DOMESTIC HOMICIDE OVERVIEW REPORT

REPORT INTO THE DEATH OF VICTIM A

Report produced by Dr Susan Mary Benbow
on behalf of Older Mind Matters Ltd

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INTRODUCTION

This report of a Domestic Homicide Review examines agency responses and support given to Victim A, a 50 year old female resident of Leeds, prior to her death on 6th April 2012.

The review considers agencies contact/involvement with Victim A and the Perpetrator from 1st January 2005 until the date of Victim A's death and back as far as 2001 where relevant.

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

TIMESCALES

This review began with a Review Panel meeting on 22nd April 2013 and was concluded when the Report was accepted by the DHR Steering Group.

CONFIDENTIALITY

The findings of this review are confidential. Information is available only to participating officers/ professionals and their line managers.

DISSEMINATION

The following recipients have received copies of this report:

Leeds DHR Steering Group
DHR6 Review Panel Members
Chief Officer, Safer Leeds
Neil Evans, Director of Environment & Housing
Dr Ian Cameron, Director of Public Health
Leeds Domestic Violence (DV) Strategic Group
Safer Leeds Executive
Leeds Safeguarding Adults Board
Leeds Safeguarding Children Board

EXECUTIVE SUMMARY

1. THE REVIEW PROCESS

This summary outlines the process undertaken by Leeds DHR6 Domestic Homicide Review Panel in reviewing the murder of Victim A.

Criminal proceedings have been completed. In late 2013 the Perpetrator appeared at Leeds Crown Court where he was sentenced to life imprisonment for the Manslaughter of Victim A.

The review process began with an initial meeting on April 22nd 2013 of all agencies that had potentially had contact with Victim A prior to the point of her death.

Agencies participating in this initial review panel meeting were:

- Association for Blind Asians Leeds (ABAL) (Individual Management Review[1] (IMR))
- Leeds & York Partnership Foundation Trust (LYPFT) (IMR)
- Leeds Clinical Commissioning Groups (CCGs)/ NHS England (IMR commissioned by NHS England)
- Leeds City Council Adult Social Care
- Leeds Domestic Violence Service
- Leeds Safeguarding Children's Board
- Leeds Safeguarding Adults Partnership Board
- Leeds Teaching Hospitals NHS Trust (LTHT) (IMR)
- Safer Leeds
- West Yorkshire Police (IMR)
- Home Office/ UK Borders Agency (now known as UK Visas and Immigration)

Agencies were asked to give chronological accounts of their contact with the victim prior to her death. Where there was no involvement or insignificant involvement, agencies advised accordingly. Each agency's report covers the following:

- a chronology of interaction with the victim, and/or perpetrator and/or their family;
- what was done or agreed;
- whether internal procedures were followed; and

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[1] An Individual Management Review (IMR) involves an agency in looking critically at their involvement with the victim and/ or perpetrator or alleged perpetrator in a domestic homicide. The person conducting an IMR should not have been directly involved with the victim, the perpetrator/ alleged perpetrator or either of their families, and should not have been the immediate line manager of any staff involved in the IMR.

- conclusions and recommendations from the agency's point of view.

The accounts of involvement cover different periods of time prior to the death. Some of the accounts have more significance than others. The extent to which the key areas have been covered and the format in which they have been presented varies between agencies.

All eleven agencies were in attendance at the initial meeting. In total, six agencies reported having had no, or insignificant, contact with either the victim, suspect or any children involved: Leeds City Council Adult Social Care; Leeds Domestic Violence Services; Leeds Safeguarding Children Board; Safer Leeds; UK Borders Agency (now known as UK Visas and Immigration).

Five agencies reported information indicating some level of involvement with the victim and/or perpetrator: West Yorkshire Police; LTHT; ABAL; LYPFT; Leeds CCGs/ NHS England. These five agencies agreed to contribute Individual Management Reviews (IMRs) to this Review.

The police report shows that on one occasion between 1/1/2005 and 6/4/2012, they had contact with Victim A in relation to allegations of harassment made by her ex-husband (Perpetrator).

2. KEY ISSUES ARISING FROM THE REVIEW

Lessons learned from this Review have the potential to improve inter-agency responses to domestic violence and contribute to lessening the chances of future domestic homicides.

2.1 Communication and continuity of care in general practice

Victim A consulted a number of different GPs, and she and/ or a family member disclosed abuse to three different GPs. When individuals are seeing a number of different GPs, communication systems become very important in ensuring that GPs who may not have met someone before have access to important information about that individual. In relation to domestic violence, when someone is consulting with a number of different GPs, a system of flagging up disclosures of domestic violence/ abuse might assist in ensuring that it can be properly considered and appropriate assessments carried out in subsequent consultations. Computer systems should make this possible.

2.2 Access to psychotherapy/ mental health services

The Perpetrator presented with mental health concerns repeatedly over a long period. Analysis suggests that his mental health issues remained a concern with discontinuities in his care and some confusion/ uncertainty regarding what service or services might appropriately have helped him. Communication was recorded as difficult on a number of occasions and may have influenced how he communicated with healthcare staff and others about his mental health. Cultural factors may also have influenced his presentation.

2.3 Ethnic/ cultural issues influencing presentation to services

The Perpetrator's mental health issues appeared to be related to ethnic/ political conflicts in his country of origin and ethnic/ cultural issues (in how he presented his symptoms) may have influenced how he communicated his needs to GPs. The difficulties in communication, which are repeatedly noted in many contacts with the Perpetrator, may have compounded the difficulty of identifying and correctly classifying his symptoms.

2.4 Language barriers and interpretation services

Both the Perpetrator and Victim A were repeatedly noted to have difficulties with communication and it appears that GPs found the use of a telephone interpretation service in an interview to be not always fit for purpose. Factors in this include use of a telephone interfering with the doctor-patient relationship and that there may be problems with the line. Victim A was also often interviewed with one of her sons as interpreter contrary to what is regarded as good practice, although there is a necessary balance between policy and pragmatism. Interpretation services need to be easily available, accurate, gender-sensitive and fit for purpose.

2.5 Communities regarded as hard to reach and domestic violence

Some communities might be regarded as hard to reach or hard to engage and might be served better by third sector specialist groups. These organisations are often small (which can be their strength) and may have less experience of domestic violence and safeguarding, less awareness of domestic violence risk indicators and how to assess risk – effectively this will present an additional barrier for people (mainly women) experiencing domestic violence in those communities. One way of supporting third sector organisations might be for them to work towards attaining the Leeds Domestic Violence Quality Mark.

2.6 Marginalisation and isolation

Some individuals are marginalised and isolated, often for a number of reasons, which may be complex and inter-related. These factors may include culture; gender; disability; language; physical and mental health. These influences may compound the individual's difficulty in accessing support and services. Equally services may not be sensitive to these issues, missing opportunities to appropriately market their services to marginalised communities in order to provide equal access to all.

3. CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

In the circumstances, it is unlikely that any specific agency intervention could have prevented the victim's death, based on the information and evidence provided to the review.

The information available to the Review Panel suggests that there were three recorded disclosures of domestic abuse and one recorded incidence of probable domestic violence between Victim A and the Perpetrator.

3.1 IMR1 Recommendations: GP services

3.1.1 Commissioners should consider appointing an identified GP adult safeguarding lead for NHS England/ the three Leeds CCGs to provide leadership, advice and support for GPs (IMR1 page 22).

3.1.2 Commissioners should ensure that all GP surgeries have an up to date electronic directory on all voluntary and statutory agencies that can provide help and support for anyone who is suffering from domestic abuse (IMR1 page 23).

3.2 IMR2 Recommendations: LYPFT

Two changes to the system have occurred which would impact on the response to a similar case: there is now a single point of access for referrals, which involves CMHTs and Psychology and Therapies. A referral addressed to Therapies, which would more appropriately be directed to the CMHT, would be automatically redirected. Safeguarding Adults level 1 training is now compulsory for all staff and includes a strand of domestic violence training.

3.2.1 Assurance is gained that all GP practices are fully aware of referral procedures into LYPFT.

3.2.2 Assurance is gained that the Single Point of Access (SPA) is able to provide appropriate guidance and direction when specialist services are requested.

3.3 IMR3 Recommendations: West Yorkshire Police

3.3.1 That all staff be briefed upon policy requirements in relation to the use of interpreters.

3.4 IMR4 Recommendations: LTHT

3.4.1 Review current signposting/ public facing information related to domestic violence support services. This should consider the following:
a) is the right amount of relevant information available and can it be made available in more community languages?
b) is the information available in all pertinent areas across relevant LTHT sites?

3.4.2 LTHT to conduct a training needs analysis on domestic violence issues.

3.4.3 LTHT to review current arrangements related to domestic violence in high volume female patient areas. This review should identify practicable

ways forward for ensuring a standard approach to alerting, signposting and investigating concerns and disclosure.

3.4.4 LTHT to establish a mechanism to work with outside agencies to ensure that key messages about domestic violence are made available to their staff on a regular basis and review how guidance and good practice can be improved and disseminated more visibly.

3.5 IMR Recommendation: ABAL

3.5.1 To attain Leeds DV Quality Mark.

3.6 Chair and Review Panel's Additional recommendations

All agencies undertaking IMRs for this Review have had sight of these recommendations and have agreed them at the appropriate level of seniority in the organisation.

3.6.1 Leeds CCGs and NHS England to explore ways of flagging up disclosures of domestic abuse/ violence on GP systems and for a mechanism to alert GPs to the fact that it has been raised in order that further enquiry might be triggered at future appointments which may be with different GPs.

3.6.2 That the GP practices directly involved in this DHR review their knowledge around domestic abuse, undertake a training needs analysis and address any gaps in knowledge using NICE guidance as a guide.

3.6.3 That the GP practices directly involved in this DHR review current signposting/ public facing information related to domestic violence support services. This should determine whether the right amount of relevant information is available and whether it can be made available in more community languages or in other ways.

3.6.4 That the GP practices directly involved in this DHR review their documentation and record keeping in respect of domestic violence disclosures.

3.6.5 All agencies undertaking IMRs for this Review and working using interpretation services should ensure that translation is sufficiently accurate, independent and gender-sensitive for the purpose for which it is employed.

3.6.6 Community Safety Partnership to commission a review of what is used and what is good practice in interpretation with vulnerable adults and produce a set of standards for agencies to sign up to.

3.6.7 Commissioners should appoint an identified GP adult safeguarding lead for Leeds CCGs to provide leadership, advice and support for GPs.

LEEDS DOMESTIC HOMICIDE DHR6 REVIEW PANEL CONCLUDING REPORT

1. INTRODUCTION

1.1 Agencies involved

This review report follows the Home Office recommended outline (Home Office 2013) and is an anthology of information and facts from 11 agencies, all of which were potential support agencies for Victim A or the Perpetrator. The agencies involved in the first meeting of the Review Panel were:

- Safer Leeds
- West Yorkshire Police
- Leeds Safeguarding Children Board
- Leeds Safeguarding Adults Partnership
- Leeds Domestic Violence Service
- Leeds Teaching Hospitals Trust
- Leeds City Council (LCC) Adult Social Care
- Association for Blind Asians Leeds
- Leeds & York Partnership Foundation Trust
- Home Office/ UK Borders Agency (now UK Visas and Immigration)
- Leeds CCGs/ NHS England

Essentially, only five agencies had records of contact with Victim A prior to her death and were asked to carry out and submit Individual Management Reviews[2] (IMRs). They are:

- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- Association for Blind Asians Leeds (ABAL)
- Leeds Teaching Hospitals Trust (LTHT)
- Leeds CCGs/ NHS England (commissioned by NHS England)
- West Yorkshire Police

The Review Panel was chaired, and this Report authored, by Dr Susan Mary Benbow, Director of Older Mind Matters Ltd. Dr Benbow is an independent professional working in mental healthcare and with families, mainly in the North West and Midlands areas.

Appendix 1 lists the acronyms used in this report.

1.2 Semi-anonymisation of names

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[2] An Individual Management Review (IMR) involves an agency in looking critically at their involvement with the victim and/ or perpetrator or alleged perpetrator in a domestic homicide. The person conducting an IMR should not have been directly involved with the victim, the perpetrator/ alleged perpetrator or either of their families, and should not have been the immediate line manager of any staff involved in the IMR.

The Victim is referred to in this report as Victim A and the person convicted of Victim A's manslaughter as the Perpetrator.

1.3 Circumstances leading to the Domestic Homicide Review

On the 6th April 2012 the Perpetrator called 999 saying he had killed his wife. Police attended the address and found Victim A apparently dead and the Perpetrator present. The Perpetrator was arrested and a murder investigation commenced. A knife was found at the scene and the Victim was found to have a ligature around her neck where her scarf had been pulled tight. A post mortem showed the cause of death to include stabbing and strangulation. The Perpetrator was subsequently convicted of manslaughter and sentenced to Life imprisonment.

1.4 Terms of Reference

	Family Details (removed to maintain confidentiality)
	Reasons for Domestic Homicide Review The Chair of the Leeds Community Safety Partnership, along with the Leeds Domestic Homicide Review Steering Group, has considered the information available in this case and takes the view that the following criteria for undertaking a Domestic Homicide Review (DHR) are met. "A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by- (a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or (b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death". (Domestic Violence Crime and Victims Act s9(3) 2004) In addition, the Home Office guidance states: "The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence." (Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office, page 6 paragraph 3.6)

	Summary of Incident: On the 6th April 2012, it is thought that the victim visited her estranged husband's address to take him some food. Police later attended a domestic incident at the husband's address after the suspect called the police saying he had killed his wife. It is alleged an argument broke out involving the victim hitting the suspect around the head with slippers. It is further alleged that the suspect then hit the victim over the head with a dumb bell causing fatal injuries. A knife was found at the scene and the victim was found to have a ligature around her neck where her scarf had been pulled tight. A post mortem showed the cause of death to include stabbing and strangulation.
	Family History The suspect came to England in 2001 from [redacted] and was given leave to remain. In 2006, his wife came to England with their [redacted] sons. The couple were married for over 30 years and resided at address1. About 3 years prior to the incident, the couple split up. Victim A and the [redacted] sons moved to address2 (about 5 minutes from the family home). The sons have had very limited contact with their father since the split. The only police record which exists for the couple relates to Victim A receiving a harassment warning on 23 March 2012 following her attendance at the marital home where she was abusive to the suspect and demanded money.
1.	**The purpose of the Domestic Homicide Review is to:** • Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence. • Identify clearly what those lessons are, both within and between agencies; how those lessons will be acted on, within what timescales and what is expected to change as a result. • Apply these lessons to service responses including changes to policies and procedures as appropriate; and • Assist in the prevention of future domestic homicides through improved intra and inter-agency working to domestic violence victims and their children. In addition, the following areas will be addressed in the Internal Management Reviews and the Overview Report:

	• The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform BME communities about services available to victims of domestic violence? • Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim. • Whether there were any barriers experienced by the victim or her family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should she have wanted to. • Whether there were any warning signs and whether opportunities for triggered or routine enquiry and therefore early identification of domestic abuse were missed. • Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed. • Give appropriate consideration to any equality and diversity issues that appear pertinent to the victim or perpetrator. • Consider any other information that is found to be relevant.
2.	**The Time Period under Review** 1st January 2005 to 6th April 2012 (plus any significant events from 2001).
3.	**Independent Chair and Overview Report Author** • Susan Benbow has been appointed to this role and will chair the panel meetings and author the overview report. • The Review Panel will consider whether the Independent Chair requires additional specialist help and support to undertake this role.
4.	**Agencies to be involved** • Safer Leeds • West Yorkshire Police (IMR) • Leeds Safeguarding Children's Board • Leeds Safeguarding Adult's Partnership • Leeds Domestic Violence Service • Leeds Teaching Hospitals Trust (IMR) • Association for Blind Asians Leeds (IMR) • Leeds & York Partnership Foundation Trust (IMR) • Clinical Commissioning Group (IMR)

5.	**Process of review** Once agreed, the terms of reference and timescales will be sent to the Home Office DHR Team and circulated to IMR authors within one week. Following the first meeting, Review Panel members will take steps to ensure that their agency's IMR and chronology are completed within agreed timescales. They will also read all the circulated management reports and chronologies prior to the next panel meeting and consider what additional information may be required.
6.	**IMRs/Chronologies** • Advice on how to complete these will be issued to all IMR authors by Safer Leeds • All relevant workers will be interviewed as part of the IMRs • Consideration by the Review Panel will be given to whether additional support will be required to enable IMR authors to complete within the timescales provided. • Timescales will be kept and organisations will commit the adequate resources to ensure this happens
7.	**Family Members, Friends and Colleagues** • Family members and friends will be given the opportunity to participate in the review • Interviews will be undertaken by the chair / author and a member of the LCC Domestic Violence Team • Safer Leeds will write to all family members and friends as appropriate to invite their contributions
8.	**Parallel investigations of practice** • Everyone involved in the Domestic Homicide Review process will be mindful of not jeopardising any criminal prosecution proceedings. The panel member for the police will therefore be asked to confirm, at the first panel meeting, whether it is suitable for the Individual Management Review Authors to interview staff members involved and whether it is appropriate to interview family members. This will be kept under review with guidance from the Crown Prosecution Service.
9.	**Publicity/Media issues** • Media and publicity meetings will be held as necessary. • All requests for information will be dealt with by Michelle De Souza. • Only the Executive Summary will be published and its content will

	take proper account of privacy/confidentiality considerations and be subject to advice from Leeds City Council lawyers and the Home Office.
10.	**Other issues** • **Legal Issues –** Individual agencies are free to seek legal advice in relation to their agency's IMR however this must not hinder agreed timescales. LCC Legal Services, on behalf of Leeds Community Safety Partnership, will advise on the content of the draft Overview Report. • **Timescale -** The Home Office was informed of the intention to conduct a DHR in this case. The guidance requires that the first review panel must be held within a month of this date and that the whole process should be completed within 6 months. However, as criminal proceedings are ongoing, the DHR process and overview report will not be finalised or published until the outcome of the proceedings is known. • **Anonymisation of Family Names -** For the purpose of the Overview Report, the victim will be known as Victim A and the suspect will be known as Suspect A (following conviction it was agreed to use the term "the Perpetrator"). • **Anonymisation of Staff** – Staff will be anonymised in IMRs and the Overview Report.

1.5 Timeframe for the Review

The agreed timeframe was from 1st January 2005 to 6th April 2012 (plus any significant events from 2001).

1.6 Methodology

An initial meeting of agencies was held on 22 April 2013. The representative of the Home Office (formerly UK Border Agency and now known as UK Visas and Immigration) noted that that their only involvement had been in 2001 when the Perpetrator first came to the UK and it was agreed that they should not sit on the Panel or take part in the Review.

Subsequently, a joint briefing for IMR authors for DHR6 was held with IMR authors involved in DHR7 on July 1st 2013. This covered the following areas:

- Domestic violence context
- Each DHR context and terms of reference
- Writing an IMR and what makes a "good" IMR

- Critical reflection
- SMART[3] action plans and recommendations

September 13th 2013 was set as the initial date for return of IMRs but several agencies had difficulties with the timescale and IMRs were received on the following dates:

Leeds CCGs/ NHS England	18/11/2013
Leeds and York Partnership NHS Foundation Trust (LYPFT)	26/9/2013
Association for Blind Asians Leeds (ABAL)	18/2/2014
Leeds Teaching Hospitals Trust (LTHT)	25/11/2013
West Yorkshire Police	before 20/9/2013

A meeting of the Domestic Homicide Review Panel was held on 10 March 2014 to consider the IMRs and a preliminary draft report. Collated feedback on the IMRs was sent to Review Panel Members for an accuracy check and agreement following the meeting. Each agency's feedback was then sent to the senior officer who signed off the report, with a request for them to provide feedback to the report author and for amended IMRs to be returned by 7 May 2014.

Amended IMRs were received as follows:

DHR6 Action Plan - Apr 2014.doc supplied by NHS England	14/5/2014
Leeds and York Partnership NHS Foundation Trust (LYPFT)	13/5/2014
Association for Blind Asians Leeds (ABAL)	27/5/2014
Leeds Teaching Hospitals Trust (LTHT)	16/5/2014
West Yorkshire Police	07/5/2014

A final Review Panel meeting was held on 28 May 2014. The Panel discussed the draft report in detail and agreed/ drafted recommendations. Subsequently the report was revised and circulated electronically to the Review Panel for approval prior to being submitted for sign-off to the July DHR Steering Group meeting.

1.6.1 Membership of the Domestic Homicide Review Panel

The following were acknowledged as members of the DHR6 panel:

- Safer Leeds
- West Yorkshire Police
- Leeds Safeguarding Children's Board
- Leeds Safeguarding Adults Partnership Board
- Leeds Domestic Violence Service
- Leeds Teaching Hospitals Trust
- LCC Adult Social Care
- Association for Blind Asians Leeds

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[3] Specific Measurable Achievable Relevant Time-specific

- Leeds & York Partnership Foundation Trust
- Leeds CCGs/ NHS England

1.6.2 Individual Management Reviews and Chronologies

IMRs were requested from:

- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- Association for Blind Asians Leeds (ABAL)
- Leeds Teaching Hospitals Trust (LTHT)
- Leeds CCGs/ NHS England
- West Yorkshire Police

1.6.3 Contact with family/ friends

The Home Office guidance on Domestic Homicide Reviews states that "members of informal support networks, such as friends, family members and colleagues may have detailed knowledge about the victim's experiences. The Review Panel should carefully consider the potential benefits gained by including such individuals from both the victim and perpetrator's networks in the review process. Members of these support networks should be given every opportunity to contribute." (Home Office 2013, p. 15). The importance of involving family members had been emphasized in the Pemberton Review which states that "it is recommended that, given the potentially important contribution of family and friends to the review process, the nature and scope of family involvement needs to be clearly established at the earliest opportunity and at all stages of the process." (Walker, McGlade et al. 2008, p. 298).

Contact was made with the family early in the review and again at a later stage both by letter and through the Family Liaison Officer (FLO). The Review process was explained to the family and they were asked to consider contributing in any way they wished, but they decided not to do so.

A letter was also sent to the Perpetrator after conviction to inform him about the Review.

At the final Review Panel meeting on 28 May 2014 the Chair/ Author and Panel agreed to make a final attempt to get information about the victim as all concerned felt that Victim A had little voice in the Report; however, the family's wishes not to be involved had to be respected. It was agreed to request a copy of the antecedent statement in the court file, but the Panel were subsequently informed that, since the family had declined to be involved, sharing this document was felt to go against the expressed wishes of the family and the Panel would not be given access to a copy.

1.6.4 Report Structure

Section 2 of this Report, The Facts, documents in chronological order the known facts about the Perpetrator and Victim A's contacts with the agencies involved.

Section 3 of this Report, Analysis, sets out an analysis of what is known. It includes analysis from the IMR authors.

Section 4 outlines the main conclusions and lessons learned.

Section 5 sets out the recommendations of the Domestic Homicide Review.

1.6.5 Referencing

Relevant documents are referenced in the main document using the short codings in the Table below:

	Organisation involved or document name	**Name of IMR Author**	**IMR Author's Role**	**Name of Officer signing off IMR**	**Role of Officer signing off the IMR**
IMR1	CCG/ Primary Care Services commissioned by NHS England	Chris Brougham	Senior Consultant/ Head of Training, on behalf of Verita	Sue Cannon	Director of Nursing, NHS England - West Yorkshire Area Team
IMR2	Leeds & York Partnership NHS Foundation Trust	Steve Wilcox	Lead Clinician for Safeguarding Adults	Beverley Murphy	Chief Nurse/ Director of Quality Assurance
IMR3	West Yorkshire Police	Granville Ward	Safeguarding Delivery Manager	Ingrid Lee	Assistant Chief Constable
IMR4	Leeds Teaching Hospitals NHS Trust	Tim Whaley	Mental Capacity Co-ordinator/ Safeguarding Adults Team Manager	Clare E Linley	Deputy Chief Nurse
IMR5	Association for Blind Asians Leeds	Neil O'Byrne,	Independent Safeguarding and Risk Manager within Leeds Safeguarding Adults Partnership	Debbani Ghosh	Manager, ABAL
CC	Combined Chronology	n/a	n/a	n/a	n/a

2. THE FACTS

The Perpetrator came to England in 2001 from [redacted] and was given Leave to Remain. In 2006, his wife, Victim A, came to England with their [redacted] sons.

The couple were married for over 30 years and resided at address 1. About three years prior to the incident leading to this Domestic Homicide Review, the couple separated. Victim A and the [redacted] sons moved to address 2 (about five minutes from the family home). The sons had very limited contact with their father following the separation.

The only police record which exists for the couple relates to Victim A receiving a harassment warning on 23 March 2012 following her attendance at the marital home where she was reported to be abusive to the Perpetrator and to have demanded money.

On the 6th April 2012, the Perpetrator called 999 saying he had killed his wife. Police attended the husband's address and found Victim A apparently dead and the Perpetrator present. The Perpetrator was arrested and a murder investigation commenced. A knife was found at the scene and the Victim was found to have a ligature around her neck where her scarf had been pulled tight. A post mortem showed the cause of death to include stabbing and strangulation. The Perpetrator was subsequently convicted of manslaughter and sentenced to Life imprisonment with a tariff of 7yrs and 6 months before Parole can be considered, less the 526 days that he had already served. The Judge also stated that he would be on a life license.

The Table below summarises the chronology of events leading up to the domestic homicide.
[Note: bold and italics have been added to the text to highlight references to disclosure of, or possible incidents related to, domestic violence.]

Date	Perpetrator	Victim
2001	The Perpetrator came to England in 2001 from [redacted] and was given leave to remain.	
2001-2003	There is no record of the Perpetrator being registered with a GP practice between 2001 and 2003. From July 2003-Jan 2004 Perpetrator was registered with MC1. GP notes from 2003 record that on 11 July the Perpetrator was dehydrated following a hunger strike.	
Jan 2004-June 2005	The Perpetrator had an appointment with GP2 on 13 January 2004. The GP record notes that Perpetrator was	

Date	Perpetrator	Victim
	assaulted in Afghanistan in 1998, although no detail was recorded about how serious the assault was. Perpetrator told the GP that he was stressed, missing his family and was lonely. GP2 referred Perpetrator to a neurologist and a counsellor.	
18 Nov 2004	The referral to neurology notes Perpetrator was complaining of 6 year history of headaches, memory loss, loss of smell, nausea following alleged assault in [redacted] He was described as very angry.	
2 Feb 2005	A letter was sent to GP2 at MC2, Leeds, from Leeds Mental Health Services acknowledging the Perpetrator's referral to clinical Psychological Therapy Service. The letter advised that the case would be discussed at the weekly referral meeting. There is no other GP record showing whether or not Perpetrator was accepted for counselling.	
March-June 2005	Contact with GP surgery and neurology regarding neurology out-patient appointment (no abnormality found on neurological examination) and back problems.	
Aug 2005-Dec 2005	Attended MC5 several times with various problems.	
24 Aug 2005	Perpetrator visited Clinical Nurse Specialist1 at MC5 complaining of dizziness, poor memory and headaches. It was noted he had previously been to hospital (for a brain scan?) but didn't know the result. The clinical nurse specialist advised that she would try and find out the outcome of the brain scan.	
9 Dec 2005	Urgent Referral letter from the Perpetrator's Doctor (GP3) at Medical Centre (MC3) received	

Date	Perpetrator	Victim
	by LYPFT requesting a psychology (counsellor) due to Perpetrator's accounts of being tortured whilst [redacted] receiving blows to the head on a number of occasions. He reported symptoms of "different body aches, back ache, tension headaches, forgetfulness and difficulty in concentration and learning." The GP records suggest that Perpetrator had been referred to a psychologist or counsellor. There is no referral letter in the GP records, but a note in the records advised that the referral was changed from a referral to counselling to post traumatic stress disorder services.	
6 Feb 2006	Letter from LYPFT Cognitive Therapist1, (service coordinator/cognitive therapist), to GP3 (Perpetrator's GP) states (the service is) unable to respond to urgent requests for care managements for clients, advising GP3 to sector psychiatry; saying "We are a specialist trauma service and our focus is on symptoms of Post-Traumatic Stress Disorder ie. Flashbacks, nightmares, avoidance and hyper-arousal symptoms. Although you mentioned the gentleman had been tortured, there was no specific mention of any Post Traumatic Stress Disorder symptoms and in our experience not all torture victims will develop Post Traumatic Stress Disorder. The main focus seems to be on physical symptoms and concentration difficulties, which may be best dealt with in secondary care."	
6 June 2006	Letter sent to a GP at MC3 from a psychotherapist from the	

Date	Perpetrator	Victim
	Health Access Team for Asylum Seekers in Leeds. The letter advises the following: Perpetrator "was referred to counselling by a befriender from the Leeds Asylum Seekers Support Network. He received 5 counselling sessions between 24 April and 5 June. He presented with stress related problems. He experienced dizziness and lost his temper easily. He had poor concentration and headaches. This resulted in him not being able to learn English despite being in the UK for several years. (Perpetrator) was convinced his problems were due to two blows to his head that he received 7/8 years ago - medical test so far have resulted in no damage. (Perpetrator) feels that an x-ray is necessary to see what's going on. (Perpetrator) worries about his family. His wife and children are in Pakistan awaiting visas. He did not find the counselling sessions useful at all. He is not taking any medication for anxiety or pain relief." The psychotherapist asked the GP to consider whether a more structured approach such as Cognitive Behaviour Therapy might be more helpful or some advice on managing stress.	
9 June 2006	A Senior Community Nurse from the Health Access Team for Asylum Seekers in Leeds wrote to a GP medical practice; requesting arrangements to be made for the Perpetrator to be registered with the practice. The letter advised that Perpetrator is from so would need an interpreter.	

Date	Perpetrator	Victim
	The letter asked the GP to follow up and review two physical conditions. The letter was received by the medical practice on 27 June. A hand written note on the letter says “not on list”.	
Aug-Dec 2006	Perpetrator visited the surgery to discuss his headaches and on one occasion an upper respiratory tract infection. The GP record in August highlights that the language line was used to interpret the conversation, but that the line was barely audible and the GP changed the interpreter but this was no better. In November a consultation was carried out in [redacted] but the Perpetrator was noted to have limited understanding of [redacted]. In December the Perpetrator’s limited English was noted.	At some stage in 2006, Victim A, came to England with the couple’s three sons.
12 Dec 2006		First GP record relating to Victim A, who was seen by GP11 with her son who interpreted. Problems were one year history of epigastric pain, exacerbated by eating, and discomfort when walking (right mid foot amputated as a child).
28 Dec 2006		Second GP contact with Victim, who was seen by GP12: son attended appointment to interpret. Problem was knee pain; longstanding discomfort when walking.
Jan-Feb 2007	Perpetrator continued with long standing health problems. On 19 January, 07 and 16 February 2007 he saw GP5 with lower back pain.	
16 Jan 2007		Victim was seen by GP11; son attended to interpret. She reported 1 year history of pain in left arm and continued

Date	Perpetrator	Victim
		abdominal pain. GP noted that language line would be helpful.
13 Feb 2007		Victim was seen by GP11 with pain in neck and spine, and history of pain in left arm related to an accident that occurred 16/17 years previously; experiencing burning pain in left arm for a year.
22 February 2007	An Advisor from the Refugee Education and Training Advisory Service wrote a letter to a doctor (unknown name and medical practice) asking the Doctor to meet with Perpetrator with an interpreter. The advisor stated that she had concerns about Perpetrator because she had been working with him over the last two years and had seen a marked deterioration in his mental health. The letter outlined the following concerns about Perpetrator: "he was forgetful, and had a constant headache; he was bashed on the head whilst in his own country and had undergone counselling for this trauma; he was short tempered and small things made him angry." Perpetrator had an appointment at Hospital2 in Leeds but there was no interpreter so the doctor sent him home.	
7 March 2007	Perpetrator went to visit GP5 complaining of a two year history of headaches and that this made him angry as it affects his study and his short term memory. An anti-depressant was prescribed. The record noted that contrary to information about Perpetrator's poor English, he spoke good English. The record also noted that the Perpetrator's wife and	

Date	Perpetrator	Victim
	sons were due in the UK within the next four months.	
March-May 2007	Monthly visits made to GP for physical problems.	
March-May 2007		Contact with GP surgery (for vitamin D deficiency, knee, neck and abdominal pain) and Hospital1 for gastroscopy (25 April) which showed acute gastritis. language line used by hospital. Husband recorded as next of kin and carer for next 24 hrs in respect of gastroscopy.
9 July 2007	Perpetrator went to see his GP with a copy of the letter sent by the Advisor from the Refugee Education and Training Advisory Service. He complained of headaches, worse if he got angry, and constant anger outbursts unrelieved by medication. The clinical records note that the GP had already seen this letter. The GP recorded that it was a difficult consultation as Perpetrator was speaking in a different dialect to the GP and Perpetrator was constantly talking over him.	
July-August 2007	Two GP consultations with shoulder pain and then asthma. Language line not booked and Perpetrator didn't speak English well enough for consultation.	GP consultations and attendance at gynaecology out-patient clinic. Smear not taken as no interpreter present in out-patients and difficulties in communication noted.
25 Sept 2007		Victim A seen by GP11 and reported marital problems. ***She said that her husband had been abusive in the past and currently is being emotionally abusive.*** Victim tearful and requested something to help her relax/sleep. She also reported acute gastritis and pain in neck, knee/feet and requested

Date	Perpetrator	Victim
		stronger pain medication. Abnormal smear result and need for follow up appointment was discussed.
28 Sept 2007		Victim A seen by GP6 for a "stress related problem": she attended appointment with son who acted as interpreter. ; explained that his father has had problems for 11 years and that the sleep in one bedroom. Son reported that father has had mental health issues in the past. GP6 recorded that the family are refugees Anti-depressant prescribed for Victim A. Son said that he would attend surgery with his father.
October 2007	Perpetrator seen twice (by GP 5 and GP6) with headaches, anger and concentration difficulties: GP6 agreed to start a trial of anti-depressants for Perpetrator on 12 Oct 2007.	Victim A seen twice regarding physical health (by GP6 and GP15).
13 Nov 2007		Victim A seen by GP4 and reported rib pain: ***"fell three days previously, hit ribs on chair. Difficult to examine because jumpy;*** GP4 advised fracture likely" and prescribed pain medication.
22 Nov 2007		Victim A seen in gynaecology out-patient clinic.
2008	Perpetrator continued to have physical health problems including a back problem; earache; and eye problems. Antidepressant treatment was reported to help "a bit" (11 Jan 2008) but his mood was "variable" and the main issue was said to be forgetfulness related to past concussion.	Victim A continued to have physical health problems (mainly pain and gastric symptoms) and was in regular contact with GP surgery.
2009	Perpetrator had regular reviews by GPs and practice nurses for	Victim A was in regular contact with the GP surgery

Date	Perpetrator	Victim
	physical problems including asthma, back pain, headaches, chest pain and upper respiratory tract infections, and for stress.	for physical health problems. 15 Sept attended A&E with abdominal pain and vomiting. Found to have multiple small gallstones and attended day surgery pre-assessment clinic on 10 Dec 2009. Comment in Oct 2009 that “son finds it difficult to interpret”.
2010	Perpetrator continued to have long term health problems and to see GP and practice team. GP1 noted in July that he spoke little English and “the consultation was difficult”. He was referred to ENT for a hearing problem and when seen the consultant noted that communication was very difficult but that it was not clear whether this was due to poor English or a hearing problem.	Victim had regular contact with GP and had a cholecystectomy in March. She moved to a different Medical Centre (MC3) in July but her symptoms of indigestion continued. On several occasions her son acted as interpreter.
2011	Perpetrator continued to experience low mood and forgetfulness (feb 2011) but memory thought to be ok when tested. He also had back, shoulder and eye problems, was diagnosed with acute macular degeneration in July and was registered partially sighted. From mid August he started to have regular contact with the Asian Blind Association for help with forms and letters relating to benefits, bus pass, digital switch over, an overpayment to Yorkshire Water, HMRC, winter fuel payment, and TV licence. He was referred to adult social care for adaptations to his home. In Dec 2011 he saw GP for review and was thought to have a memory problem as part of depression.	Victim was in regular contact with GP surgery for repeat prescriptions and with back, knee and shoulder pain. In August she registered with a different Medical Centre (MC7). 11 October 2011 she was seen with a “painful lump under left elbow”. Her son acted as an interpreter and ***“reported a history of domestic violence”.*** In December she registered with a different Medical Centre (MC8).
Jan-Feb 2012	Perpetrator attended GP surgery complaining of memory loss, tremor and headaches and was referred for neurology	Victim attended sarcoma outpatient appointment for swelling on forearm with an interpreter and agreed to have

Date	Perpetrator	Victim
	assessment. He attended eye clinic on several occasions and was given a diagnosis of Best disease (hereditary form of progressive macular dystrophy which leads to sight loss).	the lump removed. The notes record uncertainty about whether she speaks
23 March 2012	Perpetrator visited the Asian Blind Association office and was noted to be shaking. He said that he had been physically abused by his wife the previous night around 2130. The incident was reported to the Police on his behalf. Call logged by the Police at 1105 "estranged wife harassing husband. Couple have separated and female party has been attending at male's home address. She has been abusive and demanding money. Last night she hit caller with her hand bag… He has not reported any incidents previously. Caller is support worker." PC1 went round to the Perpetrator's address (address1) and carried out an initial interview using telephone interpreter. Perpetrator was taken to Killingbeck Police Station and a written witness statement was taken in assisted by interpreter1. Perpetrator wanted a formal warning not to attend his address again to be issued to the Victim. Arrangements made for Interpretor1 and Perpetrator to attend the Police Station on 24 March for update on outcome.	Victim had the lump removed from her arm as day surgery case and was discharged with her son at 1340.
24 March 2012		0915 Victim issued with harassment warning by PC1 in the presence of her son and using him as interpreter at her address.
	Perpetrator advised of this subsequently at Killingbeck Police Station using	

Date	Perpetrator	Victim
	Interpreter1.	
	1147 Police log records "victim and suspect are ex husband and wife and have been separated for the past three years. Over the last few months, the suspect (Victim A) has been attending at the victims (Perpetrator) home address on a weekly basis shouting and banging on the door demanding to be let in. This is over them getting a divorce. Victim (Perpetrator) has asked suspect (Victim A) to leave him alone, however she has refused to do so and continued attending the address. The victim (Perpetrator) was unhappy with this attention and informed his key worker who reported this to the Police. Victim (Perpetrator) wanted subject warning re leaving him alone".	
	1312 DASH risk assessment form completed to assess the risk to the Perpetrator (then victim) from the Victim (then suspect) and assessed as medium on the basis that although this was first report to police it was harassment and justified a higher risk rating. The call was identified as Domestic abuse incident non-crime.	
29 & 30 Mar 2012	Perpetrator attended the Asian Blind Association office twice regarding a jury summons and a letter from HMRC.	
30 March 2012		Victim attended plastics dressing clinic.
2 April 2012	Perpetrator attended the GP surgery complaining of cough.	
5 April 2012	Perpetrator attended GP surgery for a lung function test.	
6 April 2012	1302 Call received via 999 system from a male saying he had killed his wife.	
	1310 PC2 attended the scene and found the Victim apparently dead and the Perpetrator present. Perpetrator arrested at 1314 and murder investigation commenced.	

3. ANALYSIS

3.1 Summary Analysis

3.1.1 The Perpetrator and his mental health

Little is known about the Perpetrator's background and personality. He was a refugee from [redacted] and, when he came to the UK, he left behind his wife and [redacted] sons, who, in 2006, were said to be in Pakistan awaiting visas to come to the UK. There are references to him having been [redacted] and having been tortured and physically assaulted. There is evidence that he had long-standing physical health problems and in 2011, he was registered as partially sighted.

He came to England from [redacted] in 2001 and, from 2004 onwards, there is evidence, from his documented contacts with GP services, of mental health concerns. Throughout the documents and combined chronology there are conflicting comments about his ability to communicate in English and this, plus cultural factors, may have influenced the way he communicated his symptoms/ complaints to others and also his contact with GP and counselling services.

In February 2005 it appears that he was referred to Mental Health services for counselling (2 February 2005 "A letter was sent to GP2 at MC2, Leeds, from Leeds Mental Health Services acknowledging the Perpetrator's referral to clinical Psychological Therapy Service") but there is no record of whether any counselling resulted from this. In December 2005, he was referred to LYPT but there is no referral letter in the GP records and it appears that this referral went to the Post-Traumatic Stress Disorder (PTSD) Service and was assessed as inappropriate for that service, as documented in a letter from a cognitive therapist, suggesting that secondary care (mental health) services would be more appropriate. Between April and June 2006 there is evidence that he received five sessions of counselling from a psychotherapist with the Health Access Team for Asylum Seekers, to whom he had been referred by a befriender from the Leeds Asylum Seekers Support Network. This psychotherapist wrote to the GP asking whether cognitive behaviour therapy or advice on stress management might help the Perpetrator. These concerns and events appear to have occurred before the Perpetrator's wife (Victim A) and sons came to England (first documented contact between Victim A and services is in December 2006). In February 2007 an advisor from the Refugee Education and Training Advisory Service wrote to express concerns about deterioration in the Perpetrator's mental health. In October 2007 a GP started him on a trial of anti-depressant drug treatment, which was reported to help "a bit", but references to mental health problems/ stress continue and he was referred for neurology assessment in early 2012.

The only contact with the Police prior to the homicide was when the Perpetrator complained that his wife, from whom he had then been separated for three years, had abused him. This led to Police issuing a harassment warning to Victim A. A DASH risk assessment (Richards 2009) was

completed at that time to assess the risk to the Perpetrator from Victim A: the risk was assessed as medium on the basis that, although this was a first report to police, it was classed as harassment and justified a higher risk rating.

Analysis of contacts with the Perpetrator suggests that his mental health issues remained a concern, with discontinuities in his care and some confusion/ uncertainty regarding what service or services might appropriately help him. It is clear that a range of individuals had concerns about his mental health. Communication was recorded as difficult on a number of occasions and this may have influenced how he communicated with healthcare staff about his mental health. Cultural factors may also have influenced his presentation: there is some literature suggesting that criteria for PTSD may need to be modified if the condition is to be applicable across a range of cultures (Hinton and Lewis-Fernandez 2011), since symptoms, such as somatic symptoms, may differ between cultures. This might make it more difficult for a health professional from a different culture to recognise symptoms as related to PTSD.

3.1.2 Victim A

Little is known about Victim A's background and personality. From the GP records it is known that she had a right mid-foot amputation as a child, and this may have affected her mobility. She was 50 years old when she died. She appears to have been married to the Perpetrator for approximately 30 years; they separated about three years earlier and it appears that they had talked about getting a divorce. The couple had sons who lived with their mother after the separation and had little contact with their father.

It appears that Victim A came to the UK with her sons in 2006 as GP records start from December 2006. In 2007, when she had a gastroscopy, her husband (the Perpetrator) is recorded as next of kin and carer for the 24 hours post-gastroscopy. Throughout her health contacts, there are repeated references to language barriers and communication difficulties. One of her sons often acted as interpreter. On three occasions there are disclosures of domestic abuse:

25 September 2007: in a GP consultation, Victim A reported marital problems and ***"she said that her husband had been abusive in the past and currently is being emotionally abusive".***

28 September 2007: Three days later she was seen by a different GP for a "stress-related problem" (this may be a reference to the abuse?) with a son acting as interpreter and ***"the son talked about emotional abuse by his father"***.

11 October 2011: when seen for a painful elbow with her son acting as interpreter it is recorded that "***a history of domestic violence"*** was reported.

There is no evidence that the abuse/ domestic violence was followed up or investigated further, (apart from the fact that the consultation on 28 September 2007 may have been a follow-up consultation to the one on 25 September 2007); the action that appeared to result was to give Victim A a prescription for anti-depressant drugs. There is no evidence that further enquiry or follow up took place.

On 13 November 2007, soon after two of these disclosures, Victim A was seen by a third GP with rib pain and it is recorded that she ***"fell three days previously, hit ribs on chair":*** it was also noted that she was "***difficult to examine because jumpy"***. There is no evidence that this GP was aware of the disclosures, questioned the story of a "fall" and/ or sought more information, or considered that this might have been a result of domestic violence. In retrospect, there must be strong suspicion that this injury was the result of domestic violence and that its significance (and the opportunity to intervene) was missed.

The only contact between Victim A and the Police occurred when the Perpetrator complained that Victim A had abused him. This led to Police issuing a harassment warning to Victim A, using her then ▇ year old son as interpreter. This is contrary to West Yorkshire Police policy. In contrast, interviews with the Perpetrator (at that time the victim of alleged harassment) were conducted using an interpreter. Had an interpreter been used to communicate with Victim A, this might have been an opportunity to hear her account of events. A DASH risk assessment was completed at that time to assess the risk to the Perpetrator from Victim A (see 3.1.1) (Richards 2009).

3.2 Key issues

Key issues identified in the IMRs are:

3.2.1 IMR1: CCG/ Primary Care Services

Victim A is documented as having disclosed abuse to GP11 on 25/9/2007; to GP6 on 28/9/2007 and Family Member 1 referred to domestic violence on 11/10/2011 to GP20. These disclosures raise questions about the response to domestic abuse/ violence in GP practices; and how such disclosures are responded to, communicated and followed up. Documentation and recording of disclosures of (and incidents of) domestic violence are recognised to be important (Royal College of Nursing 2000; Heath n/d). At the time of these events GPs had no access to current information on domestic violence on the Leeds Health Pathway. Since the events described here, GPs have gained access to domestic violence information (Map of Medicines and Leeds Health Pathway) on the two systems that they access.

IMR1 documents that there is a note in the GP records dated 9/12/2005 suggesting that the Perpetrator had been referred to a psychologist or counsellor but no referral letter. It is also noted that the referral was changed from a referral for counselling to a referral for post-traumatic stress disorder (PTSD) services. In the chronology (CC) there is reference to a letter 6 Feb

2006 from a cognitive therapist to GP3 advising GP3 that a PTSD service referral was not appropriate and to refer to the sector psychiatry service. On the GP chronology there is no record of a letter being received by the GP in February 2006 from a CBT therapist advising that PTSD service was not appropriate, and there is no evidence that any action was taken by the GP.

On page 9 of IMR1 there is reference to a letter in June 2006 about the Perpetrator from a psychotherapist at the Health Access Team for Asylum Seekers in Leeds which asks the GP to consider a structured approach to his stress-related problems such as Cognitive Behaviour Therapy or stress management advice. There is no evidence that this was followed up by the GP.

3.2.2 IMR2: Leeds & York Partnership NHS Foundation Trust

The Perpetrator was referred to Psychotherapy Services for assessment in respect of PTSD in a letter received on 30/1/2006. This is presumably the letter referred to in the note on 9/12/2005 documented in IMR1. The letter did not document any symptoms of PTSD (but it is important to acknowledge the possible role of culture influencing the presentation of PTSD) so a psychotherapist wrote to the GP and recommended that referral to a Community Mental Health Team (CMHT) would be appropriate. There is no record of this letter being received by the GP or of any action being taken to refer to the CMHT.

3.2.3 IMR3: West Yorkshire Police

Following a report of harassment by Victim A on behalf of the Perpetrator, PC1 attended Victim A's address and issued a harassment warning notice. Family member 1 was used to translate the conversation – this is noted to be contrary to Force policy and best practice which requires the use of an interpreter. There was no suggestion that Victim A wished to report any abuse from the Perpetrator, and Family Member 1 was aware of previous abuse and had communicated it to GPs in the past. However this was a deviation from best practice.

3.2.4 IMR4: Leeds Teaching Hospitals NHS Trust

There is reference to Victim A appearing uneasy with her son translating at a Gynaecology appointment. It would be poor practice not to use an interpreter.

In 17 contacts with LTHT services only five staff could be identified by name, other entries were unsigned or signed but could not be identified. The GMC in Good Medical Practice states that "Documents you make (including clinical records) to formally record your work must be clear, accurate and legible" (General Medical Council 2013).

3.2.5 IMR5: Association for Blind Asians Leeds

At the time of the events described in this report, ABAL did not have a Domestic Violence policy document. Nevertheless the actions of their staff member in relation to the Perpetrator were entirely appropriate. IMR5 recommends that ABAL works towards attaining the Leeds DV Quality Mark, which will involve designing and rolling out a Domestic Violence Policy, together with a programme of training on domestic violence.

3.3 Additional and related issues

3.3.1 Communication and continuity of care in general practice

Victim A consulted a number of different GPs, and she and/ or a family member disclosed abuse to three different GPs. It is recognised that continuity of care in general practice is an important issue (Hill and Freeman 2011). Where someone is consulting with a number of different GPs there is a need to have a system of flagging up domestic violence/ abuse in order that it can be properly considered and appropriate assessments carried out in subsequent consultations. Computer systems should make this possible.

3.3.2 Access to psychotherapy services

The Perpetrator was referred by his GP for assessment by Psychotherapy Services for treatment of post-traumatic stress disorder (PTSD) in 2005. The referral was not accepted because the symptoms described in the referral letter were deemed not to be consistent with PTSD. The GP was advised instead to approach the sector psychiatry service, but this appears not to have been done. There is no record of the letter advising this course of action having been received by the GP practice. Since the time of this referral LYPFT has changed their system and now operates a single point of access, which means that a referral deemed inappropriate for Psychotherapy Services would be re-directed to sector services rather than being returned to the GP.

3.3.3 Ethnic/ cultural issues influencing presentation to services

LYPFT has noted that the Perpetrator’s mental health issues appeared to be related to ethnic/ political conflicts in his country of origin and that ethnic/ cultural issues may have influenced how he communicated his needs to GPs. The difficulties in communication, which are repeatedly noted in many contacts with the Perpetrator, may have led to difficulty in identifying and correctly classifying his symptoms. In addition, cultural factors may have influenced his presenting symptoms: some literature suggests that criteria for PTSD may need to be modified if the condition is to be applicable across a range of cultures (Hinton and Lewis-Fernandez 2011), since symptoms, such as somatic symptoms, may differ between cultures. This might make it more difficult for a health professional from a different culture to recognise symptoms as related to PTSD.

3.4 Specific questions asked of IMR authors:

Note: Appendix 2 sets out the Terms of Reference given to IMR authors.

3.4.1 The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform BME communities about services available to victims of domestic violence? Were there any missed opportunities in your agency's contact with this couple?

IMR1 found that Victim A and family member 1 knew that it was appropriate to report abuse to GPs. On 25 Sept and 28 Sept 2007 Victim A referred to marital problems/ emotional abuse in consultations with GPs (11 and 6). Victim A then presented in Nov 2007 to GP4 with rib pain attributed to hitting a chair in a fall. Victim A had mobility problems, which could have accounted for the rib injury although no other "falls" are documented: there is a strong possibility that the injury was related to domestic violence and it could have triggered a discussion about marital problems/ abuse. This was a missed opportunity but all the GPs involved missed opportunities to follow up concerns raised in 2007 in consultations which took place between then and 2012. These could have been opportunities to assess Victim A's vulnerability, the nature and extent of possible abuse, the potential risk to her, and the appropriateness of a safeguarding referral.

IMR4 found that there had been no indicators of domestic violence in contacts with LTHT but that information about domestic violence services was available in Accident and Emergency Departments, although not within Gynaecology or the Colposcopy Unit.

3.4.2 When, and in what ways were the victim's wishes ascertained and taken account of in your agency's contact with this couple? Was this information accurately recorded?

And 3.4.3

3.4.3 What assessment was undertaken by your agency in relation to this couple? Were there any missed opportunities to undertake an assessment? Do assessments and decisions appear to have been reached in an informed and professional way?

IMR1 details contacts of both Victim A and the Perpetrator with GP services. Victim A reported marital problems, and that her husband had been abusive, to GP11 on 25/9/2007 without an accompanying family member, and on 28/9/2007 was seen by GP6 and there is reference to emotional abuse. There is no record that these disclosures were flagged up or followed up. The practice manager advised the IMR author there is no mechanism for flagging up domestic violence on the system, and the adult safeguarding lead advised that this is a national problem.

3.4.4 What were the key relevant decisions made in relation to this couple? Are all case decisions based on available evidence and accurately recorded, meeting required agency standards?

In 17 contacts with LTHT services only five staff could be identified by name, other entries were unsigned or signed but the signatures could not be identified.

3.4.5 Were practitioners in your agency knowledgeable about potential indicators of domestic abuse, safeguarding responses, and how to carry out a risk assessment in terms of identifying if domestic abuse might potentially occur?

Training in adult safeguarding has improved since the time of the events reviewed here. IMR4 recommended that LTHT consider a training needs analysis on domestic violence issues; this recommendation is equally applicable to GP services. IMR5 recommends that staff of LABA receive Domestic Violence awareness training.

3.4.6 Was there any evidence that family, friends of either the victim or the perpetrator, or any other persons were aware of any abusive behaviour prior to the homicide?

IMR 1 found that Family member 1 knew that some form of abuse was taking place but concluded that there was no evidence as to how much he knew.

3.4.7 Were there any warning signs that were missed that might have led to early identification of domestic abuse?

See answer to Question 3 above (3.4.3): the disclosures of domestic abuse were not flagged up on the GP systems and there appears to be no mechanism for doing this. It is not possible to determine from the notes whether the disclosures were followed up or not. When Victim A presented with rib pain in November 2007, there is no evidence in the GP records to show that GP4 was aware of a previous disclosure of domestic abuse and that domestic violence was considered in relation to this injury. There is no evidence in the GP record that the victim was asked about the possibility of the injury resulting from domestic violence/ abuse.

3.4.8 Were there any opportunities for triggered or routine enquiry or assessment that might have led to early identification of domestic abuse?

And 3.4.9

3.4.9 Were there opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed?

There were regular contacts with GPs: these could have given the opportunity for triggered or routine enquiry or assessment that might have led to early identification of domestic abuse. These may have led to opportunities for agency intervention but this is speculation.

3.4.10 Is there evidence that barriers were experienced by the victim or her family/ friends/ in reporting any abuse, including whether the victim knew how to report domestic abuse should she have wanted to?

Language was a potential barrier and influence in a number of consultations with health staff and in the contact with West Yorkshire Police over harassment alleged by the Perpetrator (see below).

There is evidence that Victim A and Family member 1 were aware that domestic abuse was appropriate to report to GP services.

3.4.11 Were equality, diversity and disability issues that appear pertinent to the victim or perpetrator appropriately addressed by practitioners? Were practitioners aware of and sensitive to the needs of the victim in all aspects of their work? Did this include acknowledging and responding to any difficulties in communication?

Both Victim A and the Perpetrator came from a community which might be regarded as hard to engage with services. Language barriers, difficulties in communication and failure to use appropriate interpreters were a recurrent issue in the contacts with Victim A and with the Perpetrator. Victim A appears to have been isolated and, had an appropriate interpreting service been used, this might have mitigated the isolation and helped her gain access to information about potential sources of help.

IMR1 found that the telephone interpretation service used by GPs is “not always fit for purpose” and that this had been responsible for unsatisfactory quality in some consultations, and in other consultations staff used family members as interpreters. GMC guidance in the document Good Medical Practice (General Medical Council 2013, p. 13), states that doctors “should make sure that arrangements are made, wherever possible, to meet patients’ language and communication needs”. Use of professional interpreting services has been shown to produce better outcomes than use of ad hoc interpreters (including family members) (Karliner, Jacobs et al. 2007).

IMR3 noted that use of a family member to translate when Victim A was issued a harassment warning notice was a departure from policy and best practice.

IMR4 also notes use of a family member to translate at a sensitive out-patient consultation and that Victim A appeared uneasy with this.

Women from black and minority ethnic groups may face additional barriers in seeking help, in that specialist third sector services, which have undoubted strengths in their links with particular communities, may be more likely than large statutory organisations to lack awareness of domestic violence risk indicators.

There may also be generational and gender-related issues operating here. Younger workers may find it more difficult to enquire into sensitive topics with their elders irrespective of ethnicity. Male and female professionals may have differing expectations of male and female clients, perhaps particularly in the cases of those from some ethnic backgrounds.

3.5 General questions asked of IMR authors:

3.5.1 Did the people delivering this service have sufficient knowledge, skills or training to undertake the task?

IMR5 identified that ABAL staff had not received Domestic Violence awareness training since this had not been identified as a need by the agency.

Since the time of these events Safeguarding level 1 training has become compulsory for all LYPFT staff (IMR2).

3.5.2 Was record keeping in all aspects of this case accurate and accessible, meeting required professional standards?

As noted above (3.4.4), in 17 contacts with LTHT services only five staff could be identified by name, other entries were unsigned or signed but the individual concerned could not be identified from the signature. The GMC in Good Medical Practice states that “documents you make (including clinical records) to formally record your work must be clear, accurate and legible” (General Medical Council 2013), so record keeping in this respect did not meet professional standards.

A follow up question sent to the author of IMR1 enquired whether GP4, who saw Victim A on 13 Nov 2007 with rib pain after an alleged fall, was aware of the previous disclosure of abuse in September 2007, and whether there was evidence that domestic violence was considered in relation to the injury (Appendix 3). The IMR author had found no evidence in the GP records that GP4 was aware of the previous disclosure and no evidence to indicate that the disclosure was followed up. This does not mean that domestic violence was not considered in relation to the injury, but good practice in clinical record keeping involves careful documentation that disclosures have been followed up and appropriately considered and in this respect record keeping fell short of professional standards.

3.5.3 Were Senior Managers or other organisations and professionals involved at points in the case where they should have been? Was there sufficient management accountability for decision making?

No issues identified in this area.

3.5.4 Was the quality and availability of staff supervision appropriate and did this address the relevant issues for staff and the issues outlined in the case summary?

No issues identified in this area.

3.5.5 Did the agency have policies and procedures in place for dealing with concerns and disclosures of domestic abuse? Were these policies and procedures agreed by practitioners to be effective and worth using?

At the time of these events ABAL was the only agency involved in this DHR which did not have clear policies and procedures in place for dealing with concerns and disclosures of domestic abuse. ABAL did not have a DV policy document detailing actions to be followed in the eventuality an incident involving a client is reported or witnessed and, in part due to the rarity of such involvement, doubted whether one was necessary. However, in light of the Review they decided to work to attain the Leeds Domestic Violence Quality Mark which includes designing and implementing a DV policy. Attaining this Quality Mark will also require all ABAL staff to receive DV training appropriate to their role.

3.5.6 Was the work in the case consistent with the policies and procedures for safeguarding and promoting the welfare of adults in Leeds, and with wider professional standards?

At the time of these events GPs did not have access to a domestic violence page through the Leeds Health Pathways but this is now available to them. Safer Leeds is currently engaging with all commissioners to get domestic violence addressed in contracts across the city. Whether this applied in the past to specialist third sector organisations was dependent on commissioners and the detailed contract with the organisation concerned.

3.5.7 Did the agency have a process for risk assessment and risk management for domestic violence victims or perpetrators, and did these assessments inform subsequent action?

GPs would normally carry out their own risk assessment and then signpost to other services.

3.5.8 Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of these assessments?

There were three disclosures of abuse/ violence made to three different GPs but there is no evidence that relevant enquiries resulted from these (see 3.1.2 for more details). There was one suspicious injury but there is no evidence that this was considered as a possible consequence of domestic violence.

3.5.9 Were there any issues in internal and external communication, information sharing or service delivery (including links to those with responsibilities for work during normal office hours and others providing out of hours services?)

Information sharing between GPs is a possible relevant issue. It is outlined in 3.1.2 above and leads to recommendation 5.6.1.

3.5.10 Were there organisational difficulties within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issue such as vacant posts or staff on sick leave have an impact on the case?

No issues were identified in this area.

4. CONCLUSIONS AND LESSONS LEARNED

There are a number of lessons that can be learned from this Homicide Review, and lessons learned from this Review have the potential to improve the system and contribute to lessening the chances of future domestic homicides.

4.1 Lessons learned

4.1.1 Communication and continuity of care in general practice

Victim A consulted a number of different GPs, and she and/ or a family member disclosed abuse to three different GPs. It is recognised that continuity of care in general practice is an important issue (Hill and Freeman 2011) and, when individuals are seeing a number of different GPs, communication systems become very important in ensuring that GPs who may not have met someone before have access to important information about that individual.

In relation to domestic violence, when someone is consulting with a number of different GPs, a system of flagging up disclosures of domestic violence/ abuse might assist in ensuring that it can be properly considered and appropriate assessments carried out in subsequent consultations. Computer systems should make this possible but it appears that this is a national issue.

Good practice in clinical record keeping involves careful documentation that disclosures have been followed up and this was not the case in respect of disclosures made to GPs in 2007 and 2011. GP records contained a note about the disclosures but no information about whether or how they were followed up.

4.1.2 Access to psychotherapy/ mental health services

The Perpetrator presented mental health concerns repeatedly over a long period. Analysis suggests that his mental health issues remained a concern with discontinuities in his care and some confusion/ uncertainty regarding what service or services might appropriately have helped him. Communication was recorded as difficult on a number of occasions and may have influenced how he communicated with healthcare staff and others about his mental health. Cultural factors may also have influenced his presentation. He was referred by a GP for assessment by Psychotherapy Services for treatment of post-traumatic stress disorder (PTSD) in 2005. The referral was not accepted because the symptoms described in the referral letter were deemed not to be consistent with PTSD: however there is literature suggesting that criteria for PTSD may need to be modified if the condition is to be applicable across a range of cultures (Hinton and Lewis-Fernandez 2011). The GP was advised at that time to approach the sector psychiatry service, but this appears not to have been done. There is no record of the letter advising this course of action having been received by the GP practice. It appears that a diagnosis of PTSD was put forward as a potential mitigating factor in the Perpetrator’s trial.

Since the time of the Perpetrator's referral to LYPFT the Trust has changed their system and now operates a single point of access, which means that a referral deemed inappropriate for Psychotherapy Services would be re-directed to sector services rather than being returned to the GP. This should avoid at least some discontinuities in care.

4.1.3 Ethnic/ cultural issues influencing presentation to services

LYPFT has noted that the Perpetrator's mental health issues appeared to be related to ethnic/ political conflicts in his country of origin and that ethnic/ cultural issues (in how he presented his symptoms – see 4.1.2) may have influenced how he communicated his needs to GPs. The difficulties in communication, which are repeatedly noted in many contacts with the Perpetrator, may have compounded the difficulty of identifying and correctly classifying his symptoms.

4.1.4 Language barriers and interpretation services

Both the Perpetrator and Victim A were repeatedly noted to have difficulties with communication and it appears that GPs found the telephone interpretation service to be unfit for purpose on at least some occasions. Victim A was often interviewed with one of her sons as interpreter. It is important to ensure that interpretation services are easily available and fit for purpose.

4.1.5 Communities regarded as hard to reach and domestic violence

Some communities might be regarded as hard to reach or hard to engage and might be served more by third sector specialist groups. These organisations are often small (which is their strength) and likely to have less experience of domestic violence and safeguarding, less awareness of domestic violence risk indicators and less knowledge of how to assess risk – effectively this will present an additional barrier for people (mainly women) experiencing domestic violence in those communities. The individual response of the worker from the third sector organisation involved with the Perpetrator was competent and appropriate, but the organisation did not have policies to guide workers in this area. One way of supporting third sector organisations might be for them to work towards attaining the Leeds Domestic Violence Quality Mark.

The recent NICE Public Health Guidance on Domestic Violence recommends actions to help people who find it difficult to access services and this group includes people from black and minority groups and people with disabilities (National Institute for Health and Care Excellence 2014).

4.1.6 Marginalisation and isolation

Some individuals are marginalised and isolated, often for a number of reasons, which may be complex and inter-related. These factors may include

culture; gender; disability; language; physical and mental health. These influences may compound the individual’s difficulty in accessing support and services. Equally services may not be sensitive to these issues, missing opportunities to appropriately market their services to marginalised communities in order to provide equal access to all.

4.2 Final conclusions

4.2.1 In the circumstances, it is unlikely that agency intervention potentially could have prevented the victim‘s death, given the information that has come to light through the review.

4.2.2 The information available to the Review Panel suggests that there were three recorded disclosures of domestic abuse (two in 2007 and one in 2011) and one recorded incidence of probable domestic violence between Victim A and the Perpetrator.

5. RECOMMENDATIONS

A number of recommendations arising from this Review have the potential to improve the system and contribute to both improving services and lessening the chances of future domestic homicides.

5.1 IMR1 Recommendations: GP services

5.1.1 Commissioners should consider appointing an identified GP adult safeguarding Lead for NHS England/ the three Leeds CCGs to provide leadership, advice and support for GPs (IMR1 page 22).

5.1.2 Commissioners should ensure that all GP surgeries in Leeds have an up to date electronic directory on voluntary and statutory agencies that can provide help and support for anyone who is suffering from domestic abuse (IMR1 page 23).

5.2 IMR2 Recommendations: LYPFT

Two changes to the system have occurred which would impact on the response to a similar case: there is now a single point of access for referrals, which involves CMHTs and Psychology and Therapies. A referral addressed to Therapies, which would more appropriately be directed to the CMHT, would be automatically redirected. Safeguarding Adults level 1 training is now compulsory for all staff and includes a strand of domestic violence training.

5.2.1 Assurance is gained that all GP practices are fully aware of referral procedures into LYPFT.

5.2.2 Assurance is gained that the Single Point of Access (SPA) is able to provide appropriate guidance and direction when specialist services are requested.

5.3 IMR3 Recommendations: West Yorkshire Police

5.3.1 That all staff be briefed upon policy requirements in relation to the use of interpreters.

5.4 IMR4 Recommendations: LTHT

5.4.1 Review current signposting/ public facing information related to domestic violence support services. This should consider the following:
a) is the right amount of relevant information available and can it be made available in more community languages?
b) is the information available in all pertinent areas across relevant LTHT sites?

5.4.2 LTHT to conduct a training needs analysis on domestic violence issues.

5.4.3 LTHT to review current arrangements related to domestic violence in high volume female patient areas. This review should identify practicable ways forward for ensuring a standard approach to alerting, signposting and investigating concerns and disclosure.

5.4.4 LTHT to establish a mechanism to work with outside agencies to ensure that key messages about domestic violence are made available to their staff on a regular basis and review how guidance and good practice can be improved and disseminated more visibly.

5.5 IMR5 Recommendations: ABAL

5.5.1 To attain Leeds DV Quality Mark.

5.6 Chair and Review Panel's Additional recommendations

All agencies undertaking IMRs for this Review have had sight of these recommendations and have agreed them at the appropriate level of seniority in the organisation.

5.6.1 Leeds CCGs and NHS England to explore ways of flagging up disclosures of domestic abuse/ violence on GP systems and for a mechanism to alert GPs to the fact that it has been raised in order that further enquiry might be triggered at future appointments which may be with different GPs..

5.6.2 That the GP practices directly involved in this DHR review their knowledge around domestic abuse, undertake a training needs analysis and address any gaps in knowledge using NICE guidance as a guide.

5.6.3 That the GP practices directly involved in this DHR review current signposting/ public facing information related to domestic violence support services and determine whether the right amount of relevant information is

available and whether it can be made available in more community languages or in other ways.

5.6.4 That the GP practices directly involved in this DHR review their documentation and record keeping in respect of domestic violence disclosures.

5.6.5 All agencies undertaking IMRs for this Review and working using interpretation services should ensure that translation is sufficiently accurate, independent and gender-sensitive for the purpose for which it is employed.

5.6.6 Community Safety Partnership to commission a review of what is used, and what is good practice, in interpretation with vulnerable adults and produce a set of standards for agencies to sign up to.

5.6.7 Commissioners should appoint an identified GP adult safeguarding lead for Leeds CCGs to provide leadership, advice and support for GPs.

APPENDIX 1: Acronyms used in this report

ABAL	Association of Blind Asians Leeds
A&E	Accident and Emergency Department
CC	Combined Chronology
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
DASH	Domestic Abuse, Stalking and Harassment and Honour Based Violence
DHR	Domestic Homicide Review
DV	Domestic violence
ENT	Ear, Nose and Throat Department
FLO	Family Liaison Officer
GMC	General Medical Council
GP	General Practitioner
HMRC	HM Revenue and Customs
IMR	Individual Management Reviews
LCC	Leeds City Council
LTHT	Leeds Teaching Hospitals Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MC	Medical Centre
NHS	National Health Service
PC	Police Officer
PTSD	Post Traumatic Stress Disorder
SMART	Specific Measurable Achievable Relevant Time-specific
TV	Television
UK	United Kingdom

APPENDIX 2: IMR Terms of reference (given to IMR Authors)

The following Individual Management Review (IMR) Terms of Reference (ToR) were given to IMR authors:

IMRs should include a clear narrative and description of the agency's involvement. This should usually be provided in chronological order. However, information may come available during your research that you feel should be included despite it falling outside of the Terms of Reference. Please consult your agency lead and/or (two named persons at Safer Leeds) before you include such information. If it is historic information it should be placed at the beginning of the narrative with a short explanation as to why it has been included.

As the report will be read by people from different disciplines, who are not familiar with the case, the reader should be able to gain a clear understanding of the chronological narrative of your agency's involvement with the family. Do not make assumptions about the professional knowledge base of the reader.

- Keep facts, narrative and analysis separate
- Show what evidence you have collected to back up your analysis
- Do not speculate, which is different from providing a hypothesis
- Break down analysis chronologically, and if appropriate into themes.

As an IMR author you will need to demonstrate you are fully independent of the staff and/or services involved in the case; with the seniority and experience to be able to critically analyse the systems, policies and procedures of your agency in relation to this DHR.

The statement of Independence should contain the following information:
• Qualifications
• Experience
• Role in the agency
• Independence of the case

It should provide information about you as the author (name, job title) and *must* provide a clear statement that illustrates your level of independence from the line-management of, and supervision of, staff involved in the case. It should clearly describe the sources of information used to prepare the IMR (for example analysis of case records, interviews with staff) and when and by whom these were secured.

1. The victim had no known contact with any specialist domestic abuse agencies or services. Could more have been done to inform BME communities about services available to victims of domestic violence? Were there any missed opportunities in your agency's contact with this couple?
2. When, and in what ways were the victim's wishes ascertained and taken account of in your agency's contact with this couple? Was this information accurately recorded?

3. What assessment was undertaken by your agency in relation to this couple? Were there any missed opportunities to undertake an assessment? Do assessments and decisions appear to have been reached in an informed and professional way?
4. What were the key relevant decisions made in relation to this couple? Are all case decisions based on available evidence and accurately recorded, meeting required agency standards?
5. Were practitioners in your agency knowledgeable about potential indicators of domestic abuse, safeguarding responses, and how to carry out a risk assessment in terms of identifying if domestic abuse might potentially occur?
6. Was there any evidence that family, friends of either the victim or the perpetrator, or any other persons were aware of any abusive behaviour prior to the homicide?
7. Were there any warning signs that were missed that might have led to early identification of domestic abuse?
8. Were there any opportunities for triggered or routine enquiry or assessment that might have led to early identification of domestic abuse?
9. Were there opportunities for agency intervention in relation to domestic abuse regarding the victim or the alleged perpetrator that were missed?
10. Is there evidence that barriers were experienced by the victim or her family/ friends/ in reporting any abuse, including whether the victim knew how to report domestic abuse should she have wanted to?
11. Were equality, diversity and disability issues that appear pertinent to the victim or perpetrator appropriately addressed by practitioners? Were practitioners aware of and sensitive to the needs of the victim in all aspects of their work? Did this include acknowledging and responding to any difficulties in communication?

Once the Overview Report Writer[4] and Panel have accepted the IMR, it is the responsibility of the IMR writer[5] to feed back to those who were involved in the case within their agency on the lessons learned from their agency perspective. However this needs to include the understanding that the Overview Report Writer[6] may have a different perspective or make further or different recommendations for change.

Make sure these more general points are covered in your responses to the specific questions:

- Did the people delivering this service have sufficient knowledge, skills or training to undertake the task?
- Was record keeping in all aspects of this case accurate and accessible, meeting required professional standards?

[4] Writer is the term used in the ToR referring to the Overview Report Writer.
[5] As above.
[6] As above.

- Were Senior Managers or other organisations and professionals involved at points in the case where they should have been? Was there sufficient management accountability for decision making?
- Was the quality and availability of staff supervision appropriate and did this address the relevant issues for staff and the issues outlined in the case summary?
- Did the agency have policies and procedures in place for dealing with concerns and disclosures of domestic abuse? Were these policies and procedures agreed by practitioners to be effective and worth using?
- Was the work in the case consistent with the policies and procedures for safeguarding and promoting the welfare of adults in Leeds, and with wider professional standards?
- Did the agency have a process for risk assessment and risk management for domestic violence victims or perpetrators, and did these assessments inform subsequent action?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of these assessments?
- Were there any issues in internal and external communication, information sharing or service delivery (including links to those with responsibilities for work during normal office hours and others providing out of hours services?)
- Were there organisational difficulties within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issue such as vacant posts or staff on sick leave have an impact on the case?

APPENDIX 3: Questions put to the author of IMR1 by the Independent Chair/ Author and shared with the Panel

Question 1

On page 15 of the IMR is a description of the adult at risk attending the surgery and explaining that her husband had been abusive in the past and was being emotionally abusive (at that time). This was followed up by GP6 on 28 Sept 2007 (page 16).

How is domestic violence/ abuse flagged up on the GP system? Is/ was there a mechanism to alert GPs to the fact that it has been raised in order that further enquiry might be triggered at future appointments which may be with different GPs?

Answer

The practice manager has advised me there is no mechanism for flagging up domestic violence on the system. The adult safeguarding lead has advised me that this is a national problem

Question 2

On 13 Nov the adult at risk was seen by GP4 with rib pain after an alleged fall (page 16). Is there evidence that GP4 was aware of the disclosure in September and is there evidence that domestic violence was considered in relation to this injury? Was the adult at risk asked about the possibility of the injury resulting from domestic violence/ abuse?

Answer

There was no evidence in the GP records to show that GP4 was aware of a disclosure at this point.

Question 3

In 2011 family member 1 said there was a history of domestic violence at an appointment with GP20. Is there any evidence that this was followed up in any way? Could this have been flagged up on the system and used to trigger further enquiry?

Answer

There was note made in the GP record but there is no mechanism for flagging this concern up on the system

Question 4

In relation to the person alleged to have caused harm:

On page 9 of the IMR there is reference to a referral for post-traumatic stress disorder services. In the chronology there is reference to a letter 6 Feb 2006 from a cognitive therapist to GP3 advising GP3 that PTSD service was not appropriate and to refer to the sector psychiatry service - this appears to relate to the referral mentioned on page 9, but in the IMR I can't trace what happened as a result of the suggestion of a referral to the sector psychiatry service. Was the letter on 6 Feb 2006 received by the GP and what action was taken as a result?

Answer
Susan, you are probably referring to the integrated chronology that includes contacts from all agencies. On my GP chronology – there is no record of a letter being received by the GP in February 2006 from a CBT therapist advising that PTSD service wasn't appropriate. There is no evidence that any action was taken by GP3.

APPENDIX 4: Collated Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Target date
IMR1				
1. The commissioners should consider appointing an identified GP adult safeguarding lead for Leeds CCGS to provide leadership, advice and support for GPs.	Local: CCG/ Primary Care Services	To explore the need for a Safeguarding Adult GP lead position	The Director of Nursing and Quality at Leeds S&E and North CCG and Assistant Director of Nursing (Patient Experience) West Yorkshire Area Team NHS England	March 2014
2. Commissioners should ensure that GP surgeries in Leeds take heed of NICE Guidance on Domestic Violence	Local: CCG/ Primary Care Services	To review the electronic directory and update info available	Safer Leeds DV Team Health and Domestic Violence	March 2014

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Target date
(PH50) and have an up-to-date electronic directory on all voluntary and statutory agencies that can provide help and support for anyone who is suffering from domestic abuse.			Coordinator	
IMR2				
1.Assurance is gained that all GP practices are fully aware of current referral procedures into LYPFT	Local: Leeds and York Partnership NHS Foundation Trust	Review information provided to GP practices and health centres in Leeds	Janet Johnson	August 2014
2.Assurance is gained	Local: Leeds	Review current	Safeguarding	July 2014

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Target date
that the Single Point of Access (SPA) is able to provide appropriate guidance and direction when specialist services are requested.	and York Partnership NHS Foundation Trust	procedures and report to Trust Incident Review Group (TIRG)	Adults Lead	TIRG
IMR3				
1. That all staff be briefed upon policy requirements re the use of interpreters	Local: West Yorkshire Police	Force wide briefing	West Yorkshire Police	18/7/13
IMR4				
1. Review current signposting/ public facing information related to domestic violence support services. This should consider the following: a) is the right amount of relevant information available and can it be made available in more community languages?	Local: Leeds Teaching Hospitals NHS Trust	Safeguarding Team to work with relevant Trust Departments and agencies to improve the scope and access of relevant materials	Jeffrey Barlow	July 2014 August 2014

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Target date
b) is the information available in all pertinent areas across relevant LTHT sites?				October 2014
2. LTHT to conduct training needs analysis on domestic violence issues.	Local: Leeds Teaching Hospitals NHS Trust	Safeguarding Team to develop TNA and get approval for roll out of training	Caroline Abblett	September 2014 November 2014

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency		Target date	
3. LTHT to review current arrangements related to domestic violence in high volume female patient areas. This review should identify practicable ways forward for ensuring a standard approach to alerting, signposting and investigating concerns and disclosure.	Local: Leeds Teaching Hospitals NHS Trust	Networks/agencies on DV contacted and strategy agreed. Relationships developed with key groups to mutual benefit	Jeffrey Barlow		July 2014 September 2014 November 2014	
4. LTHT to establish a mechanism to work with outside agencies to ensure that key messages about	Local: Leeds Teaching Hospitals NHS Trust				September 2014	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Target date
domestic violence are made available to their staff on a regular basis and review how guidance and good practice can be improved and disseminated more visibly.				December 2014
IMR5				
1. Attain Leeds DV Quality Mark	Local	Work with Safer Leeds DV Team to achieve standards which merit Quality Mark. This will include designing and implementing a DV policy and a staff training programme.	Manager ABAL	30.06.14
Chair and Review Panel's Additional recommendations				
1. Leeds CCGs and NHS England to explore	Local	For NHS England to review possible	Leeds CCGs/ NHS England	To be agreed

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency		Target date	
ways of flagging up disclosure of domestic abuse/ violence on GP systems and for a mechanism to alert GPs to the fact that it has been raised in order that further enquiry might be triggered at future appointments which may be with different GPs.		flagging of disclosure of domestic abuse/ violence on GP systems.				
2. That the GP practices directly involved in this DHR review their knowledge around domestic abuse, undertake a training needs analysis and address any gaps in knowledge using NICE guidance as a guide.	Local: CCGs	Leeds CCGs to require GP Practices to conduct a training needs analysis on domestic violence issues.	Leeds CCGs		December 2014	
3. That the GP	Local: CCGs	Leeds CCGs to	Leeds CCGs		December	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency		Target date	
practices directly involved in this DHR review current signposting/ public facing information related to domestic violence support services. This should determine whether the right amount of relevant information is available and whether it can be made available in more community languages or in other ways.		require GP Practices to review public facing information related to domestic violence support services.			2014	
4. That the GP practices directly involved in this DHR review their documentation and record keeping in respect of domestic violence disclosures.	Local: CCGs	Leeds CCGs to require GP Practices to audit documentation and record keeping in respect of domestic violence disclosures.	Leeds CCGs		December 2014	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency		Target date	
5. All agencies under-taking IMRs for this Review and working using interpretation services should ensure that translation is sufficiently accurate, independent and gender-sensitive for the purpose for which it is employed.	Local: all agencies	All agencies to sign up to standards of good practice in interpretation.	Community Safety Partnership		March 2015	
6. Community Safety Partnership to commission a review of what is used and what is good practice in interpretation with vulnerable adults and produce a set of standards for agencies to sign up to.	Local: all agencies	Commission: Review of current practice and good practice. Produce set of standards for agencies to sign up to.	Community Safety Partnership		December 2014 March 2015	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency		Target date	
7. Commissioners should appoint an identified GP adult safeguarding lead for Leeds CCGs to provide leadership, advice and support for GPs.	Local: CCG/ Primary care services	To appoint a Safeguarding Adult GP lead position	The Director of Nursing and Quality at Leeds S&E and North CCG and Assistant Director of Nursing (Patient Experience) West Yorkshire Area Team NHS England			

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