disclose domestic abuse.

9.2 The panel also invites the Community Safety Partnership, and the Home Office, to consider how recognition in assessments of suicidal ideation in carers who are family members can be supported. Specifically, to consider the development of guidance that reflects cognisance of how this can accompany homicidal ideation alongside an inability to continue caring; appropriately aligning assessment outcomes with domestic abuse pathways, including risk assessment of, and ongoing support for, victims of domestic abuse.

10. Recommendations

I. CPFT to embed its revised Trust DA policy and use of Routine Enquiry. This will include an update to the Electronic Patient Record (EPR) system to enable improved data collection and the improved recording of routine enquiry and prompt practitioners to ask about DA.

II. All partners contributing to this review to provide reassurance to the Community Safety Partnership, through the use of data reports, that they undertake routine enquiry about domestic abuse, and that their policies and practice guidance support appropriate responses when there is a positive disclosure of abuse.

III. CUH to embed the Carer policy and share widely across the Trust. This is to

include improved recording system on the EPR.

IV. The Community Safety Partnership to seek reassurance that its constituent partners appropriately signpost carers to carers assessment.

V. Third-party information coming into the GP Practice about each patient to be considered holistically to assist the Practice and clinical staff to make informed decisions on how to support the patient.

VI. Administrative staff to be supported to assess if third-party information coming into the GP Practice should be brought to the attention of a clinician immediately.

VII. Adult Social Care to remind Home Care Service Providers of the need to ensure their records are a timely and include a clear audit trail of discussions with patients and their families.