



Huntingdonshire Community Safety Partnership

Domestic Abuse Related Death Review

Summary report into the death of Miles

March 2023

Independent Chair and Author of Report: Luke Kendall

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Dedication

Do Not Go Gentle into That Good Night - Dylan Thomas

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

Though wise men at their end know dark is right,
Because their words had forked no lightning they
Do not go gentle into that good night.

Good men, the last wave by, crying how bright
Their frail deeds might have danced in a green bay,
Rage, rage against the dying of the light.

Wild men who caught and sang the sun in flight,
And learn, too late, they grieved it on its way,
Do not go gentle into that good night.

Grave men, near death, who see with blinding sight
Blind eyes could blaze like meteors and be gay,
Rage, rage against the dying of the light.

And you, my father, there on the sad height,
Curse, bless, me now with your fierce tears, I pray.
Do not go gentle into that good night.
Rage, rage against the dying of the light.

The DHR Chair expresses their deepest sympathies to the family and loved ones of Miles, and thanks them for their contribution and support of this process.

1. Preface

- 1.1. Domestic Homicide Reviews (DHR) became statutory under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and came into force on 13 April 2011. The Act requires a review of the circumstances in which the death of a person aged sixteen or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were either related, in an intimate personal relationship with or living with in the same household.
- 1.2. The purpose of a DHR 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.
- 1.3. This DHR report examines agency responses and support given to Miles, a resident of Huntingdonshire, prior to his death. In March 2023, Miles was found deceased by lowland rescue, located facedown, caught up in the trees in the River Ouse. Huntingdonshire Police are treating Miles's death as a suspected suicide and have referred to the coroner's office.

2. Introduction

- 2.1. At the time of Miles death, he was 72 years of age living with Olivia, his partner some 20+ years. He was experiencing difficulties with alcohol dependence and management of his mental and physical health. Miles had struggled with suicidal ideation for over two decades. For several years prior to his death, he had been experiencing some degree of memory loss. He had reported being in fear of Olivia, and being subjected to sleeping on the floor, withholding money and cutting up his clothes, which he felt contributed to his deteriorating mental health.
- 2.2. Miles was the youngest of three boys and was raised in Lancashire then Greater Manchester. His father, whom was an ex-prisoner of war in Japan died suddenly of a heart attack when he was an adolescent. He lost his mother in early 1990's to a long-term illness. Miles was very close to his mother, who he described as having high standards for academic achievement. Miles did very well at school, went to Cambridge University, became a teacher of foreign language. Miles and his brothers were not particularly close. His family described

Miles as eccentric. At the age of 22 he was diagnosed with Bipolar Affective disorder. Miles was an intellectual man, he was very gentle, generous and thoughtful. He was a great jazz pianist and loved his jazz records. He was very witty, a lot of fun to be with and liked to tease his brother's family and his friends. He always had a cat. In later life Miles enjoyed walks by the river and writing short stories.

- 2.3. Miles met Olivia in Western Europe in the mid 1990's, they moved in together in Northwest Europe city. They had been married over 20 years. The first agency reports concerning domestic abuse were not raised until 2021. At the time of death Olivia was 60, living with Miles and experiencing physical health complications and lifestyle-related vulnerabilities. Olivia's family are not resident in the UK, and there is no notable support networks detailed in the reports, or from discussion the Chair had directly with Olivia. From 1978 to 2023 Miles remained largely independent from mental health services. There are no records advising that, for the duration of the relationship, Miles and Olivia were registered as each other's carer.
- 2.4. The first recorded domestic abuse related contact with services, in relation to both Miles and Olivia was in May 2021; whereby ambulance and police attend their home. Olivia contacts East of England Ambulance Service (EEAS) advising that Miles has been "sleeping more and more, is weak and his mobility is severely limited" and is not eating much. Olivia advised his behaviour has changed and he is becoming "aggressive" and that Miles "beat her" a short time prior to making the call. Olivia advised the call handler she was not injured but "sore". EEAS notified Cambridgeshire Police who were in attendance shortly after making the call. Olivia advised paramedics that a change in Miles's behaviour occurred approximately one month ago, whereby his mood changes quickly and he repeats questions. She reports he has been drinking 500ml of vodka a day for "a number of years". But that he is usually a "gentleman", but he is starting to show signs of dementia. Olivia does not support police prosecution. Police complete a domestic abuse risk assessment. The risk is graded as standard (low) risk.
- 2.5. In 2022 Miles accesses a number of support services for his alcohol dependence, self-harm, suicidal ideation, health related concerns and also to seek support for his wife, who he feels requires a carer. Reports of alcohol use levels differ throughout this report. At this time Miles discloses to Change, Grow, Live (CGL) that he is drinking alcohol on 20 out of 28 days, consuming an average of 10 units on drinking days. His Alcohol Audit score was 23, and his Severity of Alcohol Dependence Questionnaire (SAD-Q) score was 15, indicating hazardous drinking levels and potential dependence. Miles discussed that his drinking had increased since retirement, which coincided with losing his social life. He expressed a desire to achieve abstinence and worked towards some absent days as the year went on. In the summer GP referrals and, latterly, Occupational Therapy referrals take place, as an assessment of what measures can be installed in his home are required. As a result, a grabrail is installed at his home, which he reported "made things easier" for him. He also applies for a blue badge which is later declined. As the year closes out, a request is made by GP to Cambridgeshire & Peterborough Foundation Trust (CPFT) Older Peoples Mental Health Team for the Consultant Psychiatrist to review Miles's mental health medication, lithium.
- 2.6. In January 2023 Miles has a telephone call with his GP. He reports having severe depression over 30 years ago and was resistant to most treatments including electroconvulsive therapy.

He was formally diagnosed with bipolar in 1976. He reported consuming half a bottle of wine every day, having lowered his alcohol consumption in the last two weeks and is attending Alcoholics Anonymous. Later in this month, Miles's medication review with CPFT occurs with the Consultant Psychiatrist for the Older Peoples Mental Health Team. A holistic assessment was completed, and the GP was advised that Miles to no longer be prescribed lithium as the combination of lithium with his high alcohol intake and rheumatology medication (methotrexate) was causing adverse effects on Miles's health including hypothyroidism. The psychiatrist agreed to keep the referral to CPFT open and see Miles again monthly, or as requested, to monitor his medication and mental health.

- 2.7. In early February Miles spoke to the team's nurse prescriber at CPFT. He stated he was not feeling any benefit from the changes in medication and was feeling worse. Miles was advised on the limitations of any medication when combined with excess alcohol. Quetiapine, a medication to treat Bipolar Affective Disorder, was added to his medications. Later this month, Olivia contacted CPFT First Response Service (FRS) and stated Miles was lethargic and had very little appetite, he was confused and could not finish things, he had negative thoughts, but no suicidal thoughts. Olivia reported they are drinking a bottle of red wine the previous day between them, but Miles was adamant this was not true. The FRS psychiatrist concluded alcohol consumption information was not always reliable from either Olivia or Miles, and the lack of alcohol withdrawal symptoms stated by Miles was not as expected. As the month comes to an end, Miles reached out to CPFT and GP advising of low mood, feeling "depressed, obsessed about the past and hopeless". There is no record of professional curiosity into why these feelings are exacerbated at this time.
- 2.8. From March to May Miles continues to engage with CGL. He talks of his struggles with mental health and alcohol, advising that when he feels low, he would retreat to his bed and dwell on past regrets. He also details his concerns about his wife's alcohol use, and the potential to model positive changes by attending CGL. He hoped this commitment to change might positively influence his wife. Miles discussed occasional conflicts with his wife over finances. He also details to that Olivia is in full time work – so he is home alone and "enjoying the time to himself". Whilst discreet, this is the second time Miles alludes to a potential issue between himself and Olivia. Whilst the recovery worker discussed a solution of "budgeting", there is no evidence of further probing into his areas of conflict, and/or professional curiosity about any other areas of conflict that may ensue from his and his wife's problematic drinking, nor around what his past regrets are. During this period, Miles is also in contact with the GP, disclosing depression, weight loss and alcohol consumption. GP seeks to reassure him that as his medications begin to take effect his appetite and weight loss should improve.
- 2.9. In June, EEAS received a 999 call regarding Olivia, who was experiencing a period of physical discomfort and reduced mobility. She had consulted her GP the previous day, with medication prescribed for collection.
- 2.10. Later this month Miles calls CPFT Older Peoples Mental Health Team disclosing he was in mental health crisis. He stated his mood was low with fleeting suicidal thoughts. He stated his wife has reduced mobility and he cannot support her as he would like to. Miles reported he had "mostly stopped his alcohol intake" but was struggling to engage in hobbies, due to a lack of motivation. Miles said he normally keeps busy with housework and enjoys writing

short stories. Miles was encouraged to engage in activities suggested by the Occupational Therapist to help improve his mood. He declined support interventions offered by the OT to expand his quality of activities. The records do not show why Miles declined. He stated he felt better for talking to the duty worker and was happy to meet with the consultant psychiatrist the following month as planned. This is the first recorded occurrence of explicit suicidal ideation, yet there is no record of a bespoke suicide prevention plan taking place. It has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half¹. Therefore, practitioners should seek to collaborate on bespoke safety plans with victims²⁻³ that profess to suicidality, given their heightened risk - a SafeLives report into the experiences of male victims advised that two thirds of men were experiencing suicidal ideation⁴, yet some report a prevalence rate suicidal ideation in 87% of victims⁵.

- 2.11. At the end of June several contacts are had with EEAS for Olivia, who is experiencing mobility issues which has been present for 5 weeks. Olivia was recorded shouting at Miles, telling him to “fuck off”. There is no reference to concern or professional curiosity from the attending paramedics as to Miles being told to “fuck off”.
- 2.12. Days after this incident, Olivia makes a call to EEAS stating that Miles has bipolar and wants to kill himself. Approach with caution advised to crew, due to Miles audibly becoming very aggressive to the call handler and his wife - the caller. Records do not show what Miles was saying to the call handler. “URGENT DISCONNECT” warning given to the patient due to behaviour worsening. EEAS call handler advised that if a subsequent warning was deemed necessary, the call would be disconnected. Upon ambulance attendance, Miles stated that he is feeling low and has been for approximately 6 months. He is also worried about wife who has a bad back and is currently off work and may not be able to go back to work. He feels that they are spending too much time together. Miles advised that he woke up with low mood today, and Olivia’s drinking causes tension within the relationship. Miles stated that he has had feelings of not wanting to be here but does not wish to carry these out, as he is not organised enough and doesn’t have the courage. Miles mentioned to EEAS crew that he asked his wife to kill him. The crew signed posted Miles to 111 option 2 and Samaritans. Miles also agreed to GP referral. EEAS crew spoke with the FRS and arranged for a callback within four hours. There are several matters here where the application of professional curiosity may have been of benefit to understanding more about the relational dynamics. Miles’s aggression and the subsequent risk he may pose to Olivia, Miles’s reference to them spending “too much time together” and Olivia’s drinking causes tension. Later this day CPFT out of hours team have a following up call, following triage call orchestrated by EEAS. During the call, Miles denied feeling suicidal. He was given time to

¹Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. *The British Journal of Psychiatry*. 2021;219(2):419-426. doi:10.1192/bjp.2021.50

²<https://committees.parliament.uk/writtenevidence/124429/pdf/#:~:text=Research%20has%20identified%20that%20relationship,a%20man%20experiencing%20suicidal%20thoughts.>

³ <https://nspa.org.uk/wp-content/uploads/2021/04/Highlighting-the-link-between-domestic-abuse-and-suicide-1.pdf>

⁴ <https://safelives.org.uk/research-policy/men-and-boys/>

⁵ McGlinchey, E., Spikol, E., & Armour, C. (2023). Experiences and mental health impacts of intimate partner violence against men and boys: a rapid review.

talk about his thoughts and feelings but declined any additional support. The CPFT out of hours team alerted the Older Peoples Mental Health Team of Miles contact. The records do not show what Miles shared regarding his thoughts and feelings, nor what additional support her declined.

- 2.13. At the end of June, whilst engaging with CGL, Miles talks of his thyroid issues and arthritis, but also of his low mood and suicidal thoughts. He reported to being 3.5 weeks abstinent from alcohol. Miles advised his recovery worker he will call his psychiatrist tomorrow to ask to see him. There is no record of the recovery worker probing into the rationale for low mood and suicidal ideation. There is also no record of a bespoke suicide prevention plan being put in place. Miles advised to call his psychiatrist sooner, and recovery worker offered to help him with this call, but Miles declined. There is no record of following up with Miles to ascertain if he had indeed had contact with his psychiatrist. Follow up contacts are shown to significantly reduce suicide reattempts⁶, and therefore should be considered standard practice for clients who advise of suicidal ideation.
- 2.14. In July the GP passes on information to CPFT FRS, concerned about Miles's severe weight loss. Miles was seen by the FRS psychiatrist. He stated he was struggling with low mood and alcohol use; he had cut down and reported not drinking daily but still drinking twice a week, but on those days, he drank a third of a bottle of vodka. He said he had support from CGL. He also reported low motivation and reduced appetite. Miles advised his wife also drinks alcohol to excess, but she declined the suggestion of support from CGL. He stated he was not brave enough to discuss his wife's alcohol problems with her, due to his low self-esteem. Miles advised that discussions regarding alcohol intake and cutting down the amount, either in private conversations or with professionals, has led to arguments between them, and Miles wanted to avoid further arguments because he cared about her and didn't want to upset her. The Community Psychiatric Nurse's (CPN) notes advise of no indicators of domestic abuse. When asked by FRS about suicidal thoughts, Miles stated he had them but had no plans and "does not have the courage" to carry out a plan. The notes show the risk of Miles acting on these thoughts were assessed, and risk reduction strategies were put in place. He was advised to increase his activities, hobbies and social opportunities. He was also advised to take his medication regularly as prescribed. A further discussion was held re Miles's abnormal blood test results, and detailed clinic letter was sent from CPFT to the GP regarding these abnormalities. He was advised to cut down further on his alcohol intake, have his blood tests repeated in four to six weeks and for Miles to call back if the symptoms of weight loss, low mood or suicidal thoughts worsened.
- 2.15. Mid July, Miles has several contacts with CPFT. Miles was seen by the Consultant Psychiatrist. The appointment on 19th July is his 8th appointment with the consultant since January 2023. On this occasion Miles presented with increased depression and suicidal thoughts of "going to the river". Miles remarked that he felt "too much of a coward" to go through with ending his life. The consultant was concerned that Miles expressed disappointment in himself because he did not "have what it takes" to proceed with this, but that he found the suicidal thoughts comforting. Miles stated he had made no attempts to

⁶ Ghanbari B, Malakouti SK, Nojomi M, Alavi K, Khaleghparast S. Suicide Prevention and Follow-Up Services: A Narrative Review. *Glob J Health Sci.* 2015 Sep 28;8(5):145-53. doi: 10.5539/gjhs.v8n5p145. PMID: 26652085; PMCID: PMC4877223.

end his life. The consultant concluded the risk to self-had increased. Miles advised of struggling with his wife's mobility issues, he was experiencing pain due to arthritis and a recent fall in the garden and he had recently been the victim of a scam call; although he did not lose money, plus he had ongoing alcohol misuse and physical health problems, a lack of appetite and poor compliance with medication and he was elderly. Consequently, Miles's position on the waiting list for a CPN was expedited to an urgent allocation. The consultant increased Miles's antidepressant medication and contacted pharmacy for his tablets to be dispensed in easy-to-use blister packs, to help him take them consistently. A comprehensive treatment plan was agreed with Miles and some reading material about depression and the need for self-compassion was also given to him as he had ruminating negative thoughts. Contact numbers were given for the duty worker and FRS, the out of hours team. The consultant arranged to see Miles again in October, or sooner if needed. There is no record to show that a bespoke suicide prevention plan was put in place.

- 2.16. Later in July Miles has contact with the GP, reporting feeling increasingly confused. Olivia is in the background of this call. Olivia states that he "can't help thinking about the past", "the only pleasure in life at the moment is lying down and thinking about the past". He reports to feeling low, forgetful and thinking of harming himself, but advising he "doesn't have the courage to". It is unclear from the notes if a bespoke suicide plan was put in place. Advice given to call 111 option 2 if concerns worsen. The following day Miles was seen at home, in the company of his wife, by the CPFT CPN. The agreed care plan included advice on diet and weight gain, medication concordance and side effects monitoring, psychological education about the effects of drinking alcohol to excess and the impact on a person's physical and mental health, managing ruminating negative thoughts, monitoring risk of suicide, sleep hygiene, increasing positive day time activities, and relationships with others. Miles was also referred to the Occupational Therapist, and he was also under the care of the hospital for a pacemaker implant. At the end of July, he is seen at home by the Occupational Therapist, who assessed his activities of daily living and mobility. A Therapy Care Plan was written, and advice given on equipment, adaptations, psychoeducation around rumination and daily living activities.
- 2.17. In August GP records report a weight loss of 2kg in 1 month. Miles reports that his wife is "growing increasingly irritable with him and it makes him stressed and want to drink". He is struggling with energy levels, motivation and memory. He has a loss of appetite and has problems with his lips which he burned two weeks ago and teeth which means he can only eat soft foods. Records detail a capacity test taking place, but not the outcome.
- 2.18. In October CGL conducted a full risk review with Miles. His alcohol units increased, and he acknowledged deteriorating mental health. Since the increase in units he has been lying in bed ruminating but has attempted to do other things as he knows this is not healthy. Explained that Olivia drinks 3.5 bottles of wine daily, making it hard for him to keep his units down but he is motivated to reduce. Stated that he attends group as he is isolated and lonely. He recognised that his mood and motivation is better when out meeting and engaging with people. Despite living with Olivia, Miles states he is lonely and isolated. No further exploration regarding this admission documented. No goals or actions set. No discussion around detox/rehab pathways. Miles states he is working with GP/Psychiatrist for mental health, but there are no explorations or further details regarding specific concerns/treatment he is receiving have been documented. Frequency of contact or next

appointment not documented. A day later, Miles attends Foundations of Growth support group, but there are no notes documented on system regarding his attendance, presentation or contribution. This happens two further times in October.

- 2.19. Late October both Miles and Olivia meet with CPFT Consultant Psychiatrist's Outpatient Clinic. Miles stated on that day he had had a good morning; he managed to clean the oven and do some vacuuming. He does not like going out of the house and leaving Olivia alone because he cared about her, so stopped going to the library but still volunteered in the charity shop on Sundays. Olivia stated she was concerned about Miles's health especially when he is inactive and lethargic. She broke down in tears several times during the assessment, saying she felt feelings of responsibility for some of the difficulties regarding alcohol consumption. Olivia detailed her health and social challenges. Miles told Olivia she needed to reduce her drinking, stating she drinks more than him and she had gone out to buy a box of wine that morning. Miles had been attending CGL; he told them he had relapsed in his alcohol use but currently had reduced his intake from 112 units per week in January 2023 to the current 105 units per week calculated at the assessment in October. The consultant discussed with them, their "self-destructive patterns" of alcohol misuse. They were informed that it was not possible, in any conceivable way, for their current level of alcohol intake to continue and at the same time be compatible with good physical health, financial stability, good mental health and wellbeing and maintain healthy relationships with others. They had been counselled about the effects of alcohol misuse on the brain and the impact on emotions, memory and impulse control and that treatment outcomes are less effective, the longer they continue to consume alcohol at this level. Both Miles and Olivia were advised on the safest manner to reduce their alcohol intake to limit physiological complications.
- 2.20. In January 2024, when engaging with CGL, Miles advises of his low mood, rumination, that his alcohol intake has increase to 30-40 units per day and he is worried about Korsakoff syndrome as he feels forgetful and uncoordinated. He also advises he has no mobile phone. This is the third time rumination is mentioned by Miles, and this was another missed opportunity to delve into the matters he was ruminating over. There was also an absence of professional curiosity as to why Miles did not have a mobile phone, which may have been an indicator of coercive control.
- 2.21. In early February, contact from North West Anglia NHS (NWA NHS) Rheumatology department, updating that taking methotrexate had been beneficial to his joints. Records shows that his mood had not been good in the last few months and this coincides with three stone weight loss. There is no evidence here of professional curiosity into the wider social context of the significant weight loss and low mood.
- 2.22. Several days later, EEAS are called by Miles, coded as a "psychiatric suicide". Cambridgeshire Police are notified by EEAS of this call by Miles and are in attendance prior to EEAS arrival. EEAS advise Police that they have received a call from Olivia, stating Miles is becoming more aggressive towards her, shouting and experiencing "some kind of breakdown". EEAS shared concerns that Miles had assaulted Olivia, as the EEAS call handler heard a loud bang and the call terminated. Upon arrival, officers encounter a different picture. Olivia had thrown a bag of lentils over Miles's head and cut up his clothes. Olivia disclosed this was as a result of frustration over Miles not remembering how to work the

dishwasher. However, the EEAS record advises this was “punishment for not managing his bipolar”. The officers attempted a voluntary interview with Olivia who unwilling to cooperate and presenting as verbally aggressive towards Miles. She was advised, after several attempts of officers requesting her to stop her verbal aggression towards Miles and not cooperating, it would result in an arrest. Olivia did not desist, and she was subsequently arrested. The outcome was a conditional caution for Olivia. Domestic Abuse Stalking & Harassment (DASH) risk assessment completed and graded medium risk. Police shared this with their referrals to the Multi-Agency Safeguarding Hub (MASH) CPFT, Integrated Mental Health Team, CGL, Women’s Aid and Probation. EEAS make referrals to GP and Adult Social Care. Records do not show consideration from attending officers/ambulance crew to the additional risk that Miles may be at, owed to a compromised ability to answer the DASH comprehensively/coherently (owed to memory loss). Furthermore, there is no record of Police seeking to obtain information from neighbours about this, or previous DA incidents. Miles live in a small residential block of flats, with multiple neighbours. Therefore, an opportunity to exercise professional curiosity was missed; especially, considering the incongruence between what was presented to officers prior to attendance, compared to what they were met with when they attended.

2.23. The following day, Adult Social Care receive a referral from EEAS advising that Olivia is “physically abusing” him and “cutting up his clothes”. EEAS referral also advises that Olivia “is oppressive and victimises him about his mental health issues”. Senior Social Worker reviews this referral and allocated to duty to establish more facts. The EEAS referral is the first account whereby a narrative begins to form, building a picture of Miles’s lived experience, which differs from the previous narrative about Miles being the ‘aggressor’ or ‘aggressive’.

2.24. A week after, NWAFT records detail an Emergency Department visit by Miles and Olivia. A suicide screening was completed (name of assessment tool/screening details not detailed on record), and Miles was deemed low risk. Records show Miles has been in bed the last two weeks, not eating and that Olivia is worried about him. Miles has been drinking half a bottle of vodka per day and he has been on lithium for some time. Miles advised that on occasions he thought it would be better if he was dead, but “doesn’t think he would do anything but if he did, he would go in the river.” There are numerous factors here for increased risk of suicide. Of particular note, is Miles’s disclosure of how he would take his own life, which clearly evidences more progressive suicidal ideation and a preferential methodology. There are no records to show an understanding of this, or the details of a suicide prevention plan being put in place. Furthermore, the National Institute for Health and Care Excellence (NICE) guidelines suggest “Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm”⁷ and, in line with leading academics in the field⁸, stress a shift to assessment of client need and implementation of a bespoke suicide safety plan⁹.

⁷ <https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales>

⁸ O’Connor, R. (2021). When it is darkest: Why people die by suicide and what we can do to prevent it. Random House.

⁹ <https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm>

- 2.25. The following day, CGL receive the police safeguarding referral regarding the recent incident of his "wife assaulted him by throwing a bag of lentils over his head and cutting up his clothes." Miles expressed that he believed he deserved these actions because his mental health had deteriorated, and he was struggling with basic tasks. He reported feeling scared of Olivia but later withdrew his statement when informed of her potential arrest. Miles voiced suicidal thoughts if Olivia were to be taken away. He was attended to by paramedics who completed a mental health capacity assessment and offered hospital care which he denied. Miles stated he would prefer to stay at home and "mope around" waiting for her return and was adamant on trying to see her to say sorry and check on her welfare despite the verbal abuse he was receiving. The DASH risk assessment was assessed as medium risk due to Miles's vulnerability and his inability to protect himself from his wife's behaviour. Miles was described as submissive and hesitant to accept assistance. The referral also advises both Miles and Olivia are alcoholics, drinking around 1-2 bottles of wine and vodka per day. They are married, living together, with no other relatives or support and both spending all day together.
- 2.26. Mid-February, Peterborough Women's Aid men's service B-United receive a referral from the Multi Agency Safeguarding Hub for Miles - two weeks after the incident. The B-United call with Miles is short, with him advising that he does not need assistance, but his wife requires assistance with completing forms. B-United worker advises him to call Citizens Advice Bureau for this support. Miles also advised that he felt his wife needed support, and Miles was advised that B-United only support male victims. Miles was left with B-United's contact details to call back if he needed support. It is hard to ascertain, from the record provided, the level of probing from the B-United worker, around the specific risk concerns that were raised in the referrals. However, the IMR author for Peterborough Women's aid, having reviewed the DASH from the B-United Worker, advises they should have asked Miles more relevant questions according to the identified risks. These should have included an enquiry around his mental health, suicidal thoughts and verbal abuse he was subjected to. Furthermore, due to the age of the client a referral to Hourglass¹⁰, a specialist organisation around elder abuse, could have been discussed. There is also no record to show that B-United updated all support services to advise of the outcome of their support offer.
- 2.27. Several days after, Adult Social Care (ASC) records advise of a MASH practitioner reaching Miles by telephone. He asks her to call back later, which she does. This time his wife is also on the line. The ASC record shows that Miles said it was a good time to talk and his wife was also on the line with him. He said he was ill, depressed and confused and thinks he may be starting to have dementia caused by drinking (alcohol), but the consultant won't work with him until he stops drinking. He advised that his wife needs support to look after him, "I have no initiative, no memory, avoid doing things and she can get angry with me." A carers assessment was discussed, at which point Miles put Olivia on the phone. She advised that Miles needs prompting to get a shower and change his clothes and eat, highlighting that he has lost a lot of weight recently. She confirmed that he has a dosset box to take his medication and can do this independently. She confirmed they have an appointment with GP tomorrow to discuss concerns. They had signposted them to Caring Together¹¹ and referred to the Adult Early Help team. Notes allude to the MASH worker recognising the

¹⁰ <https://www.caringtogether.org/carers-directory/hourglass/>

¹¹ <https://www.caringtogether.org/>

domestic abuse but advising this was down to “carers stress”. There is a lack of professional curiosity here, as while the worker shared the referral from the ambulance service with the GP, she did not seek any further information on any past concerns relating to domestic abuse. Also, the MASH is co-located with the police, but the worker did not seek any information from the police to inform her decision making. The worker did not evidence that she had considered safe conversations which could have given Miles an opportunity to disclose without the presence of his wife.

- 2.28. The following day, Adult Early Help team, form ASC, make contact with Miles. Record shows that the worker, once more, does not allow for Miles to speak on his own and thus speaks to both parties: “They say they feel lonely and isolated. Agree to information being sent out. Follow up email send with attachments for Caring Together, Community Navigators and Alzheimer’s Society. Case closed and couple given info on how to re refer”. Once more, despite the known history of domestic abuse, potentially impacted by the previous MASH workers assessment which potentially downplays DA as “carers stress”, safe contact protocols are not followed by this worker, and Miles is not given an opportunity to speak without duress. Below we see an example of Miles disclosing when given safe spaces to do so.
- 2.29. On the same day, Miles attends CGL for another risk review. Their records show: Miles presented as thin and a little unkempt. His mood was very low and he appeared mildly confused. Miles reports being “very very depressed”, lacking energy, confidence and is “confused”. He has lost a considerable amount of weight. He does not sleep well; he dreads waking up and “stays in bed thinking about all the things he has done wrong”. He advises that Olivia also makes him sleep on the floor and that he cannot see well as his wife has destroyed his glasses. He says that he has thoughts of self-harm, although no plan to do so, and “lacks the energy to do anything about it”. He asserted that he wants to stay with CGL and that his goal is abstinence. Miles stated he had a series of breakdowns in his early 20s, and a longstanding diagnosis of bipolar disorder. He was prescribed lithium for 20-25 years, but this was replaced with a less effective alternative for unclear medical reasons. He stated financial concerns and that he was worried he could not afford the heating. He said that he had given his wife his bank card that morning, so that she could buy alcohol for herself. He said that his wife spends a great deal on luxuries they cannot afford such as clothes and perfume etc. He insists that he is fully culpable for his wife's behaviour and refused IDVA support at the present time. He did however disclose that he is “too timid to tell his wife that he doesn't love her and would like her to return to her family in [Western Europe]”. There are more insights offered here into the relational dynamics from Miles. It would seem that he felt able to disclose in this space, yet there is no record of the Recovery Coordinator probing further into the wealth of concerns raised in this meeting; which could have included further attempts to discuss B-United with Miles, or owed to the relationships that was building with the Recovery Coordinator, for them to complete the domestic abuse informed safety planning direct with Miles. An opportunity was missed to complete a domestic abuse risk assessment, a safety plan and also put in place a bespoke suicide prevention plan.
- 2.30. Later this day Miles attended the surgery by himself looking “unkempt”. He discloses feeling low in recent months and querying if lithium prescription can be reinstated. He is still experiencing problems eating, losing weight owed to lack of appetite and energy to cook.

He is experiencing thoughts of harming self but feels he doesn't think he will carry them out. He details "friction with his wife", advising she has been taking care of him, but "she gets frustrated and shouts as he is not getting better". GP enquires as to whether he feels safe at home with his wife, to which he responds that he does. He is currently drinking approximately 9 units of alcohol (vodka) a day. It was explained to Miles that his lithium could not be reinstated by the GP but will speak with the doctor who is leading on his medications now that he is working with CGL. Referral is also sent to older people's mental health.

- 2.31. The following day EEAS held a telephone assessment with Miles. He stated feeling very low, and that he doesn't think he needs an ambulance, but his wife called EEAS earlier in the day concerned for him. Miles discloses suicidal thoughts but not made any plans and states he is able to keep himself safe and hasn't harmed himself today. Miles saw his GP yesterday and advised him to come back to see them if things worsened. Miles is currently on quetiapine and under the care of the mental health team but unsure of how to contact them. Clinician advised that he calls 111 option 2. Miles didn't want to attend hospital as they just keep him there for a few hours and then just discharge him. Call handler spoke to Olivia also who advised she is particularly concerned about him as he just lays in bed all day and doesn't want to do anything. Olivia disclosed struggling to cope and doesn't know what to do and that a couple of weeks ago he said he wanted to kill himself. Olivia advised to see her GP. Miles agrees to call 111 op 2 when we finish this call.
- 2.32. Towards the end of February GCL had numerous contacts with Miles. The first was via telephone where his wife was present. He "expressed feeling very depressed but couldn't provide specific reasons due to his wife being present in the background". Miles did not attend CGL group work a few days later, for feeling unwell and a call to his landline and mobile was made in an attempt to speak with Miles on the following day, but Olivia answered both calls advising that he was not present, and she did not know where he is.
- 2.33. A close family member reported that the person had been showing signs of low mood and reduced activity in the weeks before their death, and that family members had been involved in efforts to locate them when they were reported missing. Emergency and safeguarding agencies were engaged and assessed the situation as a high-risk missing-person incident. The panel noted that some welfare information was shared with health and social-care partners and that opportunities to gather corroborative information from the local community were missed. These findings informed recommendations about improving timely information-sharing, family engagement, and multi-agency risk assessment..
- 2.34. During the missing-person inquiry a neighbour contacted police to report that they had received a number of notes from the household and had concerns about the occupant's wellbeing and behaviour. The neighbour also reported hearing arguments and incidents at the property that gave rise to concerns about safety. These matters were not immediately escalated to the specialist missing-person team and the physical notes were not retained in the police record. This identified a learning point about information-sharing and evidence retention during multi-agency missing-person investigations.

2.35. Mid-March, Miles is located in the river Ouse deceased by Lowland Rescue¹². The apparent, but unconfirmed, cause of death is listed as drowning by attending officers. Miles's body is found face down in the water, caught up in the trees.

3. Terms of reference

3.1. To provide an overview report which articulates the reality of Miles' experiences and to centralise the domestic abuse he was subjected to by Olivia as a significant factor in his suicidal ideation and behaviours.

3.2. The key lines of enquiry

- Review of any the information held by agencies that indicated the victim could be at risk of suicide as a result of any coercive and controlling behaviour.
- Review of any barriers experienced by the families in reporting any abuse or concerns, including whether they or anyone else involved knew how to report coercive control, intimate partner abuse and stalking had they wanted or felt able to.
- Review national best practice in respect of protecting adults from coercive control, intimate partner abuse, stalking and suicide.
- Evaluate training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of coercive control, intimate partner abuse and stalking process and/or services in Hertfordshire.
- Whether the work undertaken by the services in this case is consistent with its own professional standards, compliant with its own protocols, guidelines, policies and procedures in relation to victims of coercive control, intimate partner abuse, stalking and suicide – to build up a picture of what should have happened.

4. Involvement of family, friends and wider community

4.1. Following the decision to conduct a DHR in September 2023, Huntingdonshire Community Safety Partnership (CSP) notified Mile's wife Olivia in January 2025, and notified his family members in February 2025, of this decision by letter in January 2025, along with information about support services.

4.2. A response was returned to the CSP and the author, his family sharing gratitude for this report but did not wishing to have substantial involvement with the process. The author made contact with Mile's family in March by telephone and had follow up email correspondence later in March and again in April. The chair made a telephone call to Olivia in January 2025 and arranged an in-person meeting local to her in February 2025.

4.3. Consideration was given to approaching friends, work colleagues, neighbours and wider community. However, it was not possible to identify any other contacts who would be suitable to be approached.

5. Summary of agencies involved and their contact

¹² <https://www.camsar.org/>

- 5.1. Miles and Olivia had contact with a number of agencies throughout the duration of their relationship, and it is noted that there is limited safe enquiry and opportunities for Miles to speak alone, despite domestic abuse concerns and significant vulnerability. A summary is presented below.
- 5.2. Cambridgeshire Police had known Miles and Olivia from 2021, until to the time of Miles's death in March 2024. Calls concerning the couple accumulate to 6 reports in total and relate to both domestic abuse and Miles being reported missing. There are two domestic abuse related calls recorded by Cambridgeshire Police. The first in 2021, and then the second (and final) DA related call in 2024. In 2021, Miles is suspected of common assault on Olivia and in 2024, Miles is the victim of common assault and Olivia is arrested. The remaining 4 police records are related to Miles as a missing person and a singular welfare concern raised about Olivia by professionals, post Miles's being reported as a missing person.
- 5.3. CPFT held approximately 20 records provided, starting in 2022 and ending just before Miles's death (Feb 2024). Miles was first known to them via a referral from GP to their Older People's Mental Health Team, for a review of his lithium medication by a Consultant Psychiatrist. During his time being supported by the service, issues were raised about the combination of high alcohol and rheumatology medication causing adverse effects on Miles which included hypothyroidism. Records show that CPFT were also aware of Miles's low mood, lethargy, confusion, suicidal ideation, significant weight loss, alcoholism, arthritis, abnormal blood tests results. Miles was subject to cognitive testing using ACE (Addenbrooke's Cognitive Examination¹³). The ACE is used alongside a holistic assessment and additional information from family members to determine if a person has dementia. The ACE score was 89/100. Scoring below 80 would normally be an indication of dementia. However, Miles was likely to have had some alcohol in his system and professional opinion was that the score would have been higher than 89 if he was abstinent from alcohol. Therefore, the conclusion was no indication of dementia at that time. Olivia was not a patient of CPFT but had a number of contacts with CPFT in the context of her raising concerns for Miles's mental and physical health.
- 5.4. B-United (Peterborough Women's Aid) received one referral received via MASH in mid-February 2024. Five day later the B-United worker contacted Miles via telephone. Miles felt that he did not need any support, but that his wife required assistance completing forms. Advice was given to contact the Citizen's Advice Bureau for this support. Miles also felt that his wife needed help, to which the B-United Worker advised that their service supported male victims only. Miles took PWA number and said that he would reach out if he needed support. No further contact is recorded.
- 5.5. EEAS had a total of 7 contacts with Miles and Olivia from May 2021 to the time of Miles's death in March 2024. Conveyance to hospital took place on the singular occasion. The majority of calls were in relation to Miles's suicidal ideation, graded as "psychiatric suicide". EEAS attended two incidents where domestic abuse had been alleged and on both occasions Cambridgeshire Police were also in attendance.

¹³ <https://neurovascularmedicine.com/ace.pdf>

- 5.6. CGL were supporting Miles since May 2022 and continued to support him until his death. During Miles alcohol consumption reporting was varied, but throughout his involvement his Severity of Alcohol Dependence Questionnaire (SAD-Q) scores indicated hazardous drinking levels and potential dependence. Miles expressed a desire to become abstinent, and was supported in treatment through psychosocial interventions, including group work and one-to-one sessions, as well as a nurse assessment to identify and support any physical health issues related to his alcohol use. In the two months prior to his death (January-February 2024), he reported to consuming 30-40 units of alcohol a day and voiced concerns about potential Korsakoff syndrome due to forgetfulness and poor coordination. His recovery worker noted he appeared "thin and a little unkempt," with very low mood, low energy, and low confidence, stating he felt "confused". He acknowledged significant weight loss, poor sleep, and feelings of dread in the morning. He disclosed self-harm thoughts without intent, noting he 'lacked the energy to do anything about it'. During CGLS's involvement, Miles disclosed his struggles with mental ill health, "conflicts" with his wife, "enjoying time alone at home" when she was at work, concerns about his wife's alcohol use, feeling isolated and lonely.
- 5.7. There are 4 records returned from Adult Social Care (ASC), starting in early February 2024 following a referral from EEAS advising that Miles's wife has been abusing him physically, cutting up his clothes, she is oppressive and victimises him about his mental health issues. The MASH practitioner doesn't call Miles until thirteen days after receiving the referral. The referral advised that both Olivia and Miles are alcohol dependant. It is noteworthy that each time ASC spoke with Miles, it was in the presence of Olivia, potentially limiting his capacity to speak freely. Miles raised that he was concerned about the onset of dementia, brought on by drinking, he reported be being ill, depressed, lonely, isolated, confused, experiencing no initiative and no memory. He advised that he "avoids doing things and she can get angry with me". He felt that Olivia needed help looking after him. Referrals are sent to Adult Early Help and signposting to Caring Together, Community Navigators and Alzheimer's Society are completed before closing Miles to ASC. There is one further contact from Olivia, post Miles being reported missing. Olivia is concerned as Miles is still missing and she is worried. Olivia advised they had an argument, and he was fed up and he left his coat and mobile. She is in contact with Miles's family members.
- 5.8. Miles and Olivia were known to North West Anglia Foundation Trust (NWAFT) since 2023. Miles was an infrequent attendee, predominately to outpatient appointments within the Rheumatology and Respiratory medicine. These outpatients' appointments were due to unintentional weight loss over the last six months of which Miles had adapted to a soft diet which he reported was due to poor dental hygiene and decay. Miles also reported that he had recently had a burn to the lip which appeared to be slowly healing which wasn't helping his oral intake. Records also show that Miles attended the emergency department, due to his mental health concerns. He disclosed at this appointment that he had been spending long periods of time in his bed, not been eating and that Olivia was worried about him. Miles advised he'd been drinking heavily and whilst he didn't feel he would end his life, but if he were to, he would go to a river.
- 5.9. Miles was registered with Priory Fields Surgery GP practice since 1989. Over this time, he was being treated with a number of medical issues including hypothyroidism, bipolar affective disorder, diabetes, anxiety disorder, a heart condition, psoriatic arthritis, a lung

nodule, alcohol abuse and domestic abuse. He was listed as at risk of falls, and had reported shoulder injuries, tremors, burn to his lip and having unintentional weight loss. The majority of the medical history held on Miles is from 2019. Following the assault from Olivia in February 2024, the GP surgery attempted contact with Miles on several occasions unsuccessfully, resulting in the safeguarding team being notified. Consequently, a face-to-face review appointment was made at the practice towards the end of February 2024, which is the last contact the GP had with Miles. In this meeting Miles is seeking to have his lithium prescription reinstated, for he is experiencing low mood, loss of appetite and loss of energy to cook. He details "friction" with Olivia, stating she "gets frustrated and shouts as he is not getting better". He reports to feeling safe at home with Olivia, and thoughts of self-harm, but does not feel he will carry them out.

6. Conclusions

- 6.1. Whilst it is impossible to accurately divide up the proportion of responsibility for Miles' suspected death by suicide, the impact of Olivia's behaviour towards Miles appears impactful. The Review Panel extends its deepest sympathy to the family of Miles.
- 6.2. Miles' experience of physical, emotional and psychological abuse is most well defined in this report, with concerns about financial abuse also occurring. As suicide is about ending unbearable pain, it is likely that the domestic abuse Olivia subjected Miles to exacerbate the feelings of overwhelming psychological pain and loneliness, which so often are the backdrop in which suicide takes place.
- 6.3. The Review Panel has endeavoured to understand the context in which Miles' suicide occurred. The author wishes to extend his gratitude to all that helped in constructing Miles' experience. The Panel endeavoured to illuminate his life, examine where lessons can be learned and subsequently present the lessons to Huntingdon Community Safety Partnership in order to enhance their response, to people like Miles, who die by suicide in the context of domestic abuse. These lessons are detailed in section 7.
- 6.4. The Review Panel is satisfied that the Terms of Reference have been fulfilled and that discussions did take place at the Panel meeting to consider what was known prior to Miles' death in December March 2023.
- 6.5. The Review Panel is of the opinion that the agreed recommendations suitably address the matters arising under 'lessons to be learned' below, which are presented as themes.

7. Lessons to be learned

- 7.1. Theme 1: **Unseen male victims.** There is wealth of academic research and commentary that identifies men as an underserved community within the context of domestic abuse

victimisation. Academics¹⁴ and male victim specialists¹⁵ argue that framing domestic abuse as a gendered crime, whilst may feel statistically appropriate given that women are at increased risk of domestic abuse and domestic homicide victimisation^{16 17}, over dogmatically following this stance may result in agencies having a one dimensional view of domestic abuse, often leaving male victims unseen and not effectively responded to¹⁸.

- 7.2. Despite numerous indicators that Miles was at risk from Olivia, further probing around risk did not occur, and therefore (often) nor were specialist domestic abuse risk assessment protocols instigated either. Of note is the assessments from practitioners that such behaviours as cutting up Miles's clothes, oppressing and physically abusing him equated to, merely, "carers stress". This understanding of abuse steers practitioners conduct, leaving, in this instance, Miles not risk assessed appropriately, or given as many opportunities to speak with professionals in private/confidence, away from Olivia, as could have been offered. Therefore Miles's "space for action¹⁹" is reduced by this stance.
- 7.3. Indeed, it is standard risk assessment protocol to assess risk following someone disclosing domestic abuse or professionals having concern about a person who may be experiencing domestic abuse; as SafeLives advise, "it's vital to make an accurate and fast assessment of the danger they are in"²⁰. There were a number of occasions where Miles explicitly detailed risk, yet a domestic abuse informed risk assessment was not completed. These are missed opportunities.

¹⁴ Hine et al., (2022). "I Have Guys Call Me and Say 'I Can't Be the Victim of Domestic Abuse'": Exploring the Experiences of Telephone Support Providers for Male Victims of Domestic Violence and Abuse. *Journal of Interpersonal Violence*, 37, 7-8. DOI: 10.1177/0886260520944551

¹⁵ Wallace, S., & Brooks, M. (2022). Supporting male victims and survivors. In *Domestic Violence Against Men and Boys* (pp. 179-194). Routledge.

¹⁶ "In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over". Home Office, "Key Findings From Analysis of Domestic Homicide Reviews" (December 2016), p.3.

¹⁷ "Analysis of the whole Standing Together DHR sample (n=32) reveals gendered victimisation across both types of homicide with women representing 85 per cent (n=27) of victims and men ninety-seven per cent of perpetrators (n=31)". Sharp-Jeffs, N and Kelly, L. "Domestic Homicide Review (DHR) Case Analysis Report for Standing Together" (June 2016), p.69

Data were obtained for 66 countries shows 13.5% of homicides were committed by an intimate partner, and this proportion was six times higher for female homicides than for male homicides (38.6%, 30.8-45.3, vs 6.3%, 3.1-6.3). Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C. G. (2013). The global prevalence of intimate partner homicide: a systematic review.

Data from 188 DHR's occurring between April 2011 and March 2013, in 86% of cases the perpetrator was male. Bridger, E., Strang, H., Parkinson, J., & Sherman, L. W. (2017). Intimate partner homicide in England and Wales 2011–2013: Pathways to prediction from multi-agency domestic homicide reviews. *Cambridge Journal of Evidence-Based Policing*, 1(2), 93-104.

<https://doi.org/10.1007/s41887-017-0013-z>

¹⁸ Douglas, E.M., Hines, D.A. The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice. *J Fam Viol* 26, 473-485 (2011). <https://doi.org/10.1007/s10896-011-9382-4>

¹⁹ https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/Costs_of_Freedom_Report_-_SWA.pdf

²⁰ <https://safelives.org.uk/resources-for-professionals/dash-resources/>

- 7.4. A gendered analysis and therefore understanding of domestic abuse is fundamental to the safe and effective responses to victims of DA. Of potential significance to this case is professional's enquiry around Miles feeling "safe". Male victims can be prone to respond with "no" to questions pertaining to safety, which was an initial line of enquiry that Miles was subject to. There are two main factors that may influence a male victim like Miles answering in a way that may be contradictory to their actual feelings. Generally speaking, due to their physical advantage, men have the means to keep themselves safe with their female partners. However, whilst this may be generally true, this base notion does not consider how men's ability to use reasonable force to protect self is neutralised for fear of going against social norms that require men not being able to use any force on women and to abide by masculine norms: to be strong and self-reliant etc²¹. Therefore, the sense of shame and emasculation that might be experienced owed answering "no" to this safety question is important to highlight.
- 7.5. Of further relevance is Mile's age. Older people experience domestic abuse face distinct and compounding barriers to not only support, but also identification. National datasets²² show that older victims are underrepresented in domestic abuse services, they being more likely to live with the perpetrators, and less likely to self-identify as experiencing abuse. Tragically, this results in older victim's experience abuse for twice as long before accessing support (when compared to younger victims)²³. Leading charities for elder people explain how professional often misattribute coercive control, intimidation and physical harm to "carers stress", "relationship difficulties" or the general challenges associated with aging, that serves to obscure the identification of domestic abuse^{24 25}.
- 7.6. For men, the above barriers are intensified for gendered expectations around self-reliance, stoicism and reluctance to show vulnerability. Contemporary research around male victims experience of domestic abuse highlight that men are less likely to be asked about domestic abuse, less likely to recognize they are experiencing domestic abuse and more likely to minimise harm^{26 27}. Consequently, Miles faced a dual invisibility, as an older person and as a male victim, which reduced his opportunities for safe enquiry, domestic abuse informed risk assessment and specialist support.
- 7.7. The author argues that a national strategic change is part of the antidote to this theme. Male victims are presently categorised as victims under "Violence Against Women and Girls" strategy. Instead, the author argues for a parallel strategy to respond to "Violence Against Men & Boys", to cater adequately to male victims of DA, but also in the recognition that boys are just as likely as girls to experience family of origin violence when they are

²¹ Bates, E. A., Taylor, J. C., & Poynton, M. (2022). Barriers to help-seeking for male victims of intimate partner violence. In *Domestic Violence Against Men and Boys* (pp. 92-105). Routledge.

²² Office for National Statistics (ONS) (2023). *Domestic Abuse in England and Wales*.

²³ <https://safelives.org.uk/resources-for-professionals/spotlights/spotlight-older-people-and-domestic-abuse/>

²⁴ <https://www.ageuk.org.uk/notts/about-us/news/articles/2019/no-age-limit-the-hidden-face-of-domestic-abuse/>

²⁵ Hourglass (2020). *Hidden Harms: Older People and Domestic Abuse*.

²⁶ <https://safelives.org.uk/research-policy/practitioner-datasets/insights-data/>

²⁷ Taylor JC, Bates EA, Colosi A, Creer AJ. Barriers to Men's Help Seeking for Intimate Partner Violence. *J Interpers Violence*. 2022 Oct;37(19-20):NP18417-NP18444. doi: 10.1177/08862605211035870.

minors. The author recognizes the local steps that Cambridge & Peterborough Domestic and Sexual Abuse Partnership have taken in this endeavour, and therefore having an all-encompassing DASV strategy, rather than a VAWG strategy.

- 7.8. Theme 2: Domestic abuser as a **protective factor**. Those who perpetrate domestic abuse should not be seen as a protective factor for their victim's suicidality; they will be directly responsible to contributing to the victims' symptoms of suicide. Therefore, a more nuanced stance is required. To obtain a more accurate understanding of the role in which an abusive partner plays in the victims suicidality, we need to locate and consider them as first of all, a contributory factor to the clients suicide (as well as a protective factor, if there is evidence of this) and enquire with the victim as to their specific role they play within the suicidal ideation.
- 7.9. Theme 3: **Recording and 'safety netting'**. Throughout the report notions or explicit references to 'safety netting' are detailed. In a number of instances, the author and panel members could not locate precisely what measures this equates to within the IMR's. Therefore, it was hard to fathom if the responses given to Miles were in line with best practice suicide prevention. The adage of "if it's not recorded, it didn't happen" rings true here. Case note recording and record keeping practice is vital and fell short in places. Occasions to arrest, put in place protective orders like DVPO's, DVDS and enforcement of multiple breaches of bail conditions were missed.
- 7.10. Theme 4: **Bespoke suicide interventions plans save lives**. Linked to the above, The National Institute for Health and Care Excellence (NICE) guidelines suggest 'Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm'²⁸ and emphasise a shift to assessment of client need and implementation of a bespoke suicide safety plan. Indeed, it has been shown that collaborating on a bespoke suicide intervention plan can reduce risk of suicide by up to half²⁹. Therefore, practitioners should seek to collaborate on bespoke safety plans with both victims and perpetrators of abuse that profess to suicidality – given their heightened risk. This recommendation is in line with the "priority area 2, recommendation c" of the Joint Cambridgeshire and Peterborough Suicide Prevention Strategy 2022-2025³⁰.
- 7.11. NICE³¹ and lead academics in the field³², advise that bespoke suicide prevention plans should incorporate the following:
- establish the means of self-harm
 - recognise the triggers and warning signs of increased distress, further self-harm or a suicidal crisis

²⁸ <https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales>

²⁹ Nuij C, van Ballegooijen W, de Beurs D, et al. Safety planning-type interventions for suicide prevention: meta-analysis. *The British Journal of Psychiatry*. 2021;219(2):419-426. doi:10.1192/bjp.2021.50

³⁰ <https://www.cambridgeshire.gov.uk/asset-library/suicide-prevention-strategy-2022-2025-full.pdf>

³¹ <https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm>

³² O'Connor, R. (2021). *When it is darkest: Why people die by suicide and what we can do to prevent it*. Random House.

- identify individualised coping strategies, including problem solving any factors that may act as a barrier
- identify social contacts and social settings as a means of distraction from suicidal thoughts or escalating crisis
- identify family members or friends to provide support and/or help resolve the crisis
- include contact details for the mental health service, including out-of-hours services and emergency contact details
- keep the environment safe by working collaboratively to remove or restrict lethal means of suicide.

7.12. The Joint Cambridgeshire and Peterborough suicide prevention strategy³³ details that almost half of those people who died by suicide experienced relational problems³⁴. There is also a body of knowledge³⁵ that advises of suicide risk in domestic abuse cohorts. However, domestic abuse is not one of the key priority areas. Within the Joint Cambridgeshire and Peterborough Suicide Prevention Strategy DA victims are indeed recognized as a “At-Risk Group”, but they are listed as this within appendix two of the report and the penultimate listed group – almost falling off the report in terms of significance placed. The author recommends that this is reconsidered in the next suicide prevention strategy, listing domestic abuse victims (and high-risk DA perpetrators³⁶) as a priority group, and thus detailing enhanced efforts to respond accordingly.

7.13. Theme 5: **Lethal means restriction**. Means restriction is an intervention that has much empirical support^{37 38}, showing reductions in suicidality by up to 50%³⁹. It is the final stage of the above listed suicide prevention plan too. Research advises that the probability of individuals attempting suicide decreases when they are prevented or deterred from implementing their preferred method^{40 41}. For example, the drastic 40% decline in suicide rates in England and Wales between 1963 and 1975 by 40% was associated with the decrease in availability in poisonous carbon monoxide in domestic gas supply^{42 43}. A similar story was repeated in the 1980’s, showing a decrease in suicide when catalytic converters

³³ <https://www.cambridgeshire.gov.uk/asset-library/suicide-prevention-strategy-2022-2025-full.pdf>

³⁴ <https://www.hqip.org.uk/wp-content/uploads/2021/05/NCISH-Annual-Report-2021.pdf>

³⁵ Christie, C.,Rockey, J. C., Bradbury-Jones, C., Bandyopadhyay, S. & Flowe, H. D. (2023). Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report. Home Office Report. Retrieved from osf.io/4t9ab

³⁶ https://research-information.bris.ac.uk/files/375329194/Drive_suicide_V6.pdf

³⁷ Mann JJ, Apter A, Bertolote J, et al. Suicide prevention strategies: a systematic review. *JAMA* 2005; 294: 2064–74.

³⁸ Daigle MS. Suicide prevention through means restriction: assessing the risk of substitution. *A critical review and synthesis. Accid Anal Prev* 2005; 37: 625–32.

³⁹ Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person’s access to lethal means of suicide: a research agenda. *American journal of preventive medicine*, 47(3), S264-S272.

⁴⁰ Clarke R, Lester D. *Suicide: closing the exits*. New York, NY: Springer Verlag, 1989.

⁴¹ Yip PS, Caine E, Yousuf S, Chang SS, Wu KC, Chen YY. Means restriction for suicide prevention. *Lancet*. 2012 Jun 23;379(9834):2393-9. doi: 10.1016/S0140-6736(12)60521-2. PMID: 22726520; PMCID: PMC6191653.

⁴² McClure GMG. Changes in suicide in England and Wales, 1960–1997. *British Journal of Psychiatry*. 2000;176(1):64-67. doi:10.1192/bjp.176.1.64

⁴³ Clarke, R. V., & Mayhew, P. (1988). The British gas suicide story and its criminological implications. *Crime and justice*, 10, 79-116.

were introduced into car exhaust systems⁴⁴. Even when the suicidal person is not fully motivated away from suicidal behaviours, in the event of lethal means restriction, they may indeed find other means. Yet research tells us these alternative methods are often less lethal⁴⁵. The author strongly recommends, when a person is advising of their preferred method of suicidality, we engage in preventative conversations around their preferential means of ending their life.

7.14. Theme 6: **Assessment of counter allegations and unclear abuse dynamics**. Across the two police attendances Miles is noted as the alleged perpetrator on one occasion and the other Olivia is listed as the perpetrator. Despite this, there is no records of any agency considering an assessment of this incongruence. Applying professional curiosity to this issue can shed a light into the abuse dynamics at play between two parties, leading to enhanced understanding and therefore increased risk management and effective treatment.

7.15. A measure that can be utilised in such instances is the so called 'who does what to who assessment' which is located within Male Victims Toolkit⁴⁶ of Respect⁴⁷. This tool is designed to aid the practitioner analyse the relational dynamics between two parties and be guided to an assessment outcome which dictates which of Johnson's typologies⁴⁸ is present, and who is perpetrating the abuse.

7.16. Theme 7: **"They talk of my drinking but never my thirst"**⁴⁹. Miles's alcoholism is very well defined in this review (as is his mental ill health). This proverb highlights a theme across this case, where there is a lack of professional curiosity into the 'why'. What are the underlying drivers for Miles's drinking? Why is he struggling so much with rumination? What are the matters he ruminates over? What is the source of Miles's relapsing? Why is he fearful of his wife? Why does he want her to leave? Why does he consider himself not "courageous" enough to end his life? So much of Miles's experience, because these concerted enquires do not occur, remains known. This is a significant loss. These insights may have allowed Miles to be better understood, seen and heard. Each of which are considered part of the antidote to suicidality⁵⁰.

8. Single agency recommendations

8.1. The single agency recommendations are listed below, many of which were made by the respective agency within their IMR.

Police

⁴⁴ Amos T, Appleby L, Kiernan K. Changes in rates of suicide by car exhaust asphyxiation in England and Wales. *Psychol Med* 2001; 31: 935-39.

⁴⁵ *ibid*

⁴⁶ <https://www.respect.org.uk/pages/respect-male-victim-s-toolkit#:~:text=The%20Respect%20Male%20Victims%20Toolkit,for%20information%2C%20advice%20and%20support.>

⁴⁷ <https://www.respect.org.uk/>

⁴⁸ Johnson, M. P. (2008). A typology of domestic violence. Upne.

⁴⁹ Wilson, J. (2010). *Boozehound: On the Trail of the Rare, the Obscure, and the Overrated in Spirits*. Ten Speed Press.

⁵⁰ O'Connor, Rory. *When it is darkest: Why people die by suicide and what we can do to prevent it*. Random House, 2021.

- 8.2. All staff to be reminded via briefings of recording all information concerning a missing person on compact.
- 8.3. Officers to be reminded via briefings of using professional curiosity when deciding on house-to-house enquiries when attending domestic incidents.

NWAngliaFT

- 8.4. A review of documentation standards to take place, ensuring that the importance of case note recording events is reinforced. As part of this training, by way of 7-minute briefings and a 10-minute hot spot training, the latter specifically in the Emergency Department, will be rolled out across all divisions.
- 8.5. Training to be refreshed with staff across all units and wards on domestic abuse, with a specific focus of male victims and exercising professional curiosity in the context of DA disclosures or indicators.
- 8.6. MH policy review, focusing specifically on acute mental health crisis pathways and inter-agency collaboration as identified in the IMR findings.
- 8.7. NWAFT to lead the review on interface with Acute Psychiatric Liaison Service, to review: policy, referral pathways, thresholds, guidance available to Emergency Department staff and gaps in provision. TBC

Change, Grow, Live

- 8.8. Huntingdon CGL Senior Social Worker to develop robust escalation pathways for cases involving significant risks, such as severe mental health concerns or domestic abuse.
- 8.9. Huntingdon CGL staff team to have targeted training on the Care Act 2014, Domestic Abuse Act 2021, and Mental Capacity Act 2005, focusing on their practical application of the safeguarding processes.
- 8.10. Huntingdon CGL Service Manager to consider expanding the service provision to include alternatives to group sessions for socially isolated individuals or those with declining engagement.

B-United (Peterborough Women's Aid)

- 8.11. Case management Training and Policies to be refreshed to reflect the requirement for professional curiosity regarding risk to remain central.

Adult Social Care

- 8.12. Training to be refreshed with MASH staff on Domestic abuse, to include recognising indicators of domestic abuse and effective application of the SafeLives DASH case reflection activity to be carried out with the practitioners involved in the case.
- 8.13. Increasing the effectiveness of managing domestic abuse concerns within MASH, which includes refresher training on safeguarding protocols in light of DA disclosures and advanced domestic abuse training.

GP

- 8.14. GP Practice to review domestic abuse training for all Practice staff, which will include insights into the gendered experience of DA for male victims.
- 8.15. GP Practice to discuss with all staff professional curiosity for injury in adults where domestic abuse is known or suspected, or a safeguarding referral is known.
- 8.16. ICB to reflect on the advice detailed in the RCGP Safeguarding toolkit⁵¹ regarding GP's not being required to complete a DASH RIC with a victim of domestic abuse, which is in conflict with both recommendations from SafeLives⁵² and the Departments of Health Responding to Domestic Abuse resource for health professionals' guidance⁵³.

9. Multi-agency recommendations

- 9.1. **Recommendation 1:** Cambridgeshire & Peterborough DASV Partnership to raise awareness with professionals of the link between domestic abuse and suicide, enabling better risk identification, assessment and intervention.
- 9.2. **Recommendation 2:** Cambridgeshire Public Health and the Suicide Prevention Board to raise awareness with professionals across Cambridgeshire around best practice suicide intervention⁵⁴, which includes role of bespoke suicide intervention plans and how to implement them collaboratively with clients.
- 9.3. **Recommendation 3:** Cambridgeshire Public Health and the Suicide Prevention Board to consider domestic abuse being listed as a 'priority' area in the new Joint Cambridgeshire and Peterborough Suicide Prevention Strategy.
- 9.4. **Recommendation 4:** Cambridgeshire & Peterborough DASV Partnership to review their local DASV strategy, reflecting upon the operational resource allocated to respond to male victims locally, in light of the specialist male victims service at Peterborough Women's Aid ceasing to operate.
- 9.5. **Recommendation 5:** Cambridgeshire & Peterborough DASV Partnership to review their male victims training offer and resources on supporting male victims and roll out training for male victims, which should include assessment of counter allegations/unclear abuse dynamics.
- 9.6. **Recommendation 6:** Cambridgeshire Safeguarding Board to review its training offer regarding effectively responding to DA – including indicators of DA, completing a DASH RIC, application of motivational interviewing and professional curiosity.

⁵¹ <https://elearning.rcgp.org.uk/mod/book/view.php?id=15290&chapterid=901>

⁵² <https://safelives.org.uk/resources-for-professionals/dash-resources/>

⁵³ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/597435/DomesticAbuseGuidance.pdf

⁵⁴ <https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#interventions-for-self-harm>

9.7. Upon conclusion of a DHR, Huntingdonshire CSP will be responsible for embedding all of the learning detailed in this section, including the recommendations detailed below. Indeed, there is both individual agency learning and across multi-agency/collective learning for consideration. This is relevant to agencies both individually and collectively. The Cambridgeshire Domestic Abuse & Sexual Violence Partnership has a strategy and action plan, which the finding of this DHR will feed into and therefore is the basis of development of local processes, systems and partnership working. The Review Panel asserts that it is all agencies responsibility to robustly tackle domestic abuse: we all have a significant duty to make the future safer.