Leeds Safer Communities Partnership
DHR D

Overview Report

Chair & Independent Author

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Section One

Introduction and background

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1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Janet 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.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13th April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be 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 person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

A DHR was recommended and commissioned by the Community Safety Partnership in September 2014 in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

Leeds City Council initially believed that the conducted of a 'lessons learned' process in response to the incident would be sufficient to consider whether any improvements or changes would be needed to services in the light of the incident.

The decision to undertake the DHR was taken following instruction from the Home Office. Following those discussions with the Home Office it was agreed that the authority would conduct a proportionate DHR.

The care and support needs of both adults meant that the Leeds Safeguarding Adults Board (LSAB) also considered whether or not to conduct a Safeguarding Adults Review. It was agreed that the Leeds Community Safety Partnership would lead a Domestic Homicide Review, but that the LSAB would receive reports about its progress and ensure that lessons are disseminated through its Learning and Improvement Sub-group.

The first review panel was held in November 2014, with subsequent meetings in February and May 2015. This report was approved by the DHR panel prior to its submission to the Home Office.

Case Review
Panel Membership

Name	**Organisation**
Steve Appleton (Chair)	Independent Chair (Contact Consulting)
Sandra McNeill	Safer Leeds Domestic Violence Team
Det. Supt. Patrick Twiggs	West Yorkshire Police
Jeffrey Barlow *(Jeffrey left his post on 31st December 2014)* Caroline Ablett *(Replaced Jeffrey Barlow)*	Leeds Teaching Hospitals NHS Trust
Luke Turnbull	Leeds CCG/NHS England
Richard Hattersley	Leeds and York Partnership NHS Foundation Trust
Christine Pearson *(Christine left her post in January 2015)* Lynne Chambers *(Replaced Christine Pearson)*	Leeds Community Healthcare NHS Trust
Emma Mortimer	Leeds Safeguarding Adults Board

The Overview Report author

The independent author of the DHR Overview Report is Steve Appleton. Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve has had no previous involvement with the subjects of the review or the case. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy. He is a Trustee of a local charity and is an Associate of the Health Services Management Centre at the University of Birmingham.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written DHRs for a number of local authority community safety partnerships.

1.4 Subjects of the review (all pseudonyms)

Janet
White British female
Date of Birth [redacted]
Date of Death [redacted]/2013
Deceased was wife of Christopher

Christopher
White British male
Date of Birth [redacted]
Husband of Janet

Susan	Daughter of Janet and Christopher
Paul	Son of Janet and Christopher
Julie	Daughter in law of Janet and Christopher

1.5 Terms of reference

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

1. Each agency's involvement with the following family members 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 the family members listed above, 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.

Adults Safeguarding Element of The Domestic Homicide Review

The review panel (and by extension, IMR authors) will also consider the following:

8. Whether there is any learning from this case in relation to Janet or Christopher which would improve safeguarding practice in relation to domestic violence and safeguarding practice in relation to an older population and its impact on adults at risk, in particular in the areas of:

(a) communication
(b) information sharing
(c) risk assessment

1.6 Individual Management Reviews (IMRs)

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.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with Janet and Christopher as well as summary reports, scoping information and an interview with their son Paul. The IMRs have been signed off by a responsible officer in each organisation and have been quality assured and approved by the DHR panel.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The DHR Panel has received and considered the following Individual Management Review Reports (IMR):

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

1.7 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Christopher and Janet and if this played any part in how services responded to their needs.

"The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation."[1]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

1.8 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Overview Report, Action Plan are accepted by the Community Safety Partnership.

1.9 Involvement with the family

The panel has sought throughout the review to ensure that the wishes of the family members have informed the DHR Terms of Reference and are reflected in the DHR report. The panel has communicated with Paul, Janet and Christopher's son by letter, email and telephone to keep him advised of progress. The independent author has interviewed Paul to gather information to inform the report.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

Section Two

Domestic Homicide Review Panel Report

Case Review

2.1 Introduction

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Janet and Christopher. The report examines agency responses to and support given to Christopher and Janet prior to the incident on [redacted] 2013.

Three agencies had records of contact with Janet and Christopher within the time period covered by the DHR. They were:

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

None of the recorded contacts from services with Janet or Christopher indicated domestic violence.

Domestic Abuse Contact

The DHR has not found any evidence of domestic violence or abuse in this review, either from the IMRs received or the wider work of the panel.

Neither Janet or Christopher were known to the services in relation to domestic abuse, neither had ever sought any assistance from the police, or any statutory or voluntary sector agency in relation to allegations or incidents of domestic abuse

2.1.1 Summary of the facts of the case

Janet and Christopher were 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. The treatment comprised of surgery and an indwelling catheter inserted for urinary management. [redacted] Personal information [redacted] He had also been diagnosed with atrial fibrillation and more recently, he was known to suffer from headaches for which he was taking paracetamol. Janet cared for her husband and had severe rheumatoid arthritis and angina. These impacted on her mobility and also the use of her hands.

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 post mortem was undertaken on Janet on Monday [redacted], the cause of death being found to have been pressure to her neck and upper airway obstruction.
Christopher was assessed by Psychiatrists whilst in Police custody and subsequently sectioned under the Mental Health Act. He was taken to secure accommodation in Leeds. He has subsequently moved to a specialist secure hospital designed to support people with the most complex needs where he now resides.

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.

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Janet and Christopher, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[3]

The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

[3] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[4]

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

2.2.1 NHS – General Practice

The Clinical Commissioning Group (CCG) is a clinically led membership organisation and a fully authorised statutory public body which has a constitution and is run by a governing body. CCGs are overseen by NHS England (including Regional Offices and Local Area Teams) who manages primary care commissioning, including holding the NHS Contracts for GP practices. CCGs are responsible for commissioning the vast majority of NHS services within the areas they serve and every GP practice within the United Kingdom is required to be a member of a CCG.

It is important to remember that GPs are not directly employed by the NHS. Rather, they are independent contractors commissioned by the Local Area Team of NHS England. The General Practitioner (GP) service is a universal service that provides primary medical care to families 24 hours a day both at the local practice where a family is registered and through the Out of Hours service. It provides holistic medical care (to include physical and psychological health care) for families from birth to death.[5]

Janet and Christopher were both registered at the GP Practice with the same allocated GP, GP1. Christopher had limited interaction with his GP. In the six months prior to the incident he only had one routine contact with the Practice which consisted of an invitation to have his blood pressure checked. Christopher did not attend his appointment. In June 2010 he was referred to the Community Mental Health Team (CMHT)[6] as a result of memory problems, this followed an earlier referral in 2007. (See LYPFT involvement).

Christopher received a diagnosis of Alzheimer's dementia in September 2010 by and follow-up was provided by LYPFT.

[4] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.
[5] Sheffield DHR Overview Report, Cantrill, Prof. Pat December 2011
[6] Community mental health teams (CMHTs) are multidisciplinary, multi-agency teams offering specialist assessment, treatment and care to adults with mental health problems, both in their own homes and in the community. NHS Choices

The GP notes record the fact that Christopher was seen on 12 June 2013 at his home, with his wife and daughter present as part of an annual dementia review. No GPs were present at this review. During this review Lead Professional 1 (Community Mental Health Nurse from LYPFT) recorded that she discussed with both Christopher and Janet and their daughter that other agencies could become involved should the couple require additional support. It is also recorded that 'it was not felt to be necessary at that time'. It is not clear whose view this was or how the opinion was formulated.

Lead Professional 1 wrote to Christopher and the GP Practice on LYPFT notepaper following this review on 19 June 2013. The letter is stated to be a summary of Christopher's care plan and demonstrates a good level of communication between the Practice and the Trust. The letter did not specify what care options were available or whether Janet was offered a carer's assessment. (See ASC involvement)

Janet had a number of known medical conditions, specifically:

- Rheumatoid arthritis
- Chronic Kidney Disease Stage 3
- Hypertension
- Ischaemic heart disease

In September 2012 Janet was admitted to hospital for treatment of postural hypotension, for which she had been talking a number of medications. Some of these medications were stopped during that admission. In October 2012 Janet did not keep outpatient appointments in relation to her renal condition.

On 31st January 2013 Janet contacted her GP complaining of chest pains, complaining of shortness of breath and pains in her left arm. She was advised to call an ambulance; in fact one was called for her. The IMR states that there is no further information in the GP records about this incident and no evidence that Janet either attended the Accident & Emergency department or that she was admitted to hospital. No information was received by the practice.

On 1st August, the social worker contacted the GP Practice and spoke to GP2. The social worker had assessed Janet and had some concern about her mood. (See ASC involvement) There was a question about whether Janet was depressed, but that she did have capacity to make decisions about her care and whether or not to accept support. This issue is raised in the ASC IMR. Janet had stated that she did not wish to receive any support.

On 2nd August GP1 made a home visit to assess Janet following the conversation between GP2 and the social worker. It is not clear whether this was due to proactive intervention from the Practice or at the request of the social worker. GP1 established that Janet was not taking her medication, that Janet felt her own memory was poorer than previously but that she did not wish to be referred to the memory clinic. GP1 stated that Janet was not depressed but there is no evidence of any formal assessment for depression.

GP1 stated during interview for the IMR that she felt Janet to be in good health despite not taking her medication and the concerns of her family. The IMR records the matter of capacity in relation to Janet. GP1 confirmed that Janet had full capacity to make decisions about her care and treatment.

On 20th August the GP Practice was made aware that Janet had not attended for an appointment at the Rheumatology Clinic and that as a result the Rheumatologist was not happy for her to continue with the medication without review. Janet was thus discharged from the clinic back to primary care. The GP Practice records show that Janet had in fact ceased her medication on 14th September 2013. GP1 had discussed this with Janet on 2nd August but again Janet had refused to take her medication.

Analysis of General Practice involvement and lessons learned

The IMR describes the legal standards required of GPs by the General Medical Council and the principles by which GPs are expected to practice. This context has been applied in the analysis and consideration of the involvement of the GPs in this case alongside the terms of reference for the DHR.

The IMR finds that the Practice was informed of Janet's failure to attend appointments at the Rheumatology Clinic in August 2013 but there is no evidence to show that the Practice took any action on the correspondence received from the Rheumatology service. The IMR states that it is recognised good practice for GPs to advise patients that they have missed an appointment.

The GP Practice did respond swiftly and appropriately by undertaking a home visit following the discussions with the social worker from ASC. However, there is no record of the findings arising from that home visit or that any further communication was made by the Practice with ASC to advise them about what had been discussed. If such communication had taken place it would have provided the social worker with helpful information that could have assisted her.

Although the communication could have been improved, there is no evidence that this would have altered the outcome or prevented the incident. There is no evidence of any breach of professional standards in relation to the GP Practice.

There was nothing to suggest domestic violence or abuse in any of the interactions between Janet and Christopher with the Practice. There is no indication that Christopher presented any risk to Janet.

In respect of the home visit on 2nd August, the IMR finds that the GP1 took a good history, it would have been better practice to conduct a fuller assessment of Janet's physical health, particularly in relation to her rheumatology condition and the fact that Janet was declining to take her medication for the range of conditions she experienced.

The home visit on 2nd August can be regarded, at least in part, as a missed opportunity for GP1 to have seen Janet and Christopher together and to establish what ongoing difficulties

they might have been experiencing.

There is no record of GP1 communicating with family members, who had been particularly engaged in supporting Janet and Christopher about the outcome of that visit. The lack of communication does not appear to have had any broader bearing but raises an issue of learning about when and how to contact and liaise with family members in relation to a patients care and treatment, including the matter of appropriate consent to do so. It would also have been appropriate to contact the social worker following that visit.

Overall, the Practice provided a good standard of care to both Janet and Christopher. The lessons learned from the IMR following the incident as set out above relate principally to systems of communication and as such the IMR makes a single recommendation in relation to follow-up of patients who miss appointments.

2.2.2 Leeds & York Partnership NHS Foundation Trust (LYPFT)

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides specialist mental health and learning disability services to people within Leeds, York, Selby, Tadcaster, Easingwold and parts of North Yorkshire.

LYPFT had no formal involvement with Janet although the IMR notes that she was present during home visits to Christopher.

Christopher first experienced memory problems in 2007 and he was referred to LYPFT for assessment. In May 2010 Christopher's General Practitioner requested a more urgent assessment of Christopher's memory problems in response to Christopher's daughter contacting the GP with concerns regarding her father's deterioration over the previous few months. The IMR notes that although Christopher was still making an effort to answer questions his speech had very quickly become badly affected and he had no memory of the recent past.

Christopher was referred to the outpatient memory service of the South (CMHT) on the same day and allocated an outpatient appointment with Locum Consultant Dr. D the 1st June 2010 at Aire Court, the team base. Christopher was seen in the company of Janet and their daughter. The concerns were specifically regarding word finding difficulties, but there were no concerns regarding risk in terms of risks to Christopher himself or to Janet from Christopher. A CT scan was taken to investigate the working diagnosis of vascular dementia.[7] The assessment was discussed by the multi-disciplinary team, no concerns relating to risk were identified, including his fitness to drive a motor vehicle.

[7] Vascular dementia is caused by reduced blood supply to the brain due to diseased blood vessels – Alzheimer's Society - accessed May 2015

A diagnosis of Alzheimer's disease[8] was however confirmed during an outpatient appointment. The family were advised to arrange a Lasting Power of Attorney and further advised that although Christopher was still driving he would have to be tested in order to comply with DVLA rules.

A further review was planned for October 2010 which took place and following this in January 2011 Nurse H, from the CMHT saw Christopher in clinic, which was his preference rather than being seen at home.

Although Christopher still had word finding difficulties, there were no major changes with his memory and he was able to undertake tasks asked of him. Christopher had not been medically reviewed post diagnosis / treatment initiation for six months when he was discussed in MDT May 2011, but this was in keeping with the model adopted by the memory service at the time.

Subsequently the GP queried whether Christopher should still be driving. Dr. J (Consultant Psychiatrist (who was the fourth medic involved since June 2010) visited Christopher at home to discuss driving issues. Christopher had been seen driving in a confused state. Christopher's daughter agreed to contact the DVLA on her father's behalf and Dr. J was to complete report for DVLA. Dr. J also advised Christopher to attend William Merritt Centre in Leeds for a driving assessment if he wished. When Nurse H met with Christopher and his daughter again in memory clinic in November 2011 he had stopped driving and adapted well to public transport.

When Christopher returned to clinic with his daughter in June 2012, he struggled much more with word finding and it was apparent during the interview with professionals that he knew what he wanted to say but could not bring the words to mind. The care plan remained the same as there were deemed to be no current unmet care needs.

Christopher remained independent in activities of daily living (over the following year) although he did rely more on help from his wife. He continued to struggle with word finding and tended not to go out much anymore though enjoyed spending time in the garden. A visit by Nurse H took place in June 2013 and a plan was made for a further follow-up meeting in [redacted] 2013. The June meeting was the last contact by Nurse H prior to the incident in [redacted] 2013.

Analysis of LYPFT involvement and lessons learned

The LPFT IMR describes in detail the engagement of professionals in the assessment and follow-up of Christopher in relation to his memory problems. Analysis of the IMR indicates that the interventions of LPFT were appropriate and of an adequate standard.

An initial referral for Christopher was made in 2007, and he may have had an assessment but there is no documentation to substantiate this. The issue re-emerged in 2010.

It is clear from the IMR that Christopher's family were strong advocates for him in relation to his care and support from LPFT and that they were appropriately engaged in his care planning and during routine appointments. However, the role of Christopher's daughter and of Janet as carers

[8] Alzheimer's disease, named after the doctor who first described it (Alois Alzheimer), is a physical disease that affects the brain – Alzheimer's Society – accessed May 2015

does not appear to have been appropriately recognised. Had this been the case then it may have been possible to conduct an assessment of those caring needs and if needs had been identified then support could have been offered.

The IMR highlights specific discussions about Christopher's fitness to drive and it appears that the revocation of his driving licence in late 2011 was a significant event for him.

The IMR concludes that all assessments were completed by LYPT staff in accordance with Trust policy and to the required standards.

The IMR finds that no domestic violence or abuse was identified during contact with LYPFT staff. The lack of home visits, in line with Christopher's preference, may have limited the wider view of professionals in relation to the home environment and how Christopher and Janet were coping in that setting.

The IMR does not identify any specific lessons to be learned and the analysis of the IMR does not conflict with that position. The IMR makes one recommendation in relation to strengthening links with safeguarding and highlighting domestic violence pathways in the memory services.

The memory service has undergone a system review following the incident.

2.2.3 Leeds City Council Adult Social Care (ASC)

Leeds Adult Social Care provides support for adults aged eighteen years and over who need support because of their age, disability, mental health needs, drug and alcohol misuse or other illness and may be unable to care for themselves or protect themselves from harm.

ASC had a number of contacts with Janet and Christopher. The first occurred following a referral on 2nd October 2012 for the hot meal service. The referral was made by their daughter, Susan.

On 3.10.12 CL, a member of ASC phoned Susan to discuss the referral. Susan confirmed her parents were aware that she had referred them to ASC. Although the referral was for Christopher the record of the conversation showed that Christopher and Janet both had health and social care needs.

The outcome of this contact was that Susan was given information about the Leeds City Council home meals service so she could self-refer Christopher. It was agreed Susan would refer back to ASC when and if further support was needed.

On 24.5.13 Susan made a second referral to ASC, this time electronically, for Janet and Christopher to have their social care needs assessed. The content of the referral emphasises her mother's health and social care needs. Following the referral initial contact was made by a member of the Customer Access team. This took the form of an e-mail to Susan advising that if she thought her parents would benefit from support at home or going into care she should provide

specific information by e-mail or telephone so a referral could be made for a social care assessment to be completed.

On 30.5.12 a member of ASC staff telephoned Susan to discuss the referral further. Susan confirmed that her parents were aware of the referral. The referral outcome was for Janet and Christopher to each have a community care assessment.

After two previous cancellations due to Susan wishing her brother to be present and then a family funeral, the community care assessment took place on 22nd July 2013. A range of needs were identified by the social worker, but she was asked to leave by Janet during the assessment meeting after she became upset discussing her caring role. No safeguarding concerns were identified.

Services were offered to Janet and Christopher, including SkiLS (intensive short term support services to develop independent living), Hot Meals Service, Telecare, Occupational Therapy referral for bathing assessment and the Day Centre service. Support with domestic work and laundry was also discussed with Janet.

Christopher was offered support from SkILS twice a day to get fresh clothes out in the morning and offer him a drink or breakfast and support him with a microwave meal at tea time but Janet felt she could manage to support Christopher and said she would prefer to continue in her role. She was averse to having people she did not know in her home.

The outcomes of the assessment were discussed with Susan by the social worker. They agreed that Janet had the capacity to decline services. It was agreed that Susan would try to speak to her parents and would contact ASC if Janet changed her mind or became more open to suggestions.

On 29.8.12 the social worker completed case work summaries for her involvement with Janet and Christopher. She recorded that a Self-directed Assessment Questionnaire was completed for Christopher (attached to his Electronic Social Care Records) but she was unable to complete a full community care assessment for Janet as she declined help.

Analysis of ASC involvement and lessons learned

The services offered by ASC appear to be appropriate to the needs of both Janet and Christopher but were declined. However it was not possible to discuss this in any detail as Janet asked the social worker to leave the house before the end of the assessment.

The IMR appropriately highlights the lack of liaison between the social worker and the CPN to advise them of the assessment and its outcome. Although it appears that this was raised with the social worker during a supervision session, there is no record of that liaison happening in the client file. The IMR states that this was an important omission given the primacy of Christopher's mental health needs and their linkage and impact upon the wider social care needs identified.

It was the opinion of the social worker that Janet had capacity to decline services and her daughter was in agreement with this, thus no formal assessment of mental capacity was felt to be necessary.

Liaison with primary care colleagues was appropriate and the social worker did advise the GP of the current risks to Janet following her assessment.

Although it is clear that the social worker took account of the views of Janet and her son and daughter, the assessment was conducted with both Janet and Christopher present at the same time. This meant that there was no opportunity for Janet to raise any concerns or issues she may have had about Christopher or her caring role confidentially and without him being present. The lack of a carers' assessment for Janet appears to represent a missed opportunity to provide her with the means to express confidentially any concerns she had about her caring role or to have her needs as a carer formally identified and responded to by ASC. Despite this formal process not being conducted, it is clear from the IMR that Janet's role as a carer for Christopher was recognised.

In addition, while Janet had the capacity and right to refuse services in her own right, that refusal had an impact on Christopher and is well-being and there is no evidence that this was considered. The social worker appears to have responded to Christopher and Janet jointly, rather than as individuals, although both had care and support needs of their own. Although the review panel acknowledges that the social worker could not complete a full assessment as Janet asked her to leave, it is important to highlight that had they been responded to individually, a greater focus on Christopher's needs in relation to his mental health would have achieved, possibly providing a fuller understanding of how to support both. This may have provided the 'fuller picture' that their son, Paul refers to being necessary in paragraph 2.3 of this report.

There is no evidence to suggest that any of the interactions or interventions by ASC did not meet the required professional or organisational standards that would be expected.

There are examples of good practice by ASC in this case, specifically that there was timely communication from ASC staff when responding to the referrals. A range of services and support options were offered to meet Janet and Christopher's needs including respite services for Janet. It was also good practice that a phone call was made to Janet's GP to share information about risks and ensure that there was appropriate follow up from a health perspective.

The IMR identifies three key lesson learnt following the incident:

ASC should ensure that when two referrals are received from a private domestic home and allocated to one social worker that there is sufficient rigour in assessing each service users' needs and that the needs of each person have been considered thoroughly and that each person has been given an opportunity to discuss any concerns in privacy.

The need for appropriate consideration and communication regarding the mental health needs of a service user when s/he is known to a mental health service is highlighted as a key lesson learned.

There was no record of any written information being given to Janet or Christopher. Following up outcomes with written information for people who have been assessed or who are receiving services is the final learning point for ASC. It would have been expected practice for a letter to have been sent with the outcomes of the assessment, information about who could Janet could contact if she changed her view about support for herself and Christopher, including personalised services, and information about support in her role as Christopher's carer.

2.3 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 stated that neither he, nor other family members had ever seen any episodes or examples of violent behaviour between Janet and Christopher; indeed he said his father had "never raised his hand to anyone."

Paul said that his parents had been married for 60 years, and that although his mother could "sometimes be awkward" and could be "sharp with her tongue" the marriage was happy. He described Christopher as "a charming man" and that the incident itself was completely out of character.

Paul said that his parents were quite private people and that Janet in particular was resistant to having 'outsiders' in her home and regularly rejected offers of support and help from agencies and family members.

Paul reported that Christopher had been deteriorating for some time and that his loss of function had become more pronounced in the months prior to the incident. Paul stated that his father's speech had noticeably got worse and that although some words came out it was very hard for his father to communicate. Paul also stated that his father could respond to questions and that his cognitive ability appeared to him at least to be reasonably intact.

Paul confirmed that family members had been engaged in supporting their parents. His sister often took them shopping and regularly visited as well as assisting with appointments and visits, and usually visited twice a week. Paul and his wife often had Christopher for Sunday lunch and it was for this reason that his wife had gone to the house on the day she discovered the incident had occurred.

Paul felt that the GP practice could have been more proactive in their input with his parents and that they did not seem to have a full picture of the situation.

Paul said that the incident occurred "out of the blue" and he did not believe that anyone, professional or otherwise could have anticipated it. It had been a distressing experience and the conducting of the DHR was, he hoped, a point from which some closure of the incident could be achieved.

Section Three

Conclusions

3.1 Conclusions

This section sets out the conclusions of the DHR panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The chair of the DHR is satisfied that the review has:

- Been conducted according to best practice, with effective analysis and conclusions of the information related to the case.
- Established 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 vulnerable people and victims of domestic violence.
- Identified clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draws them together to present an overall set of conclusions that can be drawn about the case.

3.1.1 Conclusions of the DHR panel

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 were 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 carer's 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.

3.1.2 Predictability and preventability

The panel has 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.

Section Four

Recommendations

4.1 Recommendations

This section of the Overview Report sets out the recommendations made in each of the IMR reports and then the recommendations of the DHR panel.

4.1.1 Recommendations made in the individual IMRs

NHS England - Primary Care

Recommendation:

The Practice should ensure the adoption of a formal procedure for following up patients who do not attend appointments with specialist services. The policy should take into account the respective responsibilities of secondary services, primary services and the Patient's individual responsibility.

Intended Outcome: The procedure should improve attendance at specialist services.

Measure: The Practice should audit the staff carrying out the procedure.

Timescale: Adopt a policy within three months.
Implement the policy within six months.
Carry out an audit within one year of implementation.

LYPFT

Recommendation:

Review links with safeguarding and knowledge of domestic violence pathways within the memory service.

Action: Discuss the report and outcome of the DHR with the lead manager of the memory service to identify learning and ensure continued good engagement with safeguarding.

Measure: All staff to have good knowledge of domestic violence and have information given on induction to new staff.

Timescale: Initial actions by March 2015 with review and any further work to follow on completion of Overview Report.

Case Review
ASC

Recommendation:

Review current processes in line with the Care Act and ensure protocols are sufficiently responsive so that where both parties are active they are equally considered.

Action: Review to be completed. All new protocols to be implemented within Care Act training in February and March 2015.

Recommendation:

Full review of Team Protocols and a review of the Mental Health Unit protocol when relating to clients and patients with dementia.

Action: Review to be completed. All new protocols to be implemented within Care Act training in February and March 2015.

Recommendation:

Assessments to be multi-agency with all relevant agencies and service involved in an individual's needs assessment.

Action: The formulation and distribution of good practice guidance where there is more than one Social Care service involved to ensure greater communication and joint support planning.

Recommendation:

Carers' assessments completed for carers of clients with Mental Health needs to access knowledge of specific services available

Action: To liaise with the lead professional for Carers Leeds

Recommendation:

Letters and written information to be sent to service users when cases are closed

Action: To be embedded in revised protocols. To be integral in regular case file audits.

4.1.2 DHR recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs.

The DHR panel therefore offers 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.

Section Five

Appendices

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Neil O'Byrne
Domestic Homicide Reviews Senior Officer
Domestic Violence Team
Safer Leeds
2 Great George Street
Leeds LS2 8BA

05 July 2016

Dear Mr O'Byrne,

Thank you for submitting the Domestic Homicide Review report for Leeds D to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 25 May 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be clear and easy to follow report.

There were some aspects of the report which the Panel felt could be revised:

- The Panel recommends that the statement about predictability of death to be reconsidered in the light of some of the missed opportunities identified in the report;
- The Executive Summary could be improved by including key information, such as terms of reference and events leading up to the murder;
- Please clarify whether copy of the report was made available to the family;
- Identifying dates need to be anonymised;
- The Panel questioned whether there is more learning from adult social care that could be drawn out in the review;

The Panel does not need to see another version of the report, but I would be grateful if you could include our letter as an appendix to the report.

I would be grateful if you could email us at DHREnquiries@homeoffice.gsi.gov.uk and provide us with the URL to the report when it is published.

The QA Panel felt it would be helpful to routinely sight Police and Crime Commissioners on DHRs in their local area. I am, accordingly, copying this letter to the PCC for information.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Safer Leeds Partnership
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Contact: Neil O'Byrne
Email: [redacted]
Tel: [redacted]
Date: 24 August 2016

Mr C Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel
Public Protection Unit
2 Marsham Street
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Dear Mr Papaleontiou

Thank you for your letter of 5 July 2016 regarding our DHR [D] report and your kind comments on it being a clear and easy to follow report. We are grateful that you have authorised publication of the report and I can confirm that we will also publish your letter as an appendix to it and I will send you the URL to the publication.

Although you did not wish to see any revisions to the report I have addressed each of the points raised by the QA Panel below.

The Panel recommends that the statement about predictability of death to be reconsidered in the light of some of the missed opportunities identified in the report;

We were somewhat surprised at this recommendation as the review mirrored the view of the family members that there had never been any suggestion of Domestic Abuse in this 60 year marriage, including the period that the suspect had been diagnosed as suffering from dementia. Family members had been in weekly contact with the victim and suspect and saw no evidence that such a tragedy would follow. The Review Panel considered that the level of contact by professionals was so limited there was no evidence available to them on which to predict this death.

Case Review

The Review Panel, including some replacement members seeing the report for the first time, have given the issue of predictability further consideration and are resolute that they cannot see any evidence that would dissuade them from their original view.

We would appreciate, for future reference, knowing what issue(s) caused the QA Panel to question this determination.

The Executive Summary could be improved by including key information, such as terms of reference and events leading up to the murder;

This has been addressed.

Please clarify whether copy of the report was made available to the family;

A copy of the report was presented to the family; they agreed with the conclusions and did not wish to add any comments.

Identifying dates need to be anonymised;

The QA Panel is provided with a copy of the report that is only anonymised by way of the names of those involved being changed so panel members have the clearest possible understanding of the circumstances in each case; some of which can be lost through redaction.
Upon receipt of authorisation to publish the report it is appropriately redacted in accordance with instructions from our Information Governance Team and to comply with Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews; Section 8; paragraph 74.

The Panel questioned whether there is more learning from adult social care that could be drawn out in the review;

The Review Panel was also asked to address this point with the result that they considered all reasonable learning had been identified within the report. The Adult Social Care representative on our DHR Sub Group responded as follows:

- **The actions for ASC are timely on a number of occasions, on 3.10.12 the couple were given clear information as to re-refer too.**

- **I take the point about not necessarily seeing the two as a couple and looking at them as separate individuals for the purposes of assessment and support planning. This wouldn't necessarily have changed anything of course however it would be good practice to see people as individuals and as a couple and this we have incorporated into the Care Act Training in terms of assessing and case work.**

- **Paragraph 8, the range of options were appropriate to the presentation of the clients, good communication with the daughter, and it's good to see that the social worker engaged effectively with the daughter when assessing capacity.**

- **Whilst good communication with the GP the missing link was liaising with the CPN and this is accepted. CPA training will rectify this as will the implementation which is in situ regarding the Care Act.**

- **A formal care assessment would also have been good practice however one doubts that this would have been accepted, carer assessments are routinely offered in terms of the implementation of the Care Act and this does not need to be by a social worker working with the individuals. We commission Carer Leeds to do this work on our behalf which provides a different option in terms of engagement.**

Again, for future reference, we would appreciate details of any additional learning identified by the QA Panel.

Yours sincerely

N. O'Byrne

Neil O'Byrne
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10 October 2016

Dear Mr O'Byrne,

Thank you for your letter of 24 August responding on the points raised by the Quality Assurance (QA) Panel on the Domestic Homicide Review (DHR D that you submitted. I apologise for the delay in replying.

I am grateful to you for the clarification on the comments made by the Panel. I am particularly grateful to you for providing further background on the points made by the Panel about predictability of death and learning from adult social care.

I have noted your request and will, in future, telephone you to discuss in more detail any significant matters raised by the Panel on a DHR report before outlining them in the feedback letter.

Thank you again for your participation in the process and the work that you have put into the report in this case.

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel