



Domestic Homicide Review Overview Report

Gloria, who died in December 2022

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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. INTRODUCTION

1.1 This review has been undertaken in line with the Statutory Guidance for the undertaking of Domestic Homicide Reviews¹ (DHRs). It examines agency responses and support given to Gloria², a resident of South Cambridgeshire, prior to the point of her death. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support.

1.2 By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.3 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.

1.4 Officers spoke to the perpetrator, Marcus³ and another family member, Adult 1 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 resuscitation was not attempted.

1.5 Marcus and Adult 1 both provided an initial verbal account that they were 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.

1.6 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 they did, he told them that Marcus' 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.*"

1.7 In early 2023, Marcus attended the Police station and reported to the Police that he had killed Gloria in late December. 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.

¹ [DHR-Statutory-Guidance-161206.pdf](#)

² Pseudonym agreed with Gloria's family

³ Pseudonym agreed with Gloria's family

- He smothered Gloria with cling film that he located in the kitchen of their home.

2. TIMESCALES

2.1 This review began on 23rd May 2023 and was concluded on 18th August 2025, which is the date the report was agreed by the panel to be ready for Home Office submission. In line with the statutory guidance for the undertaking of DHRs, they should be completed, where possible, within six months of the commencement of the review, including the authorship of the overview report.

2.2 This DHR was delayed by the following events:

- The Criminal Justice process. When it was able to resume the review, the panel were mindful of the sentencing Judge's comments and ensured its approach was informed by them.
- Engagement with members of Gloria's family and the perpetrator.
- Resourcing issues within one agency, resulting in their Individual Management Report's (IMR's) late submission.
- A change in employment of the independent chair and agreement being sought from the CSP and Home Office that her new role did not compromise this review process.
- The need for the panel to consider learning from other DHRs with similar emerging themes.
- One agency not attending final panel meetings but providing feedback on the final report that required it to be re-written in parts.
- Gloria's family initially did not wish to read the final report before submission to the Home Office. They re-considered this decision once the report was available for their input and time taken to obtain and address, where possible, their feedback on it.

3. CONFIDENTIALITY

3.1 The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers. Pseudonyms used within this report have been agreed with the family and are to protect the identity of the individual(s) involved.

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

4. TERMS OF REFERENCE

4.1 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 Marcus⁴.

4.2 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.

4.3 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?
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

⁴ 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.

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?

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 domestic abuse 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.

5. METHODOLOGY

5.1 The statutory requirement⁵ to complete a Domestic Homicide Review rests with the South Cambridgeshire Community Safety Partnership (CSP) for the area in which a domestic homicide takes place.

⁵ [Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

5.2 The Cambridgeshire Constabulary, having due consideration to the definition of domestic homicide set out in section 1 of the 2004 Act⁶ (see section 2), in line with locally agreed protocols, notified the South Cambridgeshire Community Safety Partnership (the CSP) in January 2023.

5.3 Once the referral was received, the circumstances of Gloria's death were considered, and it was agreed by the CSP that the case met the criteria for a Domestic Homicide Review. The CSP informed the Home Office of this decision on 29th March 2023.

5.4 Following the decision that a DHR would be undertaken, the CSP appointed an independent chair to lead this review. The CSP also undertook a scoping exercise and from this commissioned individual management reports (IMRs).

6. INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

6.1 The panel initially liaised with Adult 1, Gloria's adult child. Adult 1 was referred to the Victim Support Homicide Service by the Police once the murder investigation commenced. Following the review's commencement, Adult 1 was contacted by the independent chair on behalf of the panel. Victim Support Homicide Service initially indicated that Adult 1 wished to contribute to this review but was feeling overwhelmed by the loss of their mother and the impact of various processes connected to the death of Gloria. It was agreed that Adult 1 would be given time to consider further if they wished to contribute. Adult 1 was kept informed of key stages of the review process by the chair through their Victim Support advocate. In January 2025, they eventually elected not to contribute to this review, and this was communicated to the chair by his Victim Support Homicide Service Advocate.

6.2 Once it was confirmed that Adult 1 felt too overwhelmed to contribute to this review, the panel considered if wider family members wished to contribute. The Police Investigation Team advised the panel that they had interviewed Gloria's three siblings and Adults 2 and 3 agreed to receive contact from the chair, but Adult 4 did not. The chair contacted Adults 2 and 3 individually.

6.3 One of Gloria's siblings, Adult 2, agreed to speak with the chair by video call and this was arranged. Adult 2 advised the chair that they were unaware of this review taking place and their contributions to it are documented where appropriate within the report.

6.4 One of Gloria's siblings, Adult 3, when contacted by the chair, agreed to contribute by telephone call. Adult 3 advised the chair that they were unaware of this review taking place until Adult 3 told them of this review. Their contributions to it are documented where appropriate within the report.

6.5 In the initial contact with them, and their respective conversations with the chair, both Adults 2 and 3 were advised by the chair of the support they could receive from either

⁶ [The Domestic Violence, Crime and Victims Act 2004. - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

the Victim Support Homicide Service or Advocacy After Fatal Domestic Abuse and were given the relevant documentation from the Police. Both declined to be referred to services for advocacy support.

6.6 Unfortunately, due to the chair and panel not being made aware of the siblings until after Adult 1's decision not to contribute to this review, by the time the chair met with Adults 2 and 3, the Terms of Reference had been agreed by the panel. Adults 2 and 3 were advised of the themes to be analysed by the chair, and they were invited to contribute further to the terms of reference or to provide questions that they wished the review to answer. Both declined to do so, advising that the only person who could give them any answers was the perpetrator, Marcus, and they felt unable to contact him following Gloria's death.

6.7 Adults 2 and 3 were updated on the progress of the review by the chair in line with their wishes. They have been offered the opportunity to review the draft report in private with plenty of time to do so and have had the opportunity to comment and make amendments if required.

6.8 Marcus initially contacted the Community Safety Partnership and requested to be involved in the review. This was discussed by the chair and panel who agreed that he would be contacted after other family members had been given opportunity to contribute.

6.9 Marcus was contacted by the chair in October 2024, and then again in November and December 2024, and invited to contribute to the review by letters that were sent via email, telephone call and by email. Marcus did not respond to those invitations.

6.10 The panel also considered if the chair should speak with Marcus' children. It noted that the death of Gloria, and Marcus' role in it, had resulted in a fractured family dynamic. Being concerned that this review should not undermine relationships further, and noting their views on his actions, the Police enabled access to a summary of their statements which is reflected below.

6.11 During the homicide investigation, Police investigators conducted enquiries at neighbouring properties. All indications from those enquiries are that Gloria and Marcus were model neighbours, a couple that appeared supportive of each other and there was no indication that either party was abusive to the other. The community was clearly shocked and saddened by the revelation of Gloria's murder.

6.12 Adult 1 informed the Police investigators that Gloria had a very good relationship with Marcus, and although they were not angry with Marcus for his actions, they became increasingly distant from Marcus when the impact of how their mother had been killed manifested. Their contact with Marcus diminished before the trial process.

6.13 Adult 2 stated that they liked Marcus, and he was good to Gloria "*prior to meeting him she was not a happy woman, but when they got together, he made her smile*".

6.14 She enjoyed the time they spent together and on family occasions it was good to

see her happy and laughing because of his company... they had similar interests and seemed happy together. He was, it would seem, a genuinely warm person welcoming toward us..." Adult 2 was clear they did not consider that Gloria was close to dying and they did not consider that her death was a mercy killing as claimed by the perpetrator. They advised the chair "his behaviour after he killed my sister was so very strange and different to [the perpetrator] we had come to know. He wrote to us before the funeral, this was, I believe, his way of admitting to us his actions and his reasons for them. But it was so cold and clinical in tone... there was no remorse, no consideration of the impact her death would have on us... at her funeral, which I am surprised he attended, his behaviour was, at best and in my view, inappropriate, at worst very odd... he was laughing and joking with people who attended to pay their respects to my sister, he did not seem to be grieving but I accept people grieve in different ways. But he knew he was the cause of [her death] yet made no apology to us... If he is telling the truth, then why he took Gloria's life in the way he did is a mystery to me... it was unkind and brutal, and denied her any shred of dignity..."

6.15 Adult 3 is an active supporter and campaigner for '*Dignity in Dying*'⁷ and informed the investigators and the chair of this review that they were close to Gloria and also noticed the decline in Gloria's health from 2017. Adult 3 described:

- Being close to Gloria as their mother had died when they and Adult 4 were young, and Gloria developed a caring role toward them.
- Feeling happy for Gloria when Gloria met the perpetrator, advising the chair "*before they met, she was lonely and had gone on a few dates but found online dating was not for her. I believe she met him online and decided to give him a go and if their meeting did not work out, she was resigned to being lonely. But she described their hitting it off straight away. He made her happy and when we spent time with them as a couple, I believed this was mutual and genuine. They appeared to be compatible, and I did not observe anything that made me feel uncomfortable in relation to their relationship*".
- Noticing a decline in Gloria's health between 2017 and by 2022, and that this decline accelerated in the final year of Gloria's life. "*I had visited over the Christmas period following contact from [Adult 1], stating that [Adult 1] was concerned about his mother's declining health...she did not appear to me to be well; she was drowsy, and I wondered why this was, but believed she was medicated appropriately...She did not have much appetite and this, I think, may have been the cause of her drowsiness.*"

6.16 Initially bearing no animosity towards Marcus referring to him as being "good" to Gloria and Adult 1, Adult 3 stated that they now feel conflicted toward Marcus as they did not believe Gloria was seriously contemplating ending her life, stating that "*it is correct that [Gloria] said she wanted to go and she was very poorly, but she never said how she wanted to go. If she did beg Marcus to kill her then I simply do not understand why he did so in such a cruel way that did not give her much dignity.*"

⁷ . The family originate from the Netherlands where there is an assisted programme of euthanasia alongside that of the neighbouring Belgium. Gloria spent her formative years living in the Netherlands.

7. CONTRIBUTORS TO THE REVIEW

7.1 The CSP also undertook a scoping exercise. Fifteen agencies were contacted and asked to confirm what contact, if any, they had with Gloria and the perpetrator. Four agencies returned positive responses. Of the positive responses received following the scoping exercises, four Individual Management Reports (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)

7.2 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.

7.3 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.

7.4 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.

8. THE REVIEW PANEL MEMBERS

8.1 The panel membership ensured safeguarding expertise specific to older people and was as follows:

Cherryl Henry-Leach	Independent Chair and Overview Report Author
Vicki Crompton	DASV Partnership Manager Cambridgeshire and Peterborough Domestic Abuse & Sexual Violence Partnership
Angie Stewart	CEO, Cambridgeshire Women’s Aid
DS Alicia Yorke	Cambridgeshire Constabulary
Catherine Hawkes	Community Safety Partnership, South Cams 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)

8.2 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.

9. AUTHOR OF THE OVERVIEW REPORT

9.1 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 has 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 Reviews⁸. 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 charities⁹.

10. PARALLEL REVIEWS

10.1 Very soon after Gloria's death and Marcus' admission that he killed her, a postmortem was undertaken, and this confirmed that her cause of death was caused by asphyxiation.

10.2 An inquest was opened by His Majesty's Coroner. This coronial process was adjourned pending the outcome of the criminal trial. Following the conclusion of the trial, the Police confirmed to the panel that the inquest proceedings had been formally concluded.

10.3 At its inaugural meeting, the panel established that a criminal investigation was being undertaken in relation to the death of Gloria, and that a trial was underway. It was agreed by the panel that all enquiries pertaining to this review would be progressed by the chair on behalf of the panel so long as they did not, in any way, compromise the criminal justice processes being undertaken.

10.4 As stated above, after his full admission to the Police, Marcus was charged with Gloria's murder and bailed pending trial. Following psychological evaluation by both the

⁸ [Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/guidance/domestic-homicide-reviews-statutory-guidance)

⁹ AAFDA's Deputy CEO ([Home - AAFDA](#)) and become the CEO for Standing Together Against Domestic Abuse ([Standing Together](#)) in January 2024.

prosecution and defence counsel, a plea to manslaughter on the grounds of diminished responsibility was accepted by the prosecution. In July 2023, Marcus pleaded guilty to manslaughter and was sentenced to two years imprisonment, which was suspended for two years.

10.5 During the perpetrator's trial, medical experts for the Prosecution and Defence indicated that he was suffering a repeat episode of distorted mental ill health that adversely impacted on his cognition when he killed Gloria:

10.6 *"It is more likely than not that [the perpetrator's] depressive episode, probably prevailing at the time of the offence, would have been severe enough to lead to substantial impairment of his ability to form a rational judgement. Individuals with depressive disorders see life through a dark lens. Their view of themselves and [report by expert 1] the world around them is pervasively negative. This prevents them thinking clearly. Their ability to see alternative, more positive viewpoints and options is often severely diminished. This irrational thinking is not in the context of psychosis, where there is clear separation from reality, it is a facet of their depressive state preventing positive thinking."*

10.7 *"Though [the perpetrator] was not able to easily articulate his mental state before the offence (it is noted that [Marcus] is not easily able to talk about feelings and emotions and tends to minimise the nature of his symptoms) there is a strong narrative of [Marcus] suffering from a moderate depressive episode. As before, this seems linked to events, in this case his partner's plight."*

10.8 *"From my review of the documentation, there is no indication that there was any form of discord within the marriage to the victim, Gloria. They had met online and enjoyed each other's company and travelled extensively. The arrival of Parkinson's Disease in Gloria brought considerable change in the direction of their lives."*

10.9 *"At the time of the killing [Marcus] was suffering from an abnormality of mental functioning caused by the recognised medical condition of a depressive episode in the context of having a bipolar disorder. Though there is a narrative of responding to his wife's pleas to die, in my opinion the abnormality of mental functioning substantially impaired his ability to form a rational judgement. The impulsive nature may indicate that it affected his self-control."*

10.10 *"In my opinion, it is likely that the abnormality of mental functioning provides an explanation for the killing. I conclude that [the perpetrator] has a defence to murder of manslaughter on the grounds of diminished responsibility."*

10.11 The sentencing Judge described Gloria's death as a "tragic case" involving a couple who had led a "loving and content, interesting life together", and added, "I accept at the time [Marcus] did believe he was doing what he believed to be an act of mercy."

11. EQUALITY AND DIVERSITY

11.1 Throughout this review, the panel were mindful of the nine protected characteristics¹⁰ outlined within the Equality Act 2010 (age, disability (including learning disabilities); gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). The panel was also mindful of the protected characteristics when, as part of its analysis of the evidence provided to it within this review, it examined barriers to accessing services experienced by Gloria and Marcus and its consideration of the service delivery provided to them.

11.2 The protected characteristics of gender reassignment, and sexual orientation do not pertain to this case in that this review established, as far as it possibly could, that neither party was at any stage of transitioning from one gender to the other, or that they held any specific religious or other beliefs. Although Gloria was the mother of an adult child, there was no evidence to the panel that pregnancy and maternity, as a protected characteristic, required its specific consideration during this review.

11.3 At the time of her death, Gloria was a 75-year-old heterosexual white British female. The panel confirmed that Gloria was registered as being a person living with a disability¹¹ and her diagnosis of Parkinson's. Toward the end of her life, she experienced substantial mobility issues that fell within the legal definition of a disability¹². Over time, and toward the end of her life, Gloria's dependency on others increased, and this resulted in her increased vulnerability.

11.4 Sex: There was collective panel agreement that sex was most definitely a feature of this review that required special consideration. The panel also noted that support was offered to Gloria during the period of the Covid 19 pandemic/national restrictions and explored if consideration of her protected characteristics informed their support of her. Women's Aid¹³ state that domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family. Between March 2017 and March 2019 data from the Home Office Homicide¹⁴ shows that over three-quarters of victims of domestic homicide were female (77% 274 victims).

11.5 Age: Over the last 10 years, there was an average of 80 female victims a year

¹⁰ [Protected characteristics | Equality and Human Rights Commission \(equalityhumanrights.com\)](https://www.equalityhumanrights.com/en/protected-characteristics)

¹¹ Section 6 of the Equality Act 2010 defines a person as having a disability if he or she has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. This is for the purposes of this Act and the legislative framework it creates to advance equality of opportunity.

¹² The Equality Act 2010 defines a person as being disabled if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities. <https://www.gov.uk/definition-of-disability-under-equality-act-2010>

¹³ Women's Aid Domestic abuse is a gendered crime, n.d.)

¹⁴ Office for National Statistics, Crime Statistics, Focus on Violent Crime and Sexual Offences, 2017/19 Chapter 2: Violent Crime and Sexual Offences – Homicide, n.d.

killed by a partner or ex-partner. Multiple disadvantages grounded in traditional gender roles, economic disparities, and barriers to health and mental health services shape the aging process of women and make older women more vulnerable to violence and abuse than their male counterparts¹⁵. Although prevalence figures are variable, the likely lifetime prevalence for women over the age of 65 is between 20% and 30%. It is estimated that approximately 120,000 individuals aged 65+ have experienced at least one form of abuse in England and Wales¹⁶.

11.6 Disability: Crime Survey for England and Wales (CSEW) data from the year ending March 2020 shows that those with a disability were more likely to have been victims of domestic abuse in the previous year (11.8%) than those without (4.6%)¹⁷. Disabled victims may also be more likely to continue living with their perpetrator and deaths involving disabled victims may be recorded as ‘due to neglect’, rather than being captured as a domestic homicide, or without acknowledgment as a domestic abuse case¹⁸. Disabled victims may also be at increased risk in relation to particular examples of abusive behaviour, either from an intimate partner, family member, or carer (who is “personally connected” to them), or face specific risks relating to their disability and related circumstances including: control of medication; refusal to interpret; denial of access to health services or equipment; actions which makes the person’s health condition worse; and otherwise using the person’s disability to control them. The Domestic Abuse Act is clear that a disabled victim includes those who live with mental health issues, long-term health conditions and neuro diverse victims¹⁹, and that these individuals may experience additional barriers in their access to support if domestic abuse is a feature for them.

11.7 Marriage: Marcus was Gloria’s husband. Domestic abuse most commonly takes place in intimate partner relationships, including same sex relationships²⁰. In the year ending March 2023, 100 domestic homicides were recorded and of these 35% were adult women victims (defined as those aged 16 years and over) who were killed by a partner or ex-partner although 10% were killed by another family member. Academic research²¹ indicates the prevalence of domestic homicide of older people by family members, including spousal domestic homicide, is underexplored.

¹⁵ Choi 2016: International movement to promote human rights of older women with a focus on violence and abuse against older women; <https://journals.sagepub.com/doi/10.1177/0020872814559562>

¹⁶ <https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf>

¹⁷ ONS. Domestic abuse victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk): Data year ending March 2020.

¹⁸ SafeLives. Spotlight Report #HiddenVictims: Disabled Survivors Too: Disabled people and domestic abuse: 2017.

¹⁹ https://assets.publishing.service.gov.uk/media/62c6df068fa8f54e855dfe31/Domestic_Abuse_Act_2021_Statutory_Guidance.pdf

²⁰ ONS. Domestic abuse prevalence and victim characteristics - Appendix tables - Office for National Statistics (ons.gov.uk): Data from year ending March 2020.

²¹ Hannah Bows, Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK, *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, Pages 1234–1253, <https://doi.org/10.1093/bjsw/bcy108>

11.8 Religion/belief: The panel noted references to Gloria receiving visits from the Hospital Chaplain but found no indication that she was a practising Christian or that she had any other faith belief.

11.9 Marcus is a white British male who was aged 81 at the time he killed his wife, Gloria. As far as the panel could determine, Marcus was not registered as having a disability although he experienced poor hearing in his later years, and this was understood by members of his family and some professionals to impact on his ability to understand information relayed to him during telephone calls. The panel also understand that he became Gloria's main carer. The panel were also mindful that his defence at trial, which was accepted by the Court, was that, at the time of his killing Gloria, he had experienced mental health issues in the past and at the time he killed Gloria. The panel understand from information shared with the Sentencing Court, that Marcus historically experienced depression during his life and was under the care of a psychiatrist and received prescribed medication for several years.

11.10 There was no evidence, provided to the panel during the course of this review, that indicated the perpetrator, in more recent times, and particularly before and immediately prior to Gloria's death, had received a clinical diagnosis of mental health illness.

12. DISSEMINATION

12.1 The following recipients have received/will receive copies of this report:

- CSP partner agencies
- Panel members listed above and their agencies
- Police and Crime Commissioner
- HM Coroner
- Domestic Abuse Commissioner

13. BACKGROUND INFORMATION (THE FACTS)

13.1 Adult 1 informed the Police investigation team that Gloria had previously been married to their biological father and was divorced from her husband (now deceased). Adult 1 advised that Gloria was a single parent and that she had reverted to her maiden name following the break-up of her first marriage, when Adult 1 was three years of age. As far as the Police investigation team could determine, there was no suggestion or indication of domestic abuse within Gloria's relationship with Adult 1's father. Adult 1 also advised the Police that Gloria gave birth to a child before she was married, the child was adopted, and no other details are known. Adult 1 informed the Police that they believed Gloria had a very good relationship with Marcus, who they saw as being "very good for her" as she had never intended to enter into a relationship after she separated from her husband many years previously.

13.2 As far as the Police investigation could determine, there was no suggestion or indication of domestic abuse within either of the perpetrator's previous relationships or within the relationship between Gloria and Marcus until the day of her death. The Police investigations team also advised the panel that neither Marcus nor Gloria had any convictions, nor had they come to the attention of the Police. As far as their enquires could establish, there was no suggestion of any financial benefit by the perpetrator as the couple had a pre-nuptial arrangement, confirmed in Gloria's will, that left her share of the couple's estate to Adult 1.

13.3 Each of the perpetrator's adult children provided, to the Police investigation team, a background of their father which summarised his relationships. This enabled the Police to advise the panel that Marcus had three biological children with his first wife, from who he was divorced and that he had no contact with his first wife. This marriage was described as being 'poor' (suggesting that the couple were not suitably matched) and they separated by mutual agreement in 1982. The perpetrator, at the time of Gloria's death, was retired but had worked as a civil engineer on construction projects outside of the UK. On one of these assignments he met his second wife, who died suddenly and unexpectedly in 2008, from complications associated with surgery for her cancer. They had no children.

13.4 The panel understand that Gloria and Marcus met through a dating agency in 2010. At that time, Gloria was living in London. Following a courtship of 12 months, the couple married. Gloria sold her property in London and used the proceeds of this to contribute to the purchase of the matrimonial home in Cambridgeshire, where they had continued to reside following their marriage and until Gloria's death. The couple had been married for 11 years; their wedding anniversary was two days before Gloria was killed.

13.5 Adult 1 and Marcus' children had frequent contact with Gloria and Marcus, and Gloria enjoyed their company. The panel understand that the perpetrator's children lived closer to the couple than Adult 1.

13.6 Marcus' children informed the Police that they believe that their father acted out of compassion. They advised the Police that they believed he was fearful of admitting what he had done to the Police, but eventually did so, seeing this as testimony to him being an entirely honourable man who was devoted to Gloria and that they believed, based on what Marcus told them at the time, he carried out her wishes.

13.7 Both Adult 1 and Marcus' three children informed the Police investigations team that Gloria and Marcus were very content in their relationship. They described the couple's relationship as strong and that they complemented each other. They all described an apparent deterioration in Gloria's health over an extended period of time. In November 2022, Gloria suffered a fall and was admitted to hospital. During her stay in hospital, she was subject to various examinations which identified she was suffering from a fracture and bruised coccyx, recorded on Gloria's discharge notes as '*not significant*.' Due to her low mood, she was also given antidepressant medication and was encouraged to be more mobile. She had remained in hospital until discharge, and it is understood that, at this time, Glora was experiencing poor mobility, Parkinson's [disease] and a low mood.

13.8 On discharge, a hospital bed was provided for her at home, and carers attended to her four times daily to assist with her hygiene care and medication. Gloria's day to day care was provided, in the main, by the perpetrator, and family members visited over the festive period. Family members informed the Police that they noted that the change in the couple's circumstances (in December 2022) was beginning to take an apparent toll on the perpetrator's health, and he seemed unable to cope as Gloria's carer as well as he had, prior to Gloria's hospital admission.

13.9 Adult 1 informed the Police they were aware of the significant changes in their mother's health in the weeks before her death and that, during this period, Marcus appeared sad and worried - which was an unusual presentation for the perpetrator. Adult 1 also advised that they had stayed with the couple for a few days, and members of his mother's immediate family had visited over the Christmas period.

13.10 Witness statements provided to the Police investigators confirmed that Gloria had discussed her desire to die with members of her family. These also apparently confirmed the perpetrator's initial account to the Police that Gloria *"wasn't very coherent before her death. Mentally also, she said she wanted to go. Conversations about her wanting to end her life were separate from other family members. She didn't discuss how she wanted to go. Didn't discuss method however spoke about wanting to end things several times...When she came home, I felt sorry for her. She could hardly eat. She ate hardly anything. I didn't feel like I needed extra help. There was nothing I could do with her. She couldn't do anything. I didn't get any explanation as to how long the recovery would take. She wasn't using her trolley and fell when carrying coffee and went backwards. She was begging me to then help her. There was no indication of how she wanted to carry it out...She was talking about going to Switzerland. Euthanasia. She knew about that, but it wasn't a possibility as she couldn't move. She was using disconnected words that I couldn't make sense of. The last few days she was talking [incoherently]."*

13.11 When Gloria was confirmed deceased by a carer, the carer instructed Marcus to call an ambulance, which arrived promptly. On their arrival, the ambulance paramedics requested the Police also attend.

13.12 The reporting officers were made aware that Gloria had mentioned wanting to take her own life and in accordance with policing procedure, requested that the on-call senior detective attend the location to oversee the sudden death investigation.

13.13 Following those initial enquiries, the Police officers and healthcare professionals concluded that the death was unexpected, despite the health issues suffered by Gloria, and an initial report was prepared for HM Coroner as would be the case for any sudden and unexpected death. The coroner later determined that a post-mortem examination should take place.

13.14 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. Paramedics who attended noted that half a bottle of whiskey and paracetamol packets

with 24g missing were found on a table. They recorded that “*Driver states on file that patient’s wife had recently died.*”

13.15 Marcus survived what was an apparent serious attempt on his own life.

13.16 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.

13.17 Marcus was arrested on suspicion of murder. He was interviewed, and stated that he killed Gloria by suffocation, after she had “*begged him*” to end her life. He had also disclosed that, in the days following Gloria’s death he had taken an overdose in an attempt to take his own life, and was treated in hospital, having been found by a delivery driver.

13.18 The Police Family Liaison team advised the panel that, understandably, family dynamics became fractured once the facts of her death had emerged.

14. CHRONOLOGICAL OVERVIEW OF AGENCY INVOLVEMENT

14.1 The panel confirmed that the only Police involvement with Gloria or Marcus followed her death.

14.2 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.

14.3 In summary, this indicated to the panel that, prior to her fall in the home and admission to hospital, Gloria experienced relatively good health and independence.

14.4 Prior to the temporal scope of this review, Gloria received a diagnosis of Parkinson’s Disease in 2018 and had been diagnosed with breast cancer. Gloria was under regular review by the CPFT Parkinson’s Specialist services and had recently been ‘discharged’ from breast cancer monitoring.

14.5 Marcus appeared to have been in relatively good health but was, in his later life, experiencing hearing loss and this led to him struggling to understand others during telephone conversations. At his sentencing hearing there was one reference to Marcus experiencing a period of mental ill health twenty years previously.

14.6 Following Gloria’s diagnosis of Parkinson’s Disease in 2018, in 2019 and 2020 she

disclosed she was 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. She was provided with 12 sessions of High Intensity Integrative Therapy (HIT), which she attended. At the conclusion of these sessions, she was reassessed and stated she was much improved. For example, when asked about her anxiety, Gloria stated her fears were around being in a car on motorways and travelling in general and after the HIT she was able to travel in cars on motorways where she hadn't before this therapy. However, the medical notes for Gloria state that the anxiety and depression were linked to 'adjustment difficulties.' In one assessment, Gloria advised that she used the Samaritans service and found them helpful.

14.7 From 2020 to 2022 the panel noted that Gloria's treatment plan was regularly reviewed, and this included medication reviews. Gloria expressed frustrations with her decreased mobility which the panel agreed was consistent with the prognosis pertaining to Parkinson's Disease. Gloria also accessed routine appointments with her GP and received vaccinations throughout the Covid 19 pandemic national restrictions. During this period, Gloria was also referred to exercise classes to aid her management of Parkinson's and attended these regularly.

14.8 Between November 2021 and January 2022, Gloria requested clinical investigations to identify the cause of gastrointestinal issues that she was experiencing, and these appeared to resolve following diagnosis and the issue of prescribed medication to ease the symptoms she was experiencing. During these investigations, Gloria described experiencing pain in her joints which was impacting on her mobility and day to day activities.

14.9 In April 2022, Gloria was referred for a community occupational therapy (OT) assessment. The outcome of the assessment enabled Gloria to maintain her independent mobility and access the wider community using a wheeled walker when outside. She also received a braked trolley to support her to transport meals/drinks from the kitchen into the living room, and a perching stool to be used in the kitchen to enable Gloria to safely prepare her own drinks and food.

14.10 During her final period of illness, Gloria required a hospital admission. She disclosed experiencing two historical bouts of depression in the past: one when her son was born, and she received psychotherapy; a second following her divorce and the loss of her home.

14.11 In early November 2022, Gloria was supported by her GP surgery with pain medication. In mid-November, Gloria was admitted, via ambulance, to Addenbrookes via A&E due to a multifactorial²² fall at home. The panel understand that the Fire Service

²² [Quality statement 2: Multifactorial risk assessment for older people at risk of falling | Falls in older people | Quality standards | NICE](#)

supported Gloria's removal from the home due to difficult access conditions.

14.12 Gloria's description of the fall was that she fell backwards onto her bottom hurting her coccyx²³ and no other person was involved in the event. Initial X-ray of Gloria's spine, pelvis and hip showed no fracture. A subsequent scan showed a fracture which was described in her medical notes as "not significant".

14.13 Gloria remained in hospital until mid-December when she was transferred home to the care of Marcus and Adult 1 with a care package in place. Whilst in hospital:

- The Early Intervention Team (EIT) reported Gloria having a supportive family. Her medical notes documented that "*Husband is independent, drives but hard of hearing, daughter lives nearby. House has multiple adaptations for her mobility needs. No cognitive needs or communication needs identified*".
- The Hospital Chaplain visited Gloria and reported she had indicated she had good support from Marcus.
- A specialist nurse also reviewed Gloria in hospital and reported her mobility was getting worse and she was now unable to walk unaided. She stated she had had some hallucinations and solid food was becoming hard to swallow. Gloria reported concern that her husband was undertaking the household chores, "*which may be too much for him*".
- Reviews were undertaken with Gloria by a physiotherapist (PT), occupational therapist (OT) review, and a speech and language therapist (SALT).
- Gloria complained of low mood but said that the antidepressants were helping a bit. She stated that she did not want CPR in the event of cardiac arrest, and she did not wish for artificial nasal gastric feeding.
- Gloria was to have poor engagement with all therapy services, low mood in hospital with poor appetite but sleep was mostly good. At home she reported she was "happy" as she liked being with her husband, but admitted losing hope that she will get better as she had been struggling to walk for so many days before her admission to hospital.

During December 2022:

- Early December: Gloria was reported to be feeling brighter and initially her engagement had improved with physical therapy exercises, however this waned throughout the sessions. Gloria was observed to be incontinent and required nursing staff to support her hygiene. This was discussed with Marcus, who advised this was an unusual presentation. He agreed to speak with Gloria about the need to try harder during her physical therapy sessions.
- Early to mid-December: Gloria reported feeling better and nausea was improving with medication. She felt physio was improving though would like to see faster improvement. It was reported that Marcus was present at this review and did not think

²³ The coccyx is a triangular arrangement of bone that makes up the very bottom portion of the spine below the sacrum. It is the final segment of the vertebral column and represents a vestigial tail, hence the common term *tailbone*. [Anatomy of the Coccyx \(Tailbone\) | Spine-health](#)

this was a concern. He advised that although Gloria had a history of low mood and depression, he did not think she was depressed, and he would recognise signs if she was. The Geriatrician noted that "*Gloria's mood appears to be much improved when husband is present*". Gloria declined the offer of a psychiatry review but later agreed to this.

14.14 Gloria was referred to the Psychiatric Liaison Service (PLS) by the hospital's Physiotherapy team, and she was assessed by PLS. The assessment recorded two historic previous depression episodes; the first after the birth of her son and Gloria was prescribed antidepressants and attended psychotherapy. The second episode occurred after her first marriage broke up and she lost her house. She received group therapy. In the assessment, Gloria advised that she currently experienced low mood due to concerns that her tall height posed challenges in her receipt of appropriate mobility equipment. The assessment also recorded: "*She... is usually a 'very happy person... She feels lucky to be married to a very good man and feels grateful for her nice life... it will be terrific to go home although everyone in the hospital has been amazingly nice to me'. Her only concern is that this admission may mark a progression in her Parkinson's disease, which until then had been very slow to progress. Subjectively bright in mood. No evidence of low mood*".

14.15 Gloria was given new equipment, better suited to a taller person, to mobilise in the hospital, and the recorded expectation was for improvement in her rehabilitation potential. Her notes also recorded "*no indications or reports of abuse or difficulties in the relationship. Gloria did not show any signs of depression at all. The only anxiety she expressed was that her fall (which preceded her admission to hospital) may represent a progression of her Parkinson's Disease which had hitherto been slow to progress. At that time there was no evidence of low mood. There was no indication she lacked capacity for treatment decisions. She said she thinks her memory is good and when she took part in a clinical trial recently, she had regular cognitive tests which she performed well on. She reported that the Parkinson's has caused a slowness to process questions or information. There were no objective signs of cognitive impairment.*"

14.16 As Gloria had consented that they could do so, the hospital staff contacted one of Gloria's adult stepchildren who shared concerns about Gloria's reduced mobility and how this could worsen if she did not mobilise. They agreed a four times a day care provision plan for Gloria and agreed to be the point of contact as Marcus had hearing loss.

14.17 During an assessment by the hospital Occupational Therapist (OT), Gloria became upset and requested home discharge and not inpatient rehab even though this meant less rehabilitation services being available to her. She consented to Marcus being contacted about equipment ordering.

14.18 Gloria showed improved engagement with physical therapy sessions but was seen to fatigue easily.

14.19 Gloria was informed nursing care at home would have to be delivered in bed. She was told that due to the need for nursing in bed, it was likely she would remain in hospital until after Christmas. Gloria withdrew her consent for a stepchild to be a point of contact,

but staff contacted a stepchild in Gloria's best interests and family members were advised to attend in the next days to support patient motivation. It was noted in Gloria's records that adaptations were to be undertaken at home.

14.20 Multiple attempts were made by the hospital staff to contact Marcus without success. Gloria's consent was sought to call her stepchild instead, but this was not given as she wanted Marcus to be contacted.

14.21 In Gloria's best interest, the stepchild was contacted as Marcus was not available. Her stepchild agreed to facilitate information exchange between Marcus and the hospital. Family members were advised to attend therapy sessions the next day to support patient motivation and learn the moving and handling equipment. Sadly, their attendance did not happen, and Gloria refused to move into the chair from the bed until Marcus visited her, which happened in the evening.

14.22 When reviewed by a Geriatrician, Gloria reported that she was feeling low in mood and suicidal. She did not indicate any active plans to end her life but described daily fleeting thoughts as she was unsure how long she can continue suffering and life is not worth living any more. The Geriatrician reminded her about her family support, but Gloria said, "*the suffering was too much for her*". There appeared to be no suicide plans in place or evidence of self-harm and the Geriatrician reported cognition intact. Gloria gave her consent to a referral for psychological support.

14.23 During the Psychiatry review, Gloria stated she constantly felt life was not worth living and would like to die but had no idea how. She described feelings of hopelessness and helplessness which were impacting on her decision-making. Gloria understood and engaged in a discussion about her being prescribed antidepressants, the impact these would have on her depression and the time it would take for them to work. Antidepressants were, with her agreement, prescribed for Gloria.

14.24 When Marcus and his daughter attended an OT session that took place with Gloria, her engagement appeared to be improved, but it was noted by the Physiotherapist that this may have been due to family being present. A private conversation was held with them. In this discussion, Marcus and his daughter were made aware of a previous conversation about risks of being bed bound on discharge and that, when this was discussed further with Gloria by the hospital staff, she appeared to be very defensive about her stepchild's concerns and was unwilling to acknowledge this was a concern. It was recorded that Gloria's family appeared upset by this information and they agreed to talk to Gloria about the importance of engaging with therapy sessions. The family also noted the use of moving and handling equipment with Gloria and there was discussion with them around Gloria's use of a call bell to request personal care.

14.25 When Marcus tried to encourage Gloria to engage better with therapy sessions, hospital staff recorded their observation that Gloria was also dismissive of Marcus.

14.26 Adult 1 also visited Gloria and stated to hospital staff that they were concerned for Gloria's psychological well-being. With Gloria's consent, hospital staff updated him on the

outcome of the Psychiatrist's review, her being described antidepressants but that they will take six weeks to be effective and required GP follow-up for review. Gloria was recorded to have expressed her anxiety over the four-week goal set by therapists to improve her mobility for discharge.

14.27 When this review took place there was discussion as to why Gloria's rehabilitation progress was slow, and it was agreed that this was attributable to Gloria's untreated depression. It was noted that access to further rehabilitation should be considered as part of the discharge plan once antidepressants became effective, and this would be reviewed again in January if Gloria was still an inpatient. A note in Gloria's records also made clear that Gloria was to be *"For onward referral to community Mental health team unless significant improvement seen pre-discharge"*. The OT attempted to discuss the discharge plan with Gloria but reported her *"...engagement was sporadic, and patient repeatedly asked what the plan was. Patient continues to decline hoisting into her chair as per plan and therapist explained to the patient the impact this is having on her recovery but acknowledged the role her mental well-being has played in this. The discharge plan is therefore for Gloria to go home to be bed-bound downstairs with 4 times a day community care and further assessment and potential improvement once anti-depressants have started working...Patient frequently asked what she could do to prepare herself to go home and the importance of engaging in therapy was emphasised to her. Physio asked to reiterate the information and the patient appeared confused. Informed patient the moving and handling equipment would not be ordered for discharge due to the risk of not being transitioned effectively due to poor patient engagement. Pressure relieving treatment to be organised for discharge"*. Gloria agreed that Marcus could be informed what the discharge plan would be. When Gloria was reviewed shortly after this review by a Geriatrician, it was recorded that Gloria *"was to be smiling more than usual and feels anti-depressants becoming effective"*.

14.28 The week before Gloria was killed, Gloria was re-referred to the Psychiatric Liaison Service (LPS) by a Physiotherapist, for the second time due to concerns about her progress, apathy and not calling for assistance with toileting. The physiotherapist and a Clinical Nurse Specialist (CNS) from PLS discussed Gloria's rehabilitation potential. It was thought that her failure to progress with rehabilitation was very likely due (at least in part) to untreated depression. Gloria had now started antidepressant treatment, and the importance of access to further rehabilitation was noted when her depression was (hopefully) treated. The CNS amended the antidepressant prescription to increase the dose after seven days as Gloria was started on the lowest dose, and requested that the discharge planning team allow Gloria time to recover from depression and to access further therapy once discharged back into the community. The CNS also recorded in Gloria's notes that the CNS would review Gloria when the CNS returned to work on their return from leave if Gloria was still in hospital after the Christmas period, and refer her to the Community Mental Health team for follow up unless she was much better by the time of discharge. The CNS also recorded that Gloria constantly stated that she felt that she wanted to die and when the CNS asked if she ever thought about ending her own life, she told the CNS that she had no idea how she would do it. Gloria agreed to a trial of antidepressants but expressed her dismay that they would take six weeks to work. The CNS told her that they would start to work much sooner than that – around two weeks.

The recorded prognosis was that the CNS had *“great hope that [Gloria] could return to her former level of functioning and good mental health with antidepressant treatment...as her mood had deteriorated from not depressed to depressed in one week, her recovery would be swift.”*

14.29 The CNS also spoke with Marcus and Gloria’s stepdaughter separately. The CNS explained the plan for antidepressants and how long it should be before they would take effect. In her discussion with him, Marcus appeared to be very quiet and was not making much eye contact, which led the CNS to consider that he might be depressed. She asked him how he was, and he answered that he was ok. She suggested that if he were struggling, to make an appointment with his GP.

14.30 A discharge care package was arranged the same day. This was supported by the Hospital Occupation Therapy Team and Intermediate Care Team (ICT). The care plan included visits from ICT four times per day which is the maximum amount of hospital discharge care available following discharge from hospital. The care provision would be handed over to a care provider as soon as an agency was available. The care package to be provided included toileting/incontinence care, washing and dressing, exercises as prescribed by the physiotherapist, monitoring of skin viability, meal preparation, fluid and nutrition, helping and assessing Gloria to move and be comfortable. The records indicated this plan was revised very soon after Gloria’s discharge to include provision of medication management because Marcus advised that he could not cope with the medication regime as it was quite complicated, as the medications were needed at specific times throughout the day.

14.31 The panel noted that the care providers’ care plan records indicate that the care plan was delivered as agreed, and there were no signs of abuse observed by the carer. The panel also noted that discussions between the carers and Marcus were recorded, but these appeared to be minimal in content. The panel could not further determine if minimal discussion between Marcus and the carers was the result of Marcus enabling their access to the property and then he left them to focus on attending to Gloria; if Marcus did not engage in conversations; or if further discussions with Marcus took place but were not recorded. The panel also noted that there was poor record keeping in the daily care plan records showing confusion of the dates of some entries.

14.32 On the day Gloria was discharged, her GP surgery received an email from the ICT. This advised the GP surgery of Gloria’s discharge, her antidepressant prescription and a review of this as suggested by the CNS. The panel noted that Gloria was discharged prior to a holiday period.

14.33 Just two days before Gloria died, the GP surgery date stamped a letter it received. The panel understand this letter was not seen by a GP until after Gloria’s death. The source or sender of the letter was unclear but stated, *“It seems that [Gloria] is not long for this world. She doesn’t make much sense when she does. She has NHS nurses visiting four times a day. I understand that you will already have a copy of her medication list, but I enclose a copy just in case. Please issue a prescription as appropriate. You may wish to come and have a look at her...”* The panel noted that this letter was sent to the

surgery during a holiday period and there was a lower level of staff working during this period.

14.34 When the CNS returned from leave, she noted that Gloria was no longer on her caseload and had been discharged from hospital. The discharge summary recorded that Gloria “*looks and feels better*” and that she “*feels the antidepressants are helping a bit*”. The CNS telephoned Gloria at home to review her progress and was advised by Gloria’s stepchild that she had died four days ago.

15. OVERVIEW

15.1 When the panel considered the chronological information, it noted Gloria was seen by a multitude of professionals, with her care and treatment being reviewed many times. It also noted that there were potential risk indicators that emerged over time and these were not identified or responded to, and it follows there was minimal evidence to suggest to the panel that these were referred as a possible safeguarding issue and assessed. The panel noted that, 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. Gloria expressed to others repeated suicidal ideation, and this correlated with reduced engagement with rehabilitation. The panel also noted that Gloria’s dependency on others increased, and there were indicators that she was concerned that this placed Marcus, as her main carer, under additional pressures. The panel found no evidence that Marcus received signposting advice as to how to access, or was offered, a carer’s assessment. Gloria was discharged home prior to a seasonal period which is known to result in a reduced period of staffing and there was minimal discussion with Marcus or Gloria on how this would impact on them, together or individually. The panel also noted that, following her discharge, Gloria may have increased her requests that Marcus support her to die. Although Marcus did have opportunities to disclose his struggles or pressure from Gloria to support her end of life, he did not do so until after he confessed to killing her.

16. ANALYSIS

16.1 The panel agreed that Gloria, at the time of her death, was an adult who required care and support in line with the Care Act 2014²⁴. The evidence presented to the panel indicated that Gloria:

- Had mental capacity to make decisions generally, but also about her care and treatment²⁵.
- Was able to make informed decisions about her care and support needs.
- Her wishes and feelings informed the care she received.
- There was evidence that her consent was obtained prior to sharing information with Marcus and her family.

²⁴ <https://www.legislation.gov.uk/ukpga/2014/23/contents>

²⁵ [Mental Capacity Act - Social care and support guide - NHS](#)

16.2 In reaching this determination, the panel noted that no key decisions were needing to be made and so there was not a requirement for a formal mental capacity assessment to be undertaken with Gloria.

16.3 The panel noted that Gloria was asked by some clinicians if domestic abuse was a feature in her life and the panel agreed this was good practice that aligned with relevant National Health guidance (NICE)²⁶. It agreed this was good practice. Gloria did not disclose that domestic abuse was part of her lived experience, but she did disclose that she had, in a previous relationship, suffered domestic abuse. Being mindful that domestic abuse can present in different ways to what a victim may have experienced in previous relationships, the panel considered if further discussion with Gloria would have been appropriate. It was clear from the many people who spent time with Marcus and Gloria, or who were part of Gloria's care, that at no time did Gloria disclose domestic abuse. Although routine enquiry was not undertaken by all agencies who had interactions with her, many noted Gloria spoke positively of the perpetrator. Some noted that there were no indicators of domestic abuse within the couple's relationship dynamic, signalling to the panel that the professionals had considered this. On many occasions Gloria indicated she was happy at home, loved her life with Marcus and that he was a 'very good man'. Neither family members or professionals had seen any evidence of abuse prior to her admission to hospital. During her stay in hospital Gloria had repeated time alone with professionals and discussed extremely personal and sensitive issues in relation to her care, and so there seemed to be no barriers to Gloria disclosing abuse. In the absence of any indications that raised concern that domestic abuse was a feature of Gloria's lived experience, the panel agreed the discussions that took place with Gloria were appropriate and proportionate to the information that presented to clinicians at the time.

16.4 The panel next considered the perpetrator's medical information and noted that he had, in the past, some years before meeting Gloria, experienced a period of mental ill health. There was no evidence to the panel that indicated he had accessed medical or clinical support in relation to his mental well-being or mental health during the period of Gloria's hospital admission and stay, or following her discharge. During this period, the panel noted that Marcus seemed to struggle with his responsibilities as a carer and his mood, to other family members and one clinician, appeared to be low. The panel agreed that Marcus had received the appropriate advice in relation to his mental wellbeing, namely that he seek GP support if he felt low.

16.5 The panel also noted that it was known to professionals that Gloria had, in the past, expressed to others that she wished to die. Information from clinicians considered by the panel included Gloria reporting to them that she was feeling helpless and hopeless, and wanting to die if ever she felt she would "be a burden" to her family and the perpetrator. At the time Gloria made these statements to professionals, the risk of suicide was assessed and recorded as low and that professional judgment informed the decision to assess the likelihood of imminent

²⁶ [Overview | Domestic violence and abuse | Quality standards | NICE](#)

completed suicide. During her more recent period of illness, Gloria was referred to LPS on two occasions, and the panel noted that on both occasions the risk of suicide was assessed, and the panel agreed the low-risk assessment outcome was correct. The panel also noted evidence that they used professional curiosity and considered her past history of suicide attempts, which included asking her about plans and methods she might deploy, and that they also considered access to methods. The agreed plan was to treat Gloria's depression whilst she was in hospital, and the panel understand that is for this reason that, when Gloria was seen by LPS, there was no discharge date/ no discharge plan. The panel found no evidence to suggest the low-risk assessment was reviewed when her health declined, and the panel noted that Gloria was referred to, and assessed twice, by the Clinical Nurse Specialist (CNS) (LPS) on 5 December 2022 and on the 22 December 2022. She died on 31 December 2022.

16.6 The panel noted and commended the (CNS) who was concerned enough to request a review of Gloria's depression in the new year. However, it agreed that whilst she was in hospital, any further suicidal thoughts or plans should be acted on immediately by the health team using the hospital's out of hours service if needed. The panel understand this service is not available to discharged patients and agreed that, at this point, there was no requirement to inform the family of that element of the plan. The CNS had anticipated seeing Gloria in hospital on return from leave and was not involved in her discharge planning.

16.7 It was unclear to the panel as to whether or not the ICB had the same information and resources to intervene if Gloria's suicidal thoughts and plans were recognised by their workers. The panel agreed this may be due to a lack of this being recorded. The panel further noted that assisted suicide was not assessed and agreed the response to any requests made by Gloria to support her to die could have formed part of the advice that could have been given to Gloria's family at the time.

16.8 After Gloria's death, Marcus is reported to have tried to take his own life using paracetamol and alcohol. He was discovered by a stranger who was undertaking a parcel delivery to their home and this prevented his worsening condition or death. Whilst in hospital Marcus did not disclose why he tried to take his own life, or his involvement in Gloria's death, but later, during Police interviews, after he confessed to the murder of Gloria, he stated his suicide attempt was linked to his actions in taking Gloria's life. The panel agreed there was no indication to suggest that Marcus posed any risk to himself prior to Gloria's death, and so it agreed that there was no indication that suggested he may pose a risk to Gloria. In reaching this determination, the panel was mindful that suicidal ideation is a high-risk indicator of domestic homicide. The panel were also cognisant of research²⁷, which it considered relevant to this case,

²⁷ Siobhan T. O'Dwyer, Astrid Janssens, Anna Sansom, Lucy Biddle, Becky Mars, Thomas Slater, Paul Moran, Paul Stallard, Julia Melliush, Lisa Reakes, Anna Walker, Charmaine Andrewartha, Richard P. Hastings; Suicidality in family caregivers of people with long-term illnesses and disabilities: A scoping

indicating that nine million people in the UK provide unpaid care to family members or friends with long-term illnesses or disabilities and highlights that the overwhelming and unrelenting pressures of caring can lead some carers to contemplate and/or attempt, homicide, suicide and/or homicide-suicide. This research also suggests that one in six carers are likely to attempt suicide in the future and one in ten have already attempted suicide and established that:

- There is currently no systematically collected evidence to indicate how many carers have died by suicide or homicide-suicide.
- Suicidal ideation in carers can be accompanied by homicidal ideation.
- Homicidal ideation has been attributed to an inability to continue caring.
- The majority of carers who kill the person for whom they care do not have a history of domestic violence.
- Consistent with the general population, depression, anxiety, dysfunctional coping strategies, and limited social support are risk factors for suicidal ideation in carers. It is important to note, however, that suicidal ideation has also been reported in carers without depression.
- There are also risk factors for suicidal ideation that are unique to carers. These include dissatisfaction with the caring role; wanting a reprieve from caring; experiencing conflict with family or health and social care professionals over the care provision; and, not having an identity or role beyond caring (such as a paid job or volunteering).
- Health and social care professionals in the UK are encountering carers at risk of suicide, but many lack the skills and resources to identify and support them.
- There have been no interventions specifically designed to address suicide (or homicide) risk in unpaid carers and, due to the dyadic nature of caring and the need to safeguard vulnerable care recipients, existing suicide prevention initiatives are unlikely to be sufficient.

16.9 Being mindful that Marcus attempted suicide after he killed Gloria, and that no agency was aware of him having any suicidal thoughts and/or behaviours or recognised these in his presentation prior to him killing her, the panel were not able to make a specific recommendation to address this learning, but it invites the Community Safety Partnership and the Home Office to consider how this research can be embedded into practice to:

- Ensure recognition in assessments of suicidal ideation in carers who are family

review, *Comprehensive Psychiatry*, Volume 110, 2021, 152261, ISSN 0010-440X,
<https://doi.org/10.1016/j.comppsy.2021.152261>.

members reflects cognisance of how this can accompany homicidal ideation alongside an inability to continue caring.

- Appropriately align assessment outcomes with domestic abuse pathways, including risk assessment of, and ongoing support for, victims of domestic abuse.

16.10 The panel next considered assessment of Marcus' ability to provide the level of care that Gloria's declining health required prior to his killing her. The panel also noted that there was no evidence to indicate that a carer's assessment was discussed with Marcus or the couple's adult children, though there was evidence that confirmed to the panel that Marcus and one of his children were both engaged in learning how to use some of the mobility equipment that was being provided, and family lived close to the couple so could provide additional support with Gloria's rehabilitation. The panel also noted that there appeared to be no recorded assessment of the perpetrator's support needs prior to her discharge, despite his being older than Gloria. The panel noted that the evidence presented to it during the course of this review indicated that at no time did any professional consider his emotional capacity to care for Gloria. He indicated to clinicians that he was not happy to administer medication to Gloria and he was not willing or able to carry out personal care tasks but was responsible for feeding her and being with her for prolonged periods of time. The panel noted that although Gloria's discharge package included the maximum care provision available, and she received four home care visits a day, the panel agreed that in the absence of Marcus' needs and capacity to care for Gloria being assessed, and a lack of him being signposted to access a carer's assessment, this was a potential missed opportunity to fully establish the impact of the significant life changes the couple were experiencing, and Marcus may have been unaware of the support he could receive as Gloria's main carer. In reaching this determination, the panel were also aware that the information presented to it during the course of this review indicated that Marcus experienced episodes of significant depression in his past and, although services supporting Gloria and liaising with Marcus and other members of her family may not have been aware of this, a carer's assessment could have enabled assessment of his current mental well-being and how this impacted on his ability to continue to provide the level of care Gloria needed following her discharge from hospital. In reaching this view, the panel noted there was an absence of any professional or family member becoming concerned about Marcus's ability to care for Gloria and agreed that a discretionary s.42 assessment under the Care Act²⁸ was not appropriate to the circumstances of this case, and agree that nothing presented to suggest to the panel that this ought to have been considered.

16.11 The panel also noted that a letter was sent to the couple's GP surgery and noted the content of this letter suggested that this was most likely from a person who was close to Marcus or from himself purporting to be someone close to him. Due to the

²⁸ <https://www.legislation.gov.uk/ukpga/2014/23/notes/division/5/1/10?view=plain>

In the area, following previous DHR learning, discretionary Section 42 assessments are now undertaken, even if someone does not present with care and support needs. This includes those undertaking caring for someone and indicated that they are struggling. A referral can be made to Adult Safeguarding for consideration of a discretionary s.42 assessment being undertaken.

holiday period, the panel understand this letter was not seen by a GP until after Gloria's death and so the panel was unable to analyse this further nor was it able to consider if:

- This was a cry for help in relation to his increased caring responsibilities or an attempt to access support in relation to the perpetrator's repeated assertions (after he killed her) that Gloria was requesting he assist her dying.
- If a GP's visit to Gloria and Marcus would have enabled recognition of the perpetrator's distress and depressive state and enabled a carer's assessment to be offered to the perpetrator.
- This was an indication of Marcus pre-planning Gloria's death.

16.12 The panel noted the IMR submitted by the ICB on behalf of the GP Practice made recommendations in relation to this letter and these are included below, having been endorsed by the panel.

16.13 During her stay in hospital, Gloria stated that she did not want to become a burden to her family, and this would be a trigger for her to consider planning her suicide. When she was discharged, Gloria had been assessed as having "full care needs", very limited mobility and diagnosed with depression. The evidence presented to the panel within the chronology suggested that Gloria responded well to High Intensity Integrative Therapy. The panel noted that toward her discharge from hospital, her mood began to improve once she commenced her prescribed antidepressant medication. As such the panel considered if Gloria had received talking therapy (TT) alongside her medication prior to her discharge from hospital and whether this may have supported or enabled her to engage in rehabilitation and reduced her desire to die. On the basis of the evidence it considered, the panel agreed that on the balance of probabilities this may have enabled Gloria to regain a more positive outlook on her life. However, the panel also noted that during her stay in hospital, Gloria was not mentally well enough to engage in TT. Gloria was assessed by the CNS who stated that following the second session, Gloria was depressed and hardly speaking. At that time, she was not suitable for referral to TT for structured therapy sessions, but the CNS believed prognosis was good and planned to follow her up in the hospital and recorded that, if at the point of discharge there was a need for TT, LPS staff could refer Gloria to receive this via a referral to Mental Health Primary Care²⁹.

16.14 The panel were aware that, following Gloria's death, Marcus consistently stated that Gloria requested that he end her life after Gloria was discharged home. Whilst this may have been true, the panel noted that Marcus did not share with professionals that Gloria was making this request of him, the difficulties this was causing him, and

²⁹ TT is commissioned through Primary Care MH who provide community based services. Following referral, this service can offer an assessment to see if a patient is suitable for TT within a short period (via video link is most common but they can offer an assessment appointment in person) and if accepted they are placed on a waiting list for therapy.

that, on her discharge home, home carers were entering the couple's home four times a day to support Gloria's care and support needs but did not record that they were aware of her making this request of him.

16.15 Being mindful of the sentencing Judge's comments, the panel noted that by the time Marcus killed Gloria, there were elements of the temporal sequencing of the Homicide Timeline³⁰ evident in this case but these were unknown to professionals prior to Gloria's death. In the absence of evidence to support it doing so, the panel make no further determination in relation to this.

16.16 The panel noted this review concluded after the consultation on the Terminally Ill Adults (End of Life) Bill and this is now being considered by a Parliamentary Committee. It invites the Home Office to consider the learning from this review be shared with the Committee so any statutory guidance to support any legislation in relation to Assisted Dying ensures that carers supporting significantly ill adults are adequately assessed, so that safeguarding concerns, including the prevalence of domestic abuse, are known to professionals and associated risks mitigated.

CHANGES THAT HAVE TAKEN PLACE SINCE THE DEATH OF GLORIA

16.17 The panel noted that the 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, and more directly, as part of practitioners' routine contacts.
- The countywide All Age Carers Strategy for Cambridgeshire and Peterborough was revised in 2024, and domestic abuse (DA) was included as a priority workstream. As part of this workstream, Cambridgeshire County Council included DA support when recommissioning the adult carer support contract in 2024. The contract provider has received training from the DASV Partnership around unpaid carers and DA, and launched a DA awareness campaign aimed at carers in April 2025. Training around unpaid carers and DA has also been delivered to Adult Social Care (ASC) and Adult Safeguarding staff at Cambridgeshire County Council and Peterborough City Council, to DASV Champions across the county and to Cambridgeshire Constabulary Vulnerability Desk staff. Finally, processes are now in place for carer support organisations to ask carers directly about DA and to refer them for support.
- The adult home care contracts are being retendered currently, and separate DA training has been included as a requirement for all providers.

17. GOOD PRACTICE IDENTIFIED WITHIN THIS REVIEW

³⁰ Monkton Smith J (2017) Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide; Sage Journals vol. 6 issue 1 <https://doi.org/10.1177/1077801219863876>

17.1 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 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 commend 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.

18. CONCLUSIONS

18.1 The review identified a wealth of systemic learning in relation to carer stress, suicidal ideation in care contexts, and discharge planning. On the basis of the information presented to the panel, the panel concluded that:

- Prior to Gloria being killed by the perpetrator, there was minimal evidence to suggest that domestic abuse was a feature in her relationship with Marcus.
- 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 self-care and therapy. She was seen by a multitude of professionals and received 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.
- Marcus had not been offered a carer's assessment nor had received signposting advice as to how to access one.
- 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 disclose or share his struggles and so concluded the risk he posed to Gloria was not known to professionals and that no agency was enabled to become aware of, or to take action, to mitigate risks posed to her.

18.2 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.

19. LESSONS IDENTIFIED

19.1 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 carers 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.

19.2 The panel 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.

20. 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, including the LPS. This is to include improved recording systems on the EPR.
- IV. The Community Safety Partnership to seek reassurance that its constituent partners appropriately signpost carers to carer's 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 clear audit trail of discussions with patients and their families