Executive Summary

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

(March 2022)

Author – Jackie Dadd

Date completed – September 2023

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

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1. The review process

1.1 This review is into the death of Richard, a 32-year-old male, who was found, having taken his own life at his workplace by a colleague in South Cambridgeshire in March 2022, following Richard's disclosures of domestic abuse subjected to him by his mother-in-law. The Police have investigated the circumstances and submitted a report to the Coroner with a finding that the death was non-suspicious and believed to be suicide by way of hanging.

Due to information provided by work colleagues, a criminal investigation into controlling and coercive behaviour was raised and transferred to the Metropolitan Police, Enfield Borough as this was the area that the crime would have been committed in. Geetika was eliminated as a suspect without being spoken to. Rationale has not been provided to the author on request and can therefore not be included. A voluntary interview was held with Ishika during which she replied no comment to the majority of questions put to her and she denied all controlling and coercive behaviour. She surrendered her phone which was forensically examined and no material supporting the allegation was found on the device. A file has been submitted to the Crown Prosecution Service (CPS) for a charging decision.

Cambridgeshire Police initially referred the matter to Enfield CSP due to the victim living with his wife and her mother (the alleged abuser) on weekends within the Enfield borough. There was a delay in commissioning the review whilst the area for responsibility was established, as Richard owned a property within Cambridgeshire, where he worked and lived alone during the week.

Richard's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

1.2 A Post-mortem was subsequently held.

The result of that post-mortem examination was: -

1a. Neck compression due to hanging

There were signs associated with a neck ligature circumferential mark around the neck, of width consistent with the accompanying belt.

There were superficial marks found on the body within the spectrum one might see in association with sports activities and hobbies and also marks caused by medical intervention during attempted resuscitation. There was no sign of recent trauma or defensive wounds.

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

1.4 The following pseudonyms, agreed by the family, have been used in this review to provide confidentiality and protect their identities:

Richard – Deceased. A white British Male, who was 32 years old, at the time of his death.

Geetika – Wife of Richard. A 34-year-old Indian female.

Alice – Mother of Richard. A white British female.

Brian – Father of Richard. A white British male.

Ishika – Mother-in-law of Richard, mother of Geetika. A 74-year-old Indian female.

Address – Name of area referred to as Cambridgeshire.

1.5 IMRs were requested from the agencies who had significant communication with Richard, Geetika or Ishika or held significant and relevant information about them. Selected agencies were asked to submit a summary report to reflect the Terms of reference and provide context to prevalent areas including familial abuse, suicide and male victims. This was to assist in analysing the depth of knowledge and support already in existence and being required in the South Cambs area.

2. Contributors to the review

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

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
IMPAKT Housing Support	Summary report, Panel member (3rd sector)
NHS Cambs and Peterborough Primary Care Integrated Care Board (ICB)	Summary report, Panel member
Peterborough and Cambridgeshire Domestic Abuse and Sexual Violence Partnership	Panel member, Oversight
South Cambs District Council/CSP	Panel member, Oversight
Cambridgeshire Public Health	Panel member
Barnet, Enfield and Haringey Mental Health Trust	IMR, Panel member
Adult Social Care (ASC)	Summary report, Panel member
Enfield Borough CSP	Co-ordination
North Middlesex University Hospital NHS Trust	Panel member, IMR

East of England Ambulance Service NHS trust (EEAST)	Panel member
Cambridge Community Services NHS Trust	Panel member

3. Review Panel members

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

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence Partnership Manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection Lead	Cambridgeshire Police
Elaine Joyce	Section Safeguarding Lead	East of England Ambulance Service NHS trust (EEAST)
Ginika Achokwu	Head of Safeguarding	Barnet, Enfield and Haringey Mental Health Trust
Ashley Holderness	GP Practice Representative.	NHS Cambs and Peterborough Primary Care ICB
Kathryn Hawkes	Communities Manager	South Cambridgeshire District Council and representing the South Cambs CSP
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Charley White	Resettlement Manager	IMPAKT Housing & Support
Tracy Brown	Adult Safeguarding Lead	Cambridge University Hospitals NHS Foundation Trust
Zoe Ward	Named Nurse Adult Safeguarding	Cambridge Community Services – NHS trust
Anna Young	Domestic Abuse and Sexual Safety Co-ordinator	Barnet, Enfield and Haringey Mental Health Trust
Jennifer Elliott	Adult Safeguarding Advisor	North Middlesex University Hospital NHS Trust

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

A total of three panel meetings have been held during this review, excluding the initial meeting to decide on the commissioning. The writing of this report had significant delays whilst awaiting the conclusion of the criminal investigation and updates from the Metropolitan Police.

The Home Office were kept informed throughout. The completed report was handed to the South Cambs Community Safety Partnership on 27th September 2023.

4. Author of the overview report and Chair

4.1 - The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police since January 2021, with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has undertaken a number of DHRs having completed the Home Office online training, the CPD accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion.

5. Terms of Reference

5.1 - Terms of reference were discussed and agreed upon during the first panel meeting on 21st September 2022.

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

1) If Domestic Abuse (DA) in any form had been a contributory factor to Richard taking his own life
2) What literature and communication in relation to domestic abuse, specifically familial abuse is available to the public and employers so that the behaviour can be recognised as such and support obtained
3) What training have professionals received in relation to recognising signs of DA, in particular, familial abuse and are sufficient opportunities provided for disclosure
4) What provisions are available within Cambridgeshire for males suffering from domestic abuse and mental health issues.

5.2 - The full Terms of Reference are below:

- The date parameters under consideration are from 2016 until present. However, if relevant information is held prior to this, can a summary be provided to provide context.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was the cause or a factor in the death of Richard.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process.
- Seek the involvement of employers and friends to provide contextualised analysis of the events.

- Establish what literature and training is available in relation to familial DA for both professionals and the public to recognise and understand it within the South Cambs and Enfield areas.
- Is there sufficient support available locally for male victims of domestic abuse and how accessible are they?
- Establish whether agencies have appropriate policies and procedures to identify and respond to domestic abuse and whether these were acted upon. Recommend any changes following the review process.
- Establish accessibility of services for those contemplating suicide and whether training has been received in relation to the effects DA may have towards this.
- Establish if there is sufficient professional curiosity and opportunity provided for disclosure of DA from professionals surrounding pregnancy, birth and fertility discussions.
- What information is available to professionals and employers within the areas of South Cambs and Enfield in regard to domestic abuse and suicide. What training have they had and what policies do they have in place to be able to respond to any disclosures from employees.
- Were procedures sensitive to the ethnic, cultural, linguistic, and religious identity of the deceased and his wife? Was consideration for vulnerability and age necessary? Were any of the other protected characteristics relevant in this case?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review

6. Summary Chronology

6.1 Richard grew up as an only child to his loving parents, excelling at school and going on to attend a London university with his long-term girlfriend to study for a design innovation degree. Richard was successful there but when his relationship came to an end, Richard did not cope well. He suffered with anxiety and depression and took medication for this.

6.2 Late in 2016, Richard went to his GP who arranged for him to receive Cognitive Behaviour Therapy as he was having suicidal thoughts. This was delivered by Crisis Resolution Home Treatment Team where he received five sessions of counselling as he had a history of self-harm which took the form of hitting himself and other objects and had increasing suicidal ideations that had been ongoing for two years. He stated he was single and expressed suicidal thoughts of escaping as a means to end his current situation. He felt hopeless, angry and worthless due to his unemployment.

In February 2017, Richard was employed as a design engineer at a Medical Technology company in South Cambridgeshire. He was good at his job and highly thought of. He showed

some autistic traits through his anxiety which were recognised by his employers and they made allowances for this in relation to working hours and support, even though he was not officially diagnosed.

Richard registered at a Cambridge GP in 2018 and although he remained on medication, he reported that he had felt better since the cognitive therapy.

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In April 2018, Richard started speaking to Geetika through online dating and they met each other in the summer. They became engaged in December 2018. Ishika chose a ring and had it made. She initially paid for it as Richard could not afford it and he had to pay her back in instalments. They were married in August 2019.

His parents noticed a change in Richard once he was married. They never saw Richard without Geetika and Ishika present. She went everywhere with them. After Christmas 2019, Richard's parents only saw him 5-6 times more due to covid restrictions limiting visits and Richard distancing himself.

When Richard stayed with his Ishika and Geetika at their house in London on a weekend, they would have to leave their bedroom door open at all times. Soon after they were married, Ishika told Richard he was not allowed to leave any of his belongings in her large house in London.

Richard disclosed numerous information to his colleagues in relation to the abuse he was receiving from his mother-in-law, Ishika and then eventually his wife, Geetika. Richard bought a house in Cambridgeshire in 2021 which his parents helped by giving him some money which they didn't expect back and also Ishika lent him some money which he had to pay back in instalments. This gave her a hold over him and in addition to this, he disclosed that he paid half of his wages into a bank account owned by Ishika and Geetika that he did not have access to.

6.4 Richard confided in colleagues that his wife and mother-in-law would make him say awful things to his parents which he knew upset them and that any texts he sent to his parents were dictated to by Ishika and eventually Geetika. He therefore contacted them less to prevent upsetting anyone.

Richard and Geetika were trying for a baby but could not conceive which Richard was ridiculed for by his mother-in-law. He went to the Doctors for fertility tests in July 2021 and Geetika fell pregnant in August 2021 prior to him obtaining the results. Richard was excited about being a father. When he met with his parents to tell them in the October, it was Ishika

that broke the news and told them that they had to have fertility tests as he struggled to get her daughter pregnant, then criticised them to Richard afterwards for not reacting in the right way. They felt shocked that Richard had not been given the opportunity to tell them himself and felt the information in regard to the fertility tests was unnecessary at that time.

Ishika would constantly ring Richard at all times of day or night 'having a go' at him which his colleagues would witness as he would just reply 'yes mum' during lengthy conversations.

On one occasion whilst in Great Yarmouth (date not known), he told his wife and mother-in-law that the way they treated him made self-harm and have suicidal thoughts. Ishika mocked him telling him to walk into the sea or step in front of a bus. She threw away his medication, telling him that he would not be able to hold his baby when it was born and threatening him that it would be easy to get him a divorce from her daughter and he was easily replaceable. Geetika went along with this to the point that Richard disclosed to a colleague that he feared they would both stop him seeing his child when it was born.

6.5 Richard told colleagues how he was not allowed to attend any antenatal checks. He would drive them there and Ishika would go into the appointment with Geetika. They would show him a scan photo afterwards.

Richard was constantly being criticised for the way he ate his food and held his arms when he walked and due to what he was being made to say to his parents, which he knew hurt their feelings, he stopped contacting them. He told colleagues 'they would find out if he tried to contact them privately'.

One day in late March 2022, Richard completed a presentation in the morning at work and did well in something he always found a little difficult. His colleague's comment that he spent most of the afternoon on the phone, taking the calls in a private room. His colleagues state that he was arguing with his mother-in-law. CCTV and phone records confirm this and Richard disclosed to a colleague via text that his mother-in-law had been on the phone on and off since 3am that morning. This was explained by him as he had been unable to respond to his colleague instantly.

CCTV shows him entering the shower room at 15.55hrs that day. Richard often worked later than others and had a set of keys. As a colleague was locking up the premises, he heard the shower running so completed the remainder of the building before returning. The shower was still running and the door was locked so he let himself in. He saw Richard slumped on his knees in the corner with his belt tied around his neck and tied to the railing pole.

6.6 The Police and ambulance were called and CPR was given by all to no avail. This was at 19.28hrs, the same day and it was estimated that he had been deceased for about two hours. The Police began an investigation. An envelope was found on Richard's desk with a list written on one side entitled 'reasons why…' which appeared to be a list of issues in his life, which, from information already received from colleagues was assumed to relate to his wife and mother-in-law.

It reads:

Reasons why…

- Feel emotionally manipulated
- My problems, fears, pain don't matter and are less than yours
- Always being told to 'man up'
- Being told it is all in my mind and I am making it up
- If I just think positive, I choose to be negative all the time
- My negative energy is bringing everyone down and is the reason for all these bad things happening
- Controlling my relationship with my parents to supposedly improve my relationship with them
- Calling my father a bad person all the time
- Always questioning everything I do, hurting me, correcting me, threatening me to improve
- Orchestrating my messages and what I should say and how behave
- Completely dismissing and undermining my pain and shutting me down, always saying you and your family's pain is greatest
- I'm afraid to voice my true feelings or concerns, in fear that they will cause arguments as they usually do
- If you mean you love and care for me as you say you would recognise what you are doing to me, listen to me, recognise the pain that you are causing rather than continue to pressure me to change, use emotional manipulation, upset me, cause me to self-harm, hit myself, want to die

  On the opposite side:

- Controlling how and when and how I talk to my parents is causing me pain and hurt that you feel I should do this
- My family is often contacted just like myself, this brings me down and makes me sad
- Drug addict has to go through shit to become a better person

Richard's mobile phone data showed that he had rung two domestic abuse helplines on the morning of the day that he died. Throughout the review, the investigation has been awaiting the submission and download of Richard's laptop. At the time of publication, the results of this have still not been received and therefore, the investigation is still ongoing.

A file was submitted to the coroner stating that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging. The Coronial process was suspended awaiting the outcome of the Police investigation and is taking place parallel to this review. This is still the case at the time of publication.

Richards baby daughter was born less than three weeks after his death. He will never get to hold her, as he dreamt of doing.

7. Key issues arising from the review

7.1 Lack of awareness for the public and employers in relation to identifying familial abuse and how they can support employees

Richard's Colleagues and employers all recognised that the behaviour he received from his mother-in-law was wrong but did not recognise this as a form of domestic abuse and did not know what familial abuse was. They did however recognise domestic abuse in relation to the treatment from his wife when he began to disclose how she had also started to dictate and belittle him.

The company's mental first aiders had not been trained in domestic abuse and were not aware of pathways they could signpost him to for support. There was no escalation policy in place for disclosures or identification of any person at risk and therefore, there was a delay in the senior members of staff being aware of Richard's situation.

All websites of the organisations represented on the panel in both the Cambridgeshire and the Enfield area have excellent literature on domestic abuse and support services including familial abuse and its definition if you use the search criteria. However, if you cannot identify that you or someone else are suffering from familial abuse and it is seen as just an 'an evil mother-in-law' as described verbally by one colleague, then the search for domestic abuse would not be made. It is not known whether Richard contacted the domestic abuse lines on the day of his death due to the behaviour received from his wife or that of his mother-in-law or both. (Recommendations refer)

The internet does not refer to either domestic or familial abuse if you utilise the search facility surrounding wording of being treated badly by your mother-in-law or suchlike.

7.2 Accessibility of suicide prevention tools for those outside of statutory organisations

Cambridgeshire Public Health have a comprehensive Suicide Prevention Plan with funding streams to provide an array of subjects that are trained to the Community/Statutory Organisations for free. One of these funding streams is to run STOP suicide workshops is suitable for businesses but they would have to self-fund and these workshops are not widely known outside of the funding stream.

There is no central support for employers from Public Health, but each individual workplace should have procedures in place.

During panel discussion, there was some reflection on some of the circumstances of Richard as the new National Suicide Prevention strategy states:

Evidence suggests autistic people, including autistic children and young people, may be at a higher risk of dying by suicide[1] compared with those who are not autistic. It is essential that health, mental health, and local authority services and education providers consider the needs of autistic people in suicide prevention activity. While many actions in this strategy will support autistic people, we need to tackle the specific preventable risk factors and tailor support to their needs.

Undiagnosed or late-diagnosed autism may be a preventable risk factor for suicide and, therefore, earlier identification and timely access to autism assessment services is vital.

Cambridgeshire Public health suggested a recommendation that ongoing suicide prevention activity is adapted to meet the needs of people with autism and learning difficulties. Key organisations need to be identified and suicide prevention resources shared with them alongside training. (Recommendations refer)

8. Conclusions

8.1 The panel were satisfied that the Cambridgeshire and Peterborough DASV had addressed the awareness and provisions for male victims of domestic abuse within the area sufficiently over the past few years. Richard accessed information and helplines available nationally for male victims on the morning of the day he died, evidencing he had managed to both identify that he was a victim of domestic abuse and obtain information on where he could speak to someone for support.

It is not known whether he had identified that he was a victim of domestic abuse from just his wife, Geetika, or from his mother-in-law, Ishika or both. It was clear that he knew the way he was treated and spoken to by Ishika was not acceptable due to the disclosures that he made to colleagues and the notes that he had written on an envelope that were found on his desk indicated that some of the points were directed at Geetika. His employers and colleagues responded to Richard's disclosures with empathy and support with no show of unconscious bias that he was a male and therefore any less of a victim. Their sentiments since his death in relation to the behaviour of his wife and mother-in-law towards him encompasses frustration that they could not have done more to help. They recognised that the way he was being spoken to and treated by Geetika was domestic abuse but did not realise the familial abuse from Ishika although they knew that her behaviour was not how a mother-in-law should behave towards a son-in-law. The company and staff have not received any training in relation to domestic abuse or suicide which they are open to and they should be commended for their support of Richard during his last few months. This

[1] Premature mortality in autism spectrum disorder - Cambridge University press. 2nd January 2018

does highlight the lack of recognition of familial abuse, not only by employers but by the public in general.

All panel members organisations in both Cambridgeshire and the Enfield Borough include familial abuse within their domestic abuse training, which is best practice, but this training is sometimes only delivered to those in specialist safeguarding positions so does not provide the understanding to the wider members of staff. The panel feels that both locally and nationally, familial abuse awareness and understanding is required amongst employers and in communities.

8.2 Richard's previous history of mental health, self-harm and suicidal ideations was manifested following his wedding by the emotional abuse initially from his mother-in-law and then from his wife and his vulnerabilities were exploited. He began to question and doubt himself due to being criticised for how he held his hands and being told his parents were at fault that he had autism as they had not brought him up properly. Ishika would then make him think he had misconstrued what she had said causing him additional confusion and emotional abuse. This was to the extent that he asked the doctor if he could be tested for a diagnosis as he had been convinced that he suffered from autism.

Controlling and coercive behaviour that would have a direct impact on his marriage begun almost immediately after the wedding with Richard not being able to leave any of his belongings at the Enfield address and having to have the door open to the bedroom whilst he slept when he stayed there on a weekend. Ishika insisted on always being present when they were together including holidays and it was initially considered by the panel as to whether Geetika was also being controlled and may require safeguarding but due to information gathered during this review with opportunities to disclose to health professionals and no concerns noted when asked and then the disclosures Richard made to his colleagues of how his wife was treating him along with the comments he made on the envelope, it would appear she was abusing him both emotionally and financially and also controlling him to a degree.

There was a missed opportunity for Richard to disclose his abuse to a professional when he attended the GP Surgery in relation to him and his wife not being able to conceive and mentioned family stress which was not explored by the Doctor. It is also not recorded as to whether he was asked why he thought he may have autism which would have been a further opportunity for him to disclose the abuse he was receiving.

Richard showed deep concern as to how he was being forced to treat his parents, knowing that it would upset them and not knowing what to do as he was trying to appease his wife and mother-in-law who both dictated to him what to say.

8.3 Richard told his colleagues how happy he was that he was going to become a father and had made steps to read books to prepare himself. However, a culmination of being told not to take his tablets for depression as he would not be able to hold his baby, fears that his marriage would end as disclosed to colleagues and being ridiculed over his mental health when he was already self-harming and in a vulnerable state would have added to Richard's turmoil over his situation with his parents and he would have felt very isolated.

The panel considered the fact that there may be aspects of Geetika and Ishika's behaviour that may be culturally influenced in regard to wanting him to earn more money to look after the family and the lack of privacy for his marriage, but without knowing their beliefs and culture, it would be remiss to speculate on the impact this may have had. However, there are examples of behaviour that would not be in the Indian culture such as Ishika threatening Richard with divorce and the panel felt that the behaviours of both Ishika and Geetika that were outlined were more controlling and coercive than cultural.

On the day he took his life, he had been receiving calls from his mother-in-law from 3am and had a pressurised presentation that he would not have been comfortable completing but did so competently.

With no other known issues or stresses in his life and the happiness at the thought of becoming a father whilst taking into account his previous mental health history, the conclusion of the panel is that the domestic abuse Richard suffered was a cause or contributory factor to him taking his own life.

9. Lessons to be learned

9.1 Communication and treatment of families when they lose a loved one through suicide

In the event of a homicide, a family are designated a Family Liaison Officer (FLO) who amongst a number of duties, acts as a conduit between the investigation and the family to keep them informed and not feel frustrated that they do not know what is going on at a time they have the most questions. In the event of a suicide, this DHR identified that the parents of the deceased were not shown empathy or understanding from the officer who attended to obtain their statement and they were not provided with details of any officer who could provide them with any information. This was identified in another Cambridgeshire DHR and recommendations were made and implemented by Cambridgeshire Police to ensure an Inspector North and South of the county provided this service in these circumstances.

When the investigation for coercive and controlling behaviour was transferred to the Metropolitan Police for investigation, they ignored several requests for updates from the parents and the Author and only contacted them when they required authority to forensically examine Richard's phone. This, by their own admission, caused additional stress and trauma to them at a time when they were grieving. The panel showed concern that if this is a snapshot of how the family are treated, then there is concern for whether victims of DA are being updated and communicated with. (Recommendation refers)

9.2 Missed opportunities to identify domestic abuse when GPs speak to patients on a one-to-one basis

The phrase 'professional curiosity' is not always liked by some but is frequently observed within DHRs when a patient will make a comment to the GP which appears to be either ignored, not recognised or not recorded for future reference.

In this case, when Richard attended a doctor's appointment in relation to fertility, it is recorded that he made a mention of family stress when speaking with the doctor. There is no record of any questions being asked in relation to this or the opportunity for disclosure even though this would have been relevant to the fertility tests he was attending for. A number of GP's now state that they can only discuss one medical issue per appointment to ensure they remain within the allocated timeslot. This raises concern that safeguarding issues including domestic abuse might not be addressed or recorded appropriately due to the time pressure on a GP. (Recommendation refers)

10.Recommendations

National

1) **A National campaign to highlight familial abuse to both the public and employers.**
   This will inform and educate people across the country about familial abuse and assist them to potentially identify this in others and themselves, leading to obtaining support and safeguarding if required.

Local

2) **Cambridgeshire and Peterborough DASV to hold a promotional campaign for the public and employers to highlight familial abuse and the provisions and pathways available to assist.**
   This will inform and educate those living and working in the area about familial abuse and assist them to potentially identify this in others and themselves, leading to obtaining support and safeguarding if required.

3) **Cambridgeshire Public Health to publicise 'Stop Suicide' to businesses within their jurisdiction and how to access this.**
   This will both inform and encourage employers within Cambridgeshire to educate themselves in this area as to how they can support their staff and what pathways are available in these circumstances.

4) **The Metropolitan Police, Enfield Borough to dip sample reports dealt with by the Domestic Abuse team for victim contact satisfaction.**

This will identify whether the Code of Practice for Victims of Crime within this department is being adhered to on a regular basis and if not, then this can be addressed.

5) **The GP Surgery to implement a process where the opportunity for disclosure of domestic abuse is provided when a patient makes a negative comment in relation to their home or family circumstances.**
This will ensure that the subject is explored and the opportunity provided whilst in a closed and safe environment with appropriate recording of the conversation thereafter. If domestic abuse is not disclosed, then mental health provisions can still be made available.

6) **Cambridgeshire Public Health to ensure ongoing suicide prevention activity is adapted to meet the needs of people with autism and learning disabilities, primarily by sharing suicide prevention resources and promote suicide prevention training to key organisations.**
This provides focussed information and advice specific to an area that has been identified as having a heightened risk and ensures availability to those who require it the most.