Leeds Safer Communities Partnership
DHR ‘D’

Overview Report Executive Summary

Chair & Independent Author

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1. Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Janet [1]on [redacted] 2013.

The DHR was commissioned by the Community Safety Partnership of Leeds City Council. On [redacted] 2013 Janet was found deceased at her home address by their daughter in law. Her husband Christopher was initially arrested in connection with Janet's murder. He suffers from dementia and subsequently faced no criminal charges and is now resident in a secure mental health hospital.

2. The DHR process

A panel of agency representatives was formed and an independent chair and author was appointed. Individual Management Reports (IMRs) were requested from the agencies that had been in contact with or providing services to both Janet and Christopher.

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Janet and Christopher.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

The DHR Panel received and considered IMRs from the following agencies:

- NHS England – primary care
- Leeds & York Partnership NHS Foundation Trust
- Leeds City Council – Adult Social Care

[1] All names within this report have been anonymised.

3. Terms of Reference

The Review Panel (and by extension, IMR authors) will consider the following:

1. Each agency's involvement with Janet and Christopher between 1st January 2013 and [redacted] 2013.

   In addition, each agency should include any significant events prior to 1st January 2013 and a summary of any contacts prior to 1st January 2013 that gave rise to concern.
   The review will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons.

   Whether, in relation to Janet and Christopher, an improvement in any of the following might have led to a different outcome for Janet

2. a. Communication between services
   b. Information sharing between services with regard to domestic violence
   c. Accessibility, availability and responsiveness of services

3. Whether the work undertaken by services in this case was consistent with each organisation's:
   a. Professional standards
   b. Domestic violence policy, procedures and protocols,
   c. Safeguarding adults policy, procedures and protocols
   d. Policy on assessment and provision of care and support

4. The response of the relevant agencies to any referrals relating to Janet and Christopher concerning domestic abuse, care, treatment and support (including emotional abuse and controlling behaviour) or other significant harm from 1st January 2013. In particular, the following areas will be explored:

   a. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards
   b. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective
   c. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
   d. The quality of the risk assessments undertaken by each agency in respect of both Christopher and Janet's mental capacity for these decisions, including Janet's capacity to refuse support.

e. Whether services and agencies ensured the welfare of any vulnerable adults/adults at risk.

f. Whether services took account of the wishes and views of members of the family in decision making and how this was done.
g. Whether thresholds for intervention were appropriately set and correctly applied in this case.

5. Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic and religious identity of the respective family members and whether any additional needs on the part of either Christopher or Janet or their carers were explored, shared appropriately and recorded.

6. Whether there were any issues identified requiring escalation and, if so, whether they were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

7. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4. Events leading to the incident

Janet and Christopher was a married couple who lived in their own home. They had been married for 60 years. Both Janet and Christopher were in poor health; Christopher had a diagnosis of Alzheimer's disease. This not only affected his memory but he also experienced a loss of other function including failing speech. Christopher was diagnosed with [redacted] cancer in 2003.

Janet and Christopher had one daughter and one son. Both adult children have remained actively involved with their parents. Until the incident both Janet an Christopher were living at home independently with support from family members, including their daughter in law Julie, who undertook some caring responsibilities for Janet and Christopher including providing some respite for Janet by having Christopher to her home on Sundays.

At 10.10hrs on Sunday the [redacted] 2013 Julie had gone to Janet and Christopher's home to collect Christopher and take him back to her home to give Janet some respite from him. When she arrived at the premises she found Christopher downstairs but unusually Janet was not there to welcome her. She asked Christopher where Janet was and he indicated that she was upstairs.

Julie found Janet lying dead on the bed in an upstairs bedroom. She had several ligatures around her throat and a jumper pulled up over her face. Her hands had been bound with a pair of “Walkman” style headphones and attached wire. There was blood smeared on her clothing and body and two blood stained knives were found lying in a separate bedroom.

The ambulance service and police were called and Christopher was arrested on suspicion of her murder. During the custody booking-in process it was found that Christopher was suffering from a stab wound to his lower abdomen. He was taken to the Leeds General Infirmary and treated before transfer to police custody.

A forensic examination of the crime scene indicated that Christopher attacked and killed his wife then stabbed himself with two knives. Christopher’s mental health condition will not improve and it will be impossible to obtain an account of the incident or the events preceding it from him the police will almost certainly never be able to interview him and obtain an account from him. No criminal proceedings have been brought and the Crown Prosecution Service has affirmed the Police view that it would not be in the public interest to pursue criminal proceedings.

5. Views of the family

The independent author of the Overview Report interviewed Janet and Christopher’s son, Paul on 6th March 2015. The purpose of this discussion was to follow-up on the correspondence from the DHR panel about the process and to gather any further relevant and helpful information about Janet and Christopher that might assist the DHR.

Paul provided helpful background and insights in to his parent’s lives, their circumstances in the period leading up to the incident and his views about the interventions and actions of those agencies with which his parents had contact.

6. Conclusions

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by Janet and Christopher's son, the panel has drawn the following conclusions:

Janet and Christopher was a couple who had good support from their family and who were attempting to live as independently as possible. Janet in particular was reluctant to accept help from statutory agencies and rejected services on more than one occasion. Indeed, she asked the social worker conducting the social care needs assessment to leave the house before the full assessment could be completed.

Janet was also reluctant to engage with health professionals in relation to her long-term conditions and did not take her prescribed medication despite encouragement to do so from her GP Practice.

The services provided by the GP Practice were of an appropriate standard but there were occasions when the communication between the Practice, secondary care services, adult social care and the family could have been improved.

The input of LYPFT in relation to Christopher's mental health was of an appropriate standard. However, the needs of Janet as a carer were not assessed or given sufficient prominence in relation to care delivery by the CMHT.

The input of ASC was of an appropriate standard but that it might have been better to have assessed Janet and Christopher separately or for them to have been allocated separate social workers. The consequence of this not happening was that it did not provide an opportunity for Janet to express privately any concerns or issues she may have had in relation to Christopher, in particular in respect to her role as his carer.

The lack of a carers' assessment presents a missed opportunity for Janet to have expressed her views confidentiality and possibly for her to have been encouraged to accept some help and support.

Communication between professionals and agencies was not as effective as it might have been. There are examples of phone calls not being noted, letters not being followed up and information exchange not taking place. These issues were not consistent, but do feature in each IMR. Although communication could have been better there is no evidence that this contributed to or could have prevented the incident from occurring.

7. Predictability and preventability

The panel considered whether the death of Janet could have been predicted or prevented. Based on the information provided, and the analysis of that information, there is no evidence to indicate that any professional could have foreseen the actions that lead to Janet's death. This view is also held by the family.

There was no history of domestic violence or abuse and no indication that Janet was at any risk.

On the basis on the information reviewed, the panel believes that the incident was neither predictable nor preventable.

8. Recommendations

The IMRs contained their own recommendations and these are set out in the main Overview Report. The DHR panel made three recommendations arising from the review:

The DHR panel therefore made four overarching recommendations for action:

Recommendation One:

We recommend that health and adult social care must ensure that existing protocols for communication and information sharing in relation to patients/clients are robust, fit for purpose and that where additions or amendments are required these are made and jointly agreed.

Recommendation Two:

We recommend that the requirement to conduct Carers' Assessments be re-emphasised in both health and social care and that the outcomes of such assessments be appropriately shared between professionals and agencies.

Recommendation Three:

We recommend that the NHS and Adult Social Care ensure that staff are conversant with the need for appropriate recording of mental capacity and are able to use the provisions of the Mental Capacity Act to establish a person's capacity where appropriate.

Recommendation Four

In circumstances where a single referral is made in relation to a couple, that provision be made for that couple to receive an individual assessment of their needs wherever possible to ensure that they are given an opportunity to discuss their needs openly and confidentially.