Anonymised for publication and dissemination

DHR 'Betty'

Month and Year of Death: December 2017

Domestic Homicide Review

Sheffield Domestic Abuse Coordination Team (DACT)

Sheffield Safer and Sustainable Communities Partnership

Independent Author and Chair: Hayley Frame

Report Dated: 31st January 2019

Contents

1. Introduction

1.1. The establishment of a Domestic Homicide Review (DHR) is set out under Section 9 of the Domestic Violence Crime and Victims Act 2004 which came into force on the 13th April 2011.

1.2. Multi-agency statutory guidance for the conduct of DHRs has been issued under Section 9 (3) of the Domestic Violence Crime & Victims Act 2004. Section 4 of the act places a duty on any person or body named within that section (4) to have regard to the guidance issued by the Secretary of State. The guidance states that the purpose of a DHR is to:

- Establish what lessons are to be learned from a 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

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

Persons Covered by the Review

1.3. The principal focus of the Review is the victim, a female who, at the request of her daughter, will be referred to as Betty. The other involved adult is the perpetrator, Betty's partner, a male referred to as Adult A.

1.4. The criminal investigation has now concluded and in November 2018 Adult A pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to a hospital order under the Mental Health Act 1983.

Confidentiality

1.5. The victim, Betty, was 46 years of age at the time of her death. She was White British. Betty is a pseudonym chosen by her daughter in order to preserve the family's confidentiality.

1.6. The perpetrator, Adult A, was also 46 years of age at the time of the fatal incident. He is White British.

Review Period

1.7. The scoping period is from 20th December 2016 (12 months prior to the homicide) until 23rd December 2017, the date when Adult A was detained in connection with Betty's death. Additional relevant information outside of the scoping period has also been incorporated into this report (section 3).

Timescales for the review

1.8. The review commenced on 7th March 2018 and was completed on 31st January 2019.

Methodology

1.9. A consideration briefing was circulated on the 26th January 2018 to the Domestic Homicide Review consideration panel, which comprised of:-

- The Executive Director of Peoples Portfolio, Sheffield City Council – Jayne Ludlam
- Head of Sheffield LDU, National Probation Service, Ann Powell
- South Yorkshire Police, Superintendent Stuart Barton
- Chief Nurse, Sheffield Clinical Commissioning Group, Mandy Philbin

The panel agreed with the recommendation that the statutory criteria for a Domestic Homicide Review had been met.

Agencies identified completed an Individual Management Review report and were represented on a DHR Panel convened to oversee the Review. Agency records were used to complete the IMRs and in some cases, staff members were spoken to by the IMR author, and where available, they attended a practitioner event. Hayley Frame, Independent Safeguarding Consultant, was appointed as the Independent Chair and Author for this DHR.

Terms of reference

The following case specific areas were addressed in the Individual Management Reviews and have shaped the analysis of this Overview Report:

- The police response to the neighbours 999 call on 20th December 2017 does not appear to have been timely. Did this apparent lack of timeliness contribute to Betty's death? Were there any other issues in relation to timeliness of response by agencies in this case?

- It is apparent that there was deterioration in Adult A's mental health. Did agencies consider what impact this may have on his relationship with Betty? Was Adult A assessed appropriately under the Mental Health Act?

- It appears that Betty was acting as a carer for Adult A. Were caring responsibilities recognised and responded to appropriately?

- It is suggested that Betty may have asked Adult A to move out of her flat as a result of financial concerns. Were agencies aware of this? Was separation considered as a possible risk factor?

- Betty appears to have been using Methadone – were agencies aware of this? If so what was the response?

- Was there appropriate information sharing between agencies?

Contributors

1.9. Agencies participating in this Review and commissioned to prepare Individual Management Reviews/summary reports are:

- Sheffield Health and Social Care NHS Foundation Trust
- South Yorkshire Police
- Citizens Advice Sheffield
- Sheffield Teaching Hospitals NHS Foundation Trust
- Sheffield City Council Housing and Neighbourhood Service
- Department for Works and Pensions
- Sheffield Clinical Commissioning Group
- Yorkshire Ambulance Service NHS Trust

Individual Management Review authors were all independent from any direct management of the case.

Involvement of family, friends, work colleagues, neighbours and wider community

1.10. Betty's daughter and close friend were approached to contribute to the Review. Betty's friend declined the invitation to contribute to the review but Betty's daughter wished to meet with the Independent Author. This could not occur until the conclusion of the criminal investigation. The meeting went ahead shortly afterwards and her perspectives are included within the report.

DHR Panel members

1.11. DHR Panel members consisted of senior representatives from the following agencies:

- Sheffield Health and Social Care NHS Foundation Trust – Anita Winter, Diane Barker and Sharon Ward
- South Yorkshire Police – Pete Horner, Sharon Baldwin and Stacey Grayson
- Citizens Advice Sheffield – Joanne Abdullah
- Sheffield Teaching Hospitals NHS Foundation Trust – Christina Blaydon
- Sheffield City Council Housing and Neighbourhood Service – Maxine Stavrianakos
- Department for Works and Pensions – Andrew Goodison
- Sheffield Clinical Commissioning Group – Amy Lampard and Kitty Reilly
- Yorkshire Ambulance Service NHS Trust – Janine Waters
- IDVAS (Action Domestic Abuse Services) – Theresa Ward

Plus Standing Panel members from:

- National Probation Service – Ann Powell
- Sheffield Safer and Sustainable Communities Partnership – Sam Martin

In addition, the DHR Panel were supported by the DACT DHR Coordinator, Alison Higgins, and Alison Howard, Business Support Officer, both employed by Sheffield City Council.

1.12. The Independent Author/Chair is a qualified and HCPC registered Social Worker having qualified in 1995. Since 2010, she has authored Serious Case Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews. This is the 8th Domestic Homicide Review authored by Hayley. She has had no connection with Sheffield City Council or with any of the agencies involved in the Review.

Parallel Reviews

1.13. The criminal investigation in respect of Betty has now concluded. Due to the guilty plea of manslaughter there is no requirement for an inquest.

1.14. As a result of initial concerns in relation to delays in resourcing the incident and any impact that they may have had, the incident was referred to the Independent Office for Police Conduct (IOPC) and South Yorkshire Police Professional Standards Department. A full investigation commenced and was concluded during April 2018. The findings report that the South Yorkshire Police response to the reported incident did not contribute to either the death of Betty or the self-inflicted injuries to Adult A. The available evidence suggests that Betty died prior to the police being contacted on the 20th December 2017. A disturbance and screams from Betty had been heard over 13 hours prior to the incident first being reported to police.

1.15. An NHS investigation under the Serious Incident Framework has been undertaken. The case did not meet the criteria for a Mental Health Homicide Review however.

Equality and Diversity

1.16. This is explored further within the analysis section of this report.

2. **The Facts**

2.1. Betty was a 46 year old female at the time of the incident and lived with the perpetrator Adult A, also aged 46, in a council property in Sheffield. Whilst the couple resided together, Betty was recorded as the sole tenant of the property. Betty had two adult children who did not live with the couple. Betty's daughter had re-established contact with her mother a few years before her death. Betty also had a brother and sister-in-law with whom she maintained contact.

2.2. At 13:04 hrs on the 20th December 2017, a neighbour of Betty contacted South Yorkshire Police having heard a disturbance at Betty's address the previous evening (19th December 2017). It was reported that it was out of character to hear such noise coming from the property and therefore, despite the delay in reporting, the neighbour was sufficiently concerned to contact the police. The call was graded as a priority by the police and officers were deployed on the afternoon of the 20th December 2017. However the officers were initially unable to gain access to the property. At 00:03hrs, on 21st December 2017, officers were deployed to the incident and attended at the property at 00.32hrs to find Betty deceased, and Adult A to have sustained injuries in the form of lacerations to his right wrist and neck. Adult A was subsequently arrested on suspicion of murder and immediately taken to hospital where he was observed for a 24 hour period having advised officers that he had consumed bleach.

2.3. A post mortem examination revealed a number of injuries in the form of stab wounds, incision wounds, abrasions and bruises, believed to have been caused by a screwdriver. There was an incised wound to the palmar surface of the right hand which is believed to have been caused by a knife. These injuries did not account for Betty's death. There was a considerable amount of injury to the neck structures including abrasions and bruising. In the pathologist's opinion, Betty died as a direct consequence of compression of the neck.

2.4. The criminal investigation has now concluded. Prior to this incident, there is no record of contact between either Betty or Adult A and South Yorkshire Police.

3. Summary of relevant individual agency contact/involvement prior to scoping period

3.1. Betty was known to Social Services since 1997 due to concerns about the volatile relationship between herself and her then husband with whom she had two children. Information within the children's files indicates that there were concerns in relation to neglect. In 2000, the Local Authority gave instruction to commence care proceedings due to a risk of sexual harm, with a proposed plan for children to be removed for three months to allow assessment of family. The instruction refers to known abusers within the extended family. It was recorded that both children presented '*as being very sad and are stuck in the middle of their parents' volatile relationship. Both parents make multiple allegations of sexual abuse against each other when they separate'.* The children were subsequently made subject to Care Orders.

3.2. In 2004, applications were made for the discharge of the Care Order. The application stated that the parents '*relationship followed a pattern of separating, reconciling and constant allegations against each other. They finally divorced in 2003, but contact between the children and Betty remained problematic….Betty continued to remain in contact with Schedule 1 Offenders in her family and concerns were raised that she failed to protect the children from contact with those family members'.* The children ceased having contact with Betty in 2005. It appears from the records that the children remained in the care of their father.

3.3. Department of Work and Pensions records state that Betty was claiming Employment Support Allowance due to a number of health conditions including depression, anxiety, and that her memory and concentration were affected. Betty was later supported by Citizens Advice Sheffield to apply for a Personal Independence Payment (PIP) which was initially refused. In 2016, on appeal, Betty was awarded a PIP plus a Severe Disability Premium (SDP)[1].

3.4. Citizens Advice Sheffield knew Betty as a single woman who lived alone. Her brother would sometimes attend appointments with her. The service was also aware that Betty had a female friend who acted as her carer, Adult B. The appeal submission recorded that Betty had a self-reported learning difficulty and needed support from her carer with budgeting, preparing food, administering medication and reading mail.

3.5. There was little professional knowledge of her relationship with Adult A until he became unwell in the months leading up to Betty's death. Betty held a tenancy with Sheffield City Council and was a sole tenant, with no other occupant listed.

3.6. Little is known from agency records about Adult A's early history. He grew up and resided in another Local Authority area and it is believed that he was a carer for an unknown male until that person's death. Records indicate that Adult A was then living in a property with Betty's brother until May 2012. He appeared then to move to Sheffield in 2017.

3.7. There is one contact with Mental Health Liaison Team for Adult A in A&E at Chesterfield Royal Hospital on 31st May 2013. It is recorded that at the time of the presentation, Adult A had no fixed address so was advised to register with a housing provider. He was also advised that he may benefit from Cognitive Behavioural Therapy to address his anxiety. It is recorded that his presentation was impacted by the fact that he had taken illegally supplied testosterone.

[1] The SDP was applicable as Betty was reported as living alone and no one was claiming a carer's allowance for her.

3.8. Department of Work and Pensions records state that Adult A was claiming Employment Support Allowance due to health conditions which included anxiety, paranoia, depression, memory and concentration issues plus perception of risk of physical danger[2].

3.9. Adult A first came to the attention of mental health services when he was referred by his GP to the Improving Access to Psychological Therapies (IAPT) service in June 2012. He was assessed in August of that year and presented with anxiety, embarrassment about his upbringing and low self-esteem. On his second appointment on 8th October 2012, Adult A disclosed previous problems with bulimia and Obsessive Compulsive Disorder. He was later referred to a Cognitive Behavioural Therapist due to low mood, OCD and social anxiety. He was discharged on 8th February 2013 after failing to attend two appointments with the Cognitive Behavioural Therapist.

[2] taken directly from DWP record – no further explanation of risk of physical danger

4. **Summary of key events within the scoping period (author comments in bold)**

4.1. On 15th December 2016, Betty visited her GP and reported low mood. It was agreed that her medication would be altered and that she would be referred to the Pre-Diabetes Team following recent blood tests. Betty was recorded as having stated that she had considered taking Methadone but had managed to stop herself.

There is no documented discussion about referrals to support agencies or talking therapies. Good practice would have been that there was an assessment of the level of lowness of mood, an offer of medication and talking therapies, signposting to other agencies and/or information provided regarding crisis intervention. Often Betty saw different GPs at the practice so no one GP had knowledge of her. It would be good practice in situations of ongoing mental ill-health for patients to be seen by the same GP.

4.2. On 22nd December 2016, Adult A visited his GP describing a history of low mood. Adult A spoke of a difficult childhood and felt that he would benefit from counselling. A referral was made for counselling. Adult A was seen again by his GP on 5th January 2017, when he was feeling very low and spoke of not having received any benefits since the beginning of December 2016. Adult A said that he had support and this kept him from thoughts of self-harm. It was agreed that he would be seen again in 4 weeks and the GP chased the counselling referral.

4.3. DWP records state that from 5th January 2017, Adult A was using Betty's address as a care of address.

4.4. Adult A contacted Housing Solutions by telephone on 16th January 2017 whilst at the Citizens Advice Sheffield drop-in. He stated that he had been of no fixed abode for 4 years but when asked about previous addresses that he had lived at, Adult A stated that he did not feel mentally strong enough to live on his own and therefore did not make a homeless application.

The review has established that Adult A and Betty had not declared that they were living together. This may be the reason why he did not wish to disclose previous addresses.

4.5. The Citizens Advice Sheffield notes state that Adult A was very vulnerable, and had mental health problems including depression and anxiety. It was recorded that he was sleeping on various friends sofas and had no fixed abode, but had a care of address for his post which he checked every week or so. He stated that due to missing an appointment for a medical assessment his benefits had stopped and he had had no money since 1st December 2016. The Advisor contacted the DWP on Adult A's behalf and he was advised to return to Citizens Advice Sheffield the following day.

Adult A chose not to disclose that he was living with Betty. It is not known why he missed his medical assessment appointment.

4.6. On 17th January 2017, Adult A attended the Citizens Advice Sheffield as agreed to complete a benefit (ESA) appeal. On 26th January 2017, he attended again to seek support completing his Job Seekers Allowance form.

4.7. On 31st January 2017, Adult A had an Improving Access to Psychological Therapies (IAPT) assessment. He was assessed as having a complex presentation being significantly depressed with anxiety and social anxiety. He reported a history of self-harm but had never attempted to end his life. Adult A felt that he would like to talk to someone about the impact of a very unstable childhood, one where his mother had a psychotic illness and his father had a diagnosis of bipolar disorder which left them unable to care for him adequately. Adult A stated during the assessment that he lived with a friend. As a result of the assessment, it was agreed that in the first instance Adult A would access counselling.

4.8. Adult A spoke again with his GP on 2nd February 2017, by telephone, reporting depression and social anxiety. Adult A reported deterioration in his mental health due to benefit difficulties and also disclosed a difficult childhood being raised by parents who both had significant mental health issues. He stated that he struggled to trust people but did have supportive friends and that he was living with a friend.

As previously stated, all information gathered within the review suggests that Adult A was living with Betty but that they chose not to disclose this to agencies.

4.9. On 9th February 2017, Adult A was seen by his GP. He was awaiting counselling sessions following the IAPT assessment. He also spoke of having suicidal thoughts, although not current. It was agreed that the GP would see him again in 4 weeks.

4.10. Betty visited her GP (a different GP practice) on 28th February 2017, stating that she had been feeling unwell with anxiety for the last 3 weeks and had resorted to using her brother's Diazepam which she had found helpful. It was agreed that a short course of Diazepam would be prescribed to allow reduction over the next few days and then cease usage.

It is recorded that Adult A was receiving repeat prescriptions for diazepam, although from a different GP in a different GP practice. It is a possibility that Betty was using her partner's diazepam rather than her brother's. Again, there is no documented discussion about referrals to support agencies or talking therapies.

4.11. That same day, 28th February 2017, Adult A attended his first counselling session where he discussed relationship issues in early childhood. Fortnightly sessions were agreed.

4.12. Adult A visited his GP on 18th May 2017 and reported that he was engaging well with his counselling sessions. It was agreed that he would be seen again for review by the GP in 8 weeks' time.

4.13. On 4th July 2017, Adult A attended his fortnightly counselling session but agreed to take a break from counselling for two months due to feeling under pressure with regard to a review of his benefits. An appointment was booked for 5th September 2017.

4.14. Adult A telephoned his GP on 27th July 2017. He spoke of having to attend a work group linked to his benefit entitlement and that this was adding pressure that was leading to him having suicidal thoughts. Adult A asked for a supporting letter from the GP so that he did not have to attend the work group. The GP agreed to this and asked whether he wanted to see the GP that day, which he declined. Adult A denied current suicidal thoughts. The following day the GP wrote to the DWP stating that the work group was putting increasing pressure on Adult A which was worsening his depression and asking whether he could be exempted from attendance.

4.15. On 3rd August 2017, Betty visited her GP and spoke of increased anxiety due to her brother being in prison in Spain. She spoke of not having anyone to talk to and asked for an increased dosage of antidepressants which was agreed.

A discussion about referrals to support agencies or talking therapies would have been appropriate in this scenario.

4.16. Adult A attended a counselling session on 5th September 2017 as arranged. It was agreed to have 2 further sessions, one each month.

4.17. On 1st November 2017 it was recorded by the DWP that there was possible compliance/fraud activity on Betty's benefit claim and that she was possibly cohabiting. A General Matching Service scan had identified that Adult A was living at the same address as Betty but that they were not claiming benefits as a couple.

The protocol in these cases is for an interview to take place with the customer and a member of the Compliance Team, in order to discuss the situation.

4.18. On 11th December 2017, Betty was interviewed by an Officer from the DWP Compliance Team. She attended alone. The purpose of the interview was to ask Betty if there was anyone else living at her address, and if so, what was the nature of the relationship. At the interview, Betty admitted that she let her boyfriend, Adult A, use her address as his postal address, as he was effectively homeless. She was adamant however that he did not live there and confirmed that she lived alone in the address in question. This version of events was accepted by the Compliance Officer and no further action was taken. Betty was advised that no further action would be taken as a result of that interview, and that her benefits would not be affected.

4.19. At 3.24pm that day, Adult A contacted his GP by telephone to say that his partner had to stop him from taking his own life the previous Saturday (9th December) and that his medication was no longer working. He was invited to attend an appointment at 5pm that day.

4.20. At 5pm on 11th December 2017, Adult A attended his GP accompanied by Betty. He stated that Betty had stopped him from killing himself with a sword in the early hours of Saturday morning, and that he had a deep laceration to his right finger. Although Adult A stated that he had no current plans to kill himself, he was unsure if his feelings might overwhelm him again. He spoke of stopping his prescribed medication over a month ago, that he had lost weight and was not sleeping. Adult A also disclosed that he was remembering negative events about his childhood, including abuse. Adult A spoke of wanting psychiatric support. It was agreed by the GP that Adult A would start taking Mirtazapine to help his sleep and weight. It was also agreed that Betty would stay with Adult A and make sure that no sharp instruments/ligatures/acid/toxic substances were available. Arrangements were made to see Adult A again in 2 days.

4.21. On 12th December 2017, the GP made an urgent referral to the Community Mental Health Team (CMHT) in respect of Adult A. The referral stated that he had made a serious suicide attempt on 9th December 2017 where he had tried to impale himself on a sword but was stopped by his girlfriend. The GP stated in the referral that Betty was to be contacted as Adult A was unable to answer his phone.

The referral letter is detailed and comprehensive, including a summary of active and past problems.

4.22. The GP telephoned Betty that day to see how Adult A was and Betty reported that he had slept and had managed to eat something.

4.23. Also on 12th December 2017, Adult A attended his final arranged counselling session, accompanied by Betty. It was recorded that Adult A was uncommunicative and appeared low in mood. Betty informed the counsellor that Adult A had tried to end his life the previous Saturday with a knife. It was recorded that Adult A had become low over the past couple of weeks since hearing that he may lose the flat he was living in with Betty. The counsellor was made aware of the referral to the CMHT. Adult A scored highly for suicidal ideation although it was noted that he had no immediate plan to self-harm and had support from Betty. Information was provided regarding the Samaritans and out of hours services. Adult A was discharged from IAPT, with his agreement.

IAPT practitioners are not mental health practitioners trained in psychological therapies. IAPT support low level, general mental health presentations. IAPT are not trained nor commissioned to deliver assessment and treatment for those presenting with more complex and high risks as this is provided by Community Mental Health Teams. For this reason, once an individual is referred to CMHT, the case is closed to IAPT.

4.24. As a result of the GP referral the CMHT reviewed Adult A's notes later on 12th December 2017 and it was recorded that as he had not expressed suicidal thoughts to his GP or during his counselling session, he would be followed up by the Duty Team the next day, however this did not happen, despite it being clearly documented in the notes.

The CMHT assessment team were on a planned away day on 12th December 2017 following mobilisation of a new service model. Cover arrangements were in place although the systems and processes in place were new and less familiar to those covering the service that day.

It is not known why the referral was not followed up on 13th December 2017 but the agency has concluded that this was due to a backlog experienced on 13th December 2017, from the day before.

4.25. Adult A went to see his GP as planned on 13th December 2017. Betty accompanied him. Although he had slept better, Adult A reported feeling like relentless messages were coming from the TV, walls and shadows and that constant speech and messages were 'hitting him, getting into his mind and from within his mind'. Adult A stated that there were too many messages coming into his mind but that he was not able to reveal the content. He stated that he only felt safe when asleep or sedated. It was agreed that he would start a course of Olanzapine and was advised of potential weight gain and sedation. It was agreed that the GP would see him again the following week and would update the CMHT, which she did in writing on 14th December 2017. The letter was faxed and marked urgent and stated that there were elements of psychosis, that he was at high risk and that this was a new and worsening unexpected event.

4.26. On 14th December 2017, the CMHT Duty Team tried to contact Adult A by telephone and messages were left on his voicemail. The initial referral was assessed as routine and followed the Scheduled Care Pathway process. It would appear that the duty worker did not have sight of the GP's second letter although the reason for this is unknown.

The referral from the GP had stated to contact Betty rather than Adult A as he was unable to answer his phone.

The Scheduled Care Pathway is the routine pathway, where an appointment is offered. The Acute Care Pathway requires an individual to be seen that day. The assessment to determine which pathway is based upon suicidal intent, and in the case of Adult A, it was felt that during his final IAPT appointment he did not have any immediate plans to self-harm.

4.27. A telephone conversation took place 18th December 2017 between Betty and the GP for Adult A. Betty stated that Adult A was very weak and was still not eating. His heart rate was very fast. The GP called an ambulance to take Adult A to Accident and Emergency.

4.28. Adult A attended Accident and Emergency at 4:30pm via ambulance. Betty followed in her car. The ambulance crew described Adult A as anxious without Betty and requiring reassurance that Betty would attend the hospital. Whilst in the ambulance, Adult A spoke of his housing situation and was concerned that Betty would incur a financial loss as a result of Adult A living at the property.

4.29. Adult A stated whilst in A&E that he had not eaten for some time and had lost a lot of weight. He spoke of hearing voices, sleeping problems and attempted suicide using a samurai sword. An entry in his notes stated 'referral made to Liaison' however no referral was received by the Liaison Mental Health team, and they only became aware of Adult A at 10.00pm when Betty approached them to ask when he would be seen.

It is not known why the referral to the Liaison Team was not made.

4.30. A crisis assessment was carried out by two members of the Liaison Team at 11.30pm. The records stated that Adult A was having a 'meltdown' after seeing a letter for Betty for a benefit assessment. It was recorded that Adult A tried to impale himself on a Samurai sword on 9th December 2017 but that Betty had prevented him from doing so. It was stated that Adult A lived with Betty and that she had cleared the house of sharps and ligatures. It was noted that Betty was concerned about Adult A as he had suffered with his mental health for the 14 years that they had been together but that this was the worst that he had been and that she did not leave him alone when he was feeling that way. Adult A stated that he had lost 4 stone in 4 weeks as he had not eaten during that time. He reported poor sleep, poor motivation and concentration, and was described as low in mood, subdued, poor eye contact and closed body language with speech that was difficult to understand at times. It was noted that there was a history of self-harm but no suicidal thoughts at that time; that he showed evidence of hope and was willing to engage with agencies. The agreed plan was for his appointment to be brought forward; for him to continue his medication; for his GP to be contacted to manage his poor sleep and for crisis numbers to be given. A risk assessment was completed, with scores for dangerousness at 3/5; support 5/5; cooperation 4/5; totalling 12. Adult A was discharged home with Betty at 13.48pm on 19th December 2017.

Given the time of arrival at A&E (4.30pm) and that Adult A was seen by the Liaison Team at 11.30pm, the review believes that it is more likely that Adult A was discharged at 1.48am on 19th December 2017 however, the records state 13.48pm.

Adult A was seen alone for the assessment and also seen with Betty. Betty was not seen alone by the practitioners.

The scoring is formed via the crisis triage weighting scale, which are a set of measures scored from 1 to 5 across the domains of 'dangerousness'; 'support system' and 'ability to cooperate'. The scale is developed to rapidly screen psychiatric patients and differentiate between patients who require hospitalisation from those who are suitable for outpatient intervention. The lowest score is 3 and the highest score is 15 (lower scores indicate greater distress/urgency). Studies have placed scores of 10 and above to indicate that hospitalisation is not required.

4.31. Later on 19th December 2017, the CMHT tried to contact Betty as stated on Adult A's notes. There was no answer but a voicemail was left requesting contact. Betty then returned the call, and stated that Adult A had difficulty sleeping so advice was given about seeking medication from the GP. It is recorded that during the telephone conversation Betty stated that Adult A had had '*another episode'.* Betty was told that an appointment with the CMHT would be sent out in the near future.

The worker who spoke with Betty did not explore what 'another episode' meant.

4.32. Betty then contacted Adult A's GP, who agreed to a sedative being prescribed. Betty also stated that she was struggling to get Adult A to take the medication already prescribed.

4.33. On 20th December 2017, at 1.04pm, a neighbour contacted the police to report a disturbance the night before at Betty's home address. The call was assessed as requiring a priority grading which requires that officers attend the incident within an hour. This did not happen due to other priority incidents. When officers attended at 6pm, they were unable to gain access to the main communal entrance so made efforts to gain access via buzzing the doorbells of other neighbours to no avail. An unsuccessful attempt was also made to contact the neighbour who had reported the incident. The incident remained ongoing, with a further visit planned for later that day.

4.34. At just after half past midnight, the police visited the property again and a neighbour allowed the officers access to the property. Betty was found to be deceased in the living room and Adult A had stab wounds.

4.35. At 12.40am, the police contacted the ambulance service. At 12.48am a rapid response vehicle arrived at the address and at 12.52am an ambulance arrived at the address. It was documented by the attending crew that Betty was on the living room floor with a stab wound to her neck, and there were no signs of life. A Recognition of Life Extinct form was completed by the ambulance crew at 1.10am.

4.36. The ambulance crew documented that Adult A had a cut to his neck and right wrist, that he had drunk toilet cleaner and had taken all of his prescribed medication. It is recorded that

Adult A had stabbed Betty and then stabbed himself causing the injuries. He was then taken to hospital by ambulance accompanied by the police.

4.37. Adult A disclosed during a police interview on 22nd December 2017 that Betty had stated on the night of the murder that the relationship was over. Within the criminal proceedings it was stated that after the murder, Adult A told an assessing psychiatrist that he believed Betty was a decoy robot that had been placed in their home. He was diagnosed with recurrent depressive disorder, which was severe in nature, with psychotic symptoms.

5. Family Member and Practitioner Perspectives, to include a pen portrait of Betty

5.1. Adult B is referred to within Betty's benefit claims and appeals as being her carer. There is no reference to Adult B in any other agency records. As part of this review Adult B has been contacted and she has stated that she was friends with both Betty and Adult A. She last saw the couple two days prior to Betty's death when she and Adult A visited her house and everything appeared to be fine between them. She confirmed that she did attend 'Social Security' appointments with Betty, as moral support.

5.2. Betty's daughter met with the Independent Author. She described her mother as being loving, caring and helpful to others, and that she went out of her way to help people. She cared about animals and children and she enjoyed life. Betty was described as very popular and having lots of friends. Regarding Betty's health, her daughter said that she had curvature of the spine, asthma and arthritis but she could care for herself and was otherwise perfectly healthy.

5.3. Betty's daughter stated that her father prevented her from having contact with her mother and that this had resumed in recent years after Betty contacted her on Facebook. Betty's daughter was living in Leeds at the time and Betty came to visit her on the coach with Adult A. Betty's daughter's view is that Adult A was not loving towards her mother and she spoke of how he never held her hand. Betty adored Adult A and in her opinion: 'worshipped the ground he walked on.' Betty's daughter did not however think that her mother was at risk of harm.

5.4. Betty's daughter last saw her mother on the 19th December 2017. On this occasion she felt that Betty was not herself especially when Adult A was present. She stated that Adult A was mumbling all day and at one point they saw a hearse go past and Betty had said to Adult A 'do you want to end up in one of them?' They also visited a DIY shop and bought a screwdriver, which Betty's daughter now wonders whether this was the tool used when her mother was murdered. They then went for a meal at a carvery and Adult A sat and stared at Betty throughout the meal. There were plans for Betty to pick her brother up from the airport the following day and her son was coming to visit too for Christmas. Betty's daughter in retrospect wishes that she had said something to her mother that day – that she was concerned about her.

5.5. With regard to her mother's murder, Betty's daughter feels that the neighbours should have acted when they heard Betty saying 'please don't' and him responding 'shut up'. She also blames the hospital for not keeping Adult A in hospital the night before. She shared that Betty had told her the day before that she had called an ambulance for Adult A to do with his blood pressure and that he hadn't been eating. Betty had said it was to do with a letter as she had told the council that he had moved into her property but he did not want to do a joint claim as this would mean sharing the benefits.

5.6. Betty's daughter hopes that the Domestic Homicide Review achieves greater awareness around domestic abuse.

5.7. The DWP Work Coach who had regular dealings with Adult A remembered him and recalled that he was always receptive to suggestions made with regard to looking for work. Adult A never mentioned having a partner, Betty. The Work Coach did recall Adult A raising concerns

about not having received a letter sent to his C/O address and that he was appealing against the decision to move him from Employment and Support Allowance (ESA) to Job Seekers Allowance (JSA).

5.8. The IAPT Counsellor who worked with Adult A was interviewed as part of this review. She held between 15 and 20 sessions with Adult A. She described him as smartly dressed, punctual and articulate. Adult A was also described as being generally upset and depressed but not aggressive, and that she did not feel ill at ease with him. Adult A was struggling to move on from the impact of childhood events and spoke of harming himself but not of harming others. The IAPT Counsellor was not aware that he had a long term partner as he always stated that he lived with a friend.

5.9. The IAPT Counsellor met Betty on one occasion (Adult A's final session). The IAPT Counsellor described Betty as a lovely woman, very warm and supportive and that she observed no friction between the couple. She stated that there was nothing from their presentation as a couple that caused her to be concerned although during that final session Adult A was very withdrawn and not really speaking. The IAPT Counsellor stated that Betty appeared to be a capable and competent woman who was observed to provide reassurance to Adult A.

5.10. As part of the agency's IMR, it is reported that the Liaison Team who assessed Adult A in A&E were similarly not concerned about the relationship between Betty and Adult A. It was stated that there was no evidence of control or a sense that Betty was in any way intimidated or scared of Adult A. The Liaison Team were reported as having no sense that Betty needed to be seen alone. Normal practice is to offer to see a partner alone if there appears to be an 'underlying' disparity due to them being together. Betty appeared strong mentally, with no impression of vulnerability. Adult A seemed like a gentle person, with no perceived risk of violence.

5.11. The practitioner event, held as part of this review, highlighted that Betty presented very differently to the Citizens Advice Bureau (CAB) who dealt with her benefits appeals in 2016, to the agencies who had contact with her as part of their dealings with Adult A in 2017. The CAB worker who saw her on two occasions described Betty as a vulnerable and very quiet person who needed to be prompted. She was perceived as having a high level of care needs herself (see 3.4).

5.12. The GP for Adult A who had contact with Betty in late 2017, described her as being able to talk about Adult A's medication in detail and that she could recall phone numbers without looking at her phone. She described Betty as a competent woman who was well kempt. The observed body language between the couple was positive and Betty seemed to be a good carer of Adult A and the GP felt that Betty was a safety net, a protective factor for Adult A.

5.13. Adult A's GP also described how, in the weeks prior to Betty's death, Adult A had stopped eating and had significant weight loss. He was described as being withdrawn, appearing 'hopeless' and having extremely poor physical presentation. He spoke of this being due to the fact that it had been discovered that they were living together without having declared it to the authorities. The GP spoke of an appointment where Betty accompanied Adult A and was seen to reassure Adult A that this issue was now resolved and that he no longer needed to worry. The GP described the couple as warm and mutually supportive and she had no reason to be concerned. She did not feel that Betty was displaying carer stress and there was, in her

opinion, no suggestion of the need for a carer assessment. The GP for Adult A described Betty as composed in a crisis. Adult A however had a real sense of shame regarding claiming benefits and the guilt was a preoccupation for him.

5.14. The Paramedics who took Adult A to A&E on 18th December 2017, recalled how Adult A had lost weight and could not get down the stairs. They were concerned about his demeanour; '*a picture of depression, hopelessness like he had come out of concentration camp. No aggression, frustration, all internal, withdrawn, given up'*. Adult A was in constant need of reassurance that Betty was driving behind the ambulance in her car and appeared to be extremely regretful for having lived with Betty and not declaring it. Betty was described as being concerned about Adult A being suicidal.

5.15. The review has established that none of the professionals who had contact with Betty, as part of their dealings with Adult A, felt any need or trigger to see Betty alone (this included Adult A's GP and the Liaison Team).

5.16. The criminal investigation established that Adult A was a very active man and neighbours referred to him as a 'fitness fanatic' who would run or bike most days. There was a considerable amount of gym and fitness equipment in the flat. The review has considered whether he could have potentially been anxious about his weight gain hence not taking prescribed medication.

6. Analysis (Terms of Reference)

6.1. The police response to the neighbour's 999 call on 20th December 2017 does not appear to have been timely. Did this apparent lack of timeliness contribute to Betty's death? Were there any other issues in relation to timeliness of response by agencies in this case?

As a result of the apparent lack of timeliness of the police response and any impact that this may have had, the incident was referred to the Independent Office for Police Conduct (IOPC) and South Yorkshire Police Professional Standards Department. A full investigation commenced and was concluded during April 2018. The findings report that the South Yorkshire Police response to the reported incident did not contribute to either the death of Betty or the self-inflicted injuries to Adult A. The available evidence suggests that Betty died prior to the police being contacted on the 20th December 2017. A disturbance and screams from Betty had been heard over 13 hours prior to the incident first being reported to police.

The timeliness of the response by the Community Mental Health Team following the GP's referral(s) for Adult A is discussed below.

6.2. It is apparent that there was deterioration in Adult A's mental health. Did agencies consider what impact this may have on his relationship with Betty? Was Adult A assessed appropriately under the Mental Health Act?

The IAPT intervention ceased at a point when Adult A was mentally very unwell. The agency IMR states that IAPT cease their involvement once a need for secondary mental health services has been identified as IAPT practitioners are not trained to manage complex presentations. However, this therefore means that there is a gap in service delivery. Consideration should be given to continuing established IAPT interventions until secondary mental health services have become actively involved. If this isn't achievable, the gap in service delivery is essentially 'held' by the GP, although the likelihood is that it would be for the patient to present to the GP to request interim support.

The GP referrals made to the CMHT were not processed smoothly. The first referral was triaged with a plan to contact Adult A the following day, although this did not happen. There is no known reason why this did not take place as it is clearly documented in the notes. The agency concludes that this was due to the backlog of the previous day. The Duty Worker did not see the GP's second referral, although the reason for this is unknown. It is evident that the two referrals were not linked, possibly due to two different administration workers taking the referrals and not linking the two on the electronic referral system.

This meant that the second referral was not seen at any point by a clinician. Within the agency's IMR it is stated that had the second referral been seen then the degree of urgency of response would not have followed the Scheduled Care Pathway; which is one where an appointment is offered. The only alternative pathway is the Acute Care Crisis and Urgent Care Pathway, where an individual is seen within 4 hours or 24 hours which, if followed, may have resulted in an assessment and prevented Adult A's attendance at A&E in crisis on 18th December 2017.

At the time of the incident, the CMHT service was being reconfigured and during this transition period new systems and processes were being mobilised at the same time as inheriting a number of routine outstanding assessments from the previous service structure. Standard Operating Procedures were in place and had been reviewed at the service away day on 12th

December 2017, however, these were new to all staff and as a result there was a feeling of staff anxiety in the service.

Referrals triaged as being crisis and urgent were being prioritised. At the time of the incident it was difficult to predict how long a routine assessment appointment would have taken to be processed and offered to Adult A. The agency IMR states that the Trust should have a process in place where major service design does not compromise service user care.

Regardless of the service changes occurring, it is still not clear why the referral(s) were assessed as routine given the clear concerns of the GP and her assessment of the urgency required. Although Adult A's notes were viewed by the Duty Worker, it is clear that during his final IAPT session he scored highly for suicidal ideation, having disclosed an attempt to end his life 3 days earlier, so the rationale for a routine response is difficult to understand. There was no follow-up conversation held with the GP to provide a clearer picture and verify decisions. Had there been so then the CMHT worker would have been aware of the fact that there were two referrals made by the GP. As the pathway had been determined by the CMHT Duty Worker, i.e. a routine response, this meant that no immediate appointment was offered, and Adult A's case was added to a waiting list. In the circumstances and based on the information in the second referral, the Acute Care Pathway would have been appropriate and this would have meant that Adult A was seen that day or within 24 hours.

On 19th December 2017, the day which is believed to be when Betty died, she was spoken to on the telephone by the CMHT worker and stated that Adult A had had 'another episode'. Had this been explored, this could have led to an urgent response that day or within 24 hours or a referral to the Out-of-Hours service to provide additional support. This could have led to further telephone contact, an over the phone assessment and a decision made regarding whether Adult A needed to be seen. It is reported in the agency IMR that the brevity of the telephone conversation was in the context of the working environment and that the worker had said that she probably felt rushed so did not explore what the other episode was.

Adult A was assessed by the Liaison Team in A&E late on 18th December 2018. The assessment did not indicate the need for an admission either formally or informally (voluntarily), therefore an assessment under the Mental Health Act was not relevant.

With regard to the impact of Adult A's deteriorating mental health upon Betty, there appeared to be little exploration of this. As part of this review the crisis assessment documents completed for Adult A on 18th December 2017 have been submitted, and has sections for the assessed level of risk of harm to others and risk to dependents. No risk was identified.

It is clear from this review that there was minimal information held by agencies in respect of Betty and Adult A and even less so with regard to them as a couple. There is no record of any professional concern in relation to domestic abuse. All professionals who came into contact with the couple did not have reason to be concerned about Betty's safety. Her daughter did not believe her to be at risk of harm.

Betty was never seen alone by professionals who came into contact with her as Adult A's mental health declined. The review panel have considered whether this was due to a lack of professional curiosity or an over estimation of Betty's capabilities or even coercive control being a feature of the couple's relationship. There has been no evidence from this review, either from agency records or from practitioners themselves, to indicate that coercive control was a factor or that there were indicators of risk of domestic abuse that went without identification.

The review panel have explored the use of routine enquiries with regard to domestic abuse, and a pilot has been completed within GP practices which is a positive development. Selective enquiries are used in A&E rather than routine enquiries due to the impact upon capacity within busy emergency departments. Although this is understandable, consideration should be given to selective enquires being made in cases of presenting acute mental illness, for the patient and for any partner accompanying them.

6.3. **It appears that Betty was acting as a carer for Adult A. Were caring responsibilities recognised and responded to appropriately?**

There was little professional knowledge of Betty's relationship with Adult A until he became unwell in the months leading up to Betty's death. Betty held a tenancy with Sheffield City Council and was a sole tenant, with no other occupant listed. Neither Betty nor Adult A disclosed to agencies that they were living together, which is very likely to have been due to separate benefit claims. The Neighbourhood Housing Officer was aware that Adult A was living at the property although this was not discussed with Betty, and Betty never asked that Adult A be added as an occupant to the household.

Tenants are made aware on their Housing Benefit Claim that they must disclose a change in circumstances immediately to the Local Authority Benefits Service (Sheffield Benefits Service). Likewise claimants of DWP benefits are made aware as part of the claim that they must disclose a change in circumstances immediately to the DWP. Where Sheffield Benefits Service is aware of a change in circumstances they share this information with the DWP, and vice versa. When the Housing Service is made aware by the tenant that a new occupant(s) has moved into the property, housing management systems must be updated with occupant(s) details and, if the tenant is in receipt of benefit, the Sheffield Benefits Service should be informed. The tenant should also be advised to contact the relevant agencies regarding their change in circumstances. This did not happen in this case as the Neighbourhood Housing Officer did not have any direct communication with Betty about Adult A.

It is evident that a number of agencies became aware of Betty's caring responsibilities as Adult A's mental health deteriorated. She accompanied him to GP appointments, his final IAPT session, to A&E and was the nominated telephone contact. There is no evidence to suggest that agencies discussed with her what her caring responsibilities entailed or whether a referral for a carer's assessment would be appropriate. Practitioners who have participated in this review commented on Betty not displaying signs of carer stress, being a competent woman and, in the opinion of the GP for Adult A, there was no suggestion of the need for a carer's assessment. It is the view of the review panel that carer's assessments should be offered regardless of the perception of need and/or carer stress.

Once Adult A had been accepted by secondary mental health services, Betty may have been offered a carer's assessment.

Given Betty's assessment for disability benefits, supported by GP letters, where it is clearly stated that she had care needs of her own, it is difficult to understand how well equipped she might have been to manage the responsibility of care for Adult A, although in theory a person with a disability in receipt of disability benefits can also be a carer for someone else. There is reference to Betty having a carer herself (Adult B) within her benefit claims and appeals but this individual does not feature in agency records and was not known to the Sheffield Carers Centre. Betty's daughter described Betty having physical disabilities but there is no sense from her or from the professionals who have contributed to his review that Betty had any degree of learning needs, or care needs, other than that which she self-reported to the CAB worker.

Locally in Sheffield, in 3 recent Domestic Homicide Reviews (including this one) and one serious case review, the person affected was a carer. Agencies working with the person had not recognised the person was a carer or then referred to support. As part of the reviews of these incidents, it has been highlighted that there is a need for a better understanding of carers by services and agencies working with domestic abuse cases. Actions to be taken include carer awareness raising sessions and a review of referral guidance. On 18th June 2018, a letter was sent by the Sheffield Domestic Abuse Coordination Team to all partner agencies asking them to ensure that all staff are aware of the need to identify carers and signpost / refer to the Sheffield Carer's Centre for support which includes carer specific information and advice.

The Sheffield City Council 'Young Carer, Parent and Adult Carer Strategy 2016-2020' states clearly that if organisations do not continue to champion carers' and enable them to continue to care it can have far reaching consequences for the carer and for the person being cared for, i.e. poor mental and physical health, financially and / or socially excluded, being subject to or perpetrating abuse. These would appear to be relevant factors for Betty and Adult A.

6.4. **It is suggested that Betty may have asked Adult A to move out of her flat as a result of financial concerns. Were agencies aware of this? Was separation considered as a possible risk factor?**

There is nothing within agency records, or the reflections and knowledge of the practitioners involved, to suggest that Betty asked Adult A to move out of her flat. The fact that they were living together and had not declared this was known to be a significant stressor for Adult A but Betty was observed to reassure him that this was resolved. The compliance interview accepted her account that they were not living together. Whether she intended to ask him to leave is not known.

Adult A disclosed during a police interview on 22nd December 2017 that Betty had stated on the night of the murder that the relationship was over. It must be noted however that Adult A has been deemed to have been mentally unwell at the time of the murder and remains so to date.

6.5. **Betty appears to have been using Methadone – were agencies aware of this? If so, what was the response?**

There is only one record of Methadone use by Betty held within the GP records. There is no exploration of this. Betty was not known to drugs services.

It is clear however that there was a usage of Diazepam by Betty and Adult A which was not explored in any depth, particularly with Betty who was not offered talking therapies.

6.6. **Was there appropriate information sharing between agencies?**

There are a number of opportunities within this case where communication could have been improved.

It is known that the Neighbourhood Housing Officer was told by the third party that Adult A was residing with Betty. There was no discussion around this with Betty which might have been helpful.

There was no direct communication between the IAPT worker and the GP, nor between the CMHT and the GP. The former meant that once the IAPT worker discharged Adult A, he was without services pending the CMHT referral being processed. The latter was particularly significant given that the CMHT triaged the GP referral for Adult A on the basis of one referral and did not provide any clinical response to the GPs second referral. Communication with the GP could have clarified concerns and agreed an appropriate response, and in all likelihood determined that the Acute Care Pathway was appropriate.

In addition, communication between the GP for Adult A and the GP for Betty would have been beneficial. Adult A's GP was having direct contact with Betty so a dialogue with her GP might have ensured that support was offered to her in her own right.

6.7. **Were any issues of disability, diversity, culture or identity relevant?**

The review panel have considered this and feel that the issue of disability is relevant within this case. Betty described herself as having a Learning Disability but she was not on the Learning Disability Case Register and was not in receipt of any support services. When she signed for her tenancy she did not indicate that she had any support needs. What is unclear is the level of her reported disability and whether Adult A's level of care needs led to stress within their relationship. That said, all professionals who had contact with the couple described them in positive terms and had no reason to be concerned from their presentation.

The risk of welfare benefits being stopped and reassessed and the fear of benefit sanctions appear to have directly contributed to Adult A's levels of stress and worsening mental health. The evidence available would suggest that the couple purposefully kept the fact that they lived together hidden from agencies. The impact of poverty and financial stress and, in the case of Adult A, the associated shame of this are, relevant factors in this case. There is a well-documented link between debt, financial crisis and both suicidal ideation and completed suicides. Analysis of the British Adult Psychiatric Morbidity Survey by Meltzer et al (2011) demonstrated that those who have had a "major financial crisis" in the past six months are nearly eight times as likely to experience suicidal thoughts than those who have not.

The review panel have considered the issue of economic abuse but have not felt there to be any evidence of this.

The review panel has also considered that for both Betty and Adult A Adverse Childhood Experiences (ACE) are relevant. This is where early childhood trauma is linked to poor life outcomes on a range of indicators: 'Exposure [to identified] ACEs has been associated with poor health outcomes including substance use, mental ill-health, obesity, heart disease and cancer, as well as unemployment and continued involvement in violence [and] the impact of ACEs appears to be cumulative, with risks of poor outcomes increasing with the number of ACEs suffered' (Bellis 2013).

Locally in Sheffield, there is a commitment to a better understanding of ACEs and in developing interventions that reduce the risk factors in vulnerable families[3], with a work stream starting in 2019.

[3] https://www.sheffield.gov.uk/content/dam/sheffield/docs/public-health/health-wellbeing/Director%20of%20Public%20Health%20Report%202017.pdf

7. Conclusions and lessons learned

7.1. Betty and Adult A had an enduring relationship, lasting approximately 14 years. There was no evidence of or reported concerns regarding domestic abuse. This review has not established any information to suggest that Betty was experiencing domestic abuse from Adult A. However there is no evidence to suggest that any professionals asked Betty whether domestic abuse was a feature in her life. Betty and Adult A also did not wish for agencies to know that they were living together, and it is most likely that this was due to fear of sanctions being imposed with regard to their welfare benefit claims. This was a significant stressor for Adult A.

7.2. Adult A's mental health deteriorated significantly and with some speed. His GP responded effectively and made urgent referrals to the Community Mental Health Team. These referrals were not processed effectively and as a result the urgency of the situation was not appreciated. That said, even if the acute pathway had been followed, this would have led to an earlier assessment and not Adult A's detention under the Mental Health Act given what was established from his subsequent presentation in A&E.

7.3. There was no assessment of Betty's support needs as a carer for Adult A. This was based on the fact that all professionals who came into contact with the couple as Adult A's mental health deteriorated believed Betty to be a capable carer.

7.4. In addition, there was no explicit assessment of any risk that Adult A might pose to Betty. This was due to there being no indication that Adult A posed a risk of harm to anyone other than himself. Due to this Betty's death could not have been predicted.

7.5. This is an extremely tragic case, where a woman who was well liked and who cared greatly for her partner was killed whilst he was experiencing significant mental health issues. He had been assessed following presentation at the Accident and Emergency Department on 18th December 2017 which is likely to have been the day before Betty's death. The assessment did not indicate that the threshold was met for admission under the Mental Health Act and as such this review has determined that sadly her death was not preventable.

7.6. There are areas however where practice could be improved and these form the basis of the recommendations of this review.

8. Overview Recommendations

All agency IMR recommendations are submitted as an appendix to this Review.

The overview recommendations are as follows:

a) in cases of ongoing mental ill-health, good practice would be for a patient to be seen by the same General Practitioner
b) in cases of ongoing low mood, and misuse of medication, talking therapies should always be offered by the General Practitioner
c) when early intervention mental health services cease once a need for secondary mental health services is identified, consideration needs to be given to what will 'bridge the gap'.
d) the Sheffield Safer and Sustainable Communities Partnership to seek assurance from SHSC NHS Foundation Trust with regard to the following:

- future service redesign safeguards against any adverse impact upon service delivery
- timely and robust processes for referrals made to CMHT which incorporates the learning from this DHR

e) Consideration should be given to selective domestic abuse enquires being made in cases of presenting acute mental illness within A&E, for the patient and for any partner accompanying them.
f) For the use of routine domestic abuse enquiries to be rolled out within all GP practices within Sheffield.
g) Ongoing priority is given to the need for a better understanding of carers, their needs and vulnerabilities and referral routes. Best practice would be for people who are identified as carers to be routinely offered signposting or referral for a carers assessment and to be seen alone.
h) For the Sheffield City Council Public Health ACE workstream to consider the learning from this DHR
i) For the SSSCP to explore options for promoting local community awareness of domestic abuse and neighbourhood watch initiatives.

Appendix A – Terms of Reference

Specific Terms of Reference for Consideration by the Betty Domestic Homicide Review

The Domestic Homicide Review will be conducted according to best practice, with effective analysis of the information related to the case.

The purpose of the Domestic Homicide Review is to:

Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

- 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 including their dependent children.

- 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

- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

In addition the following areas will be addressed in the Internal Management Reviews and the Overview Report:

- The Police response to the neighbours 999 call on 20th December 2017 does not appear to have been timely. Did this apparent lack of timeliness contribute to Betty's death? Were there any other issues in relation to timeliness of response by agencies in this case?
- It is apparent that there was deterioration in Adult A's mental health. Did agencies consider what impact this may have on his relationship with Betty? Was Adult A assessed appropriately under the Mental Health Act?
- It appears that Betty was acting as a carer for Adult A. Were caring responsibilities recognised and responded to appropriately?
- It is suggested that Betty may have asked Adult A to move out of her flat as a result of financial concerns. Were agencies aware of this? Was separation considered as a possible risk factor?
- Betty appears to have been using methadone – were agencies aware of this? If so what was the response?
- Was there appropriate information sharing between agencies?

<u>Any obvious failings identified</u>

- It appears SHSC did not document whether Adult A had been considered under the Mental Health Capacity Act.
- SYP have referred themselves to the IPCC regarding the delay in responding to the call on 20th December.

Similarities with other domestic homicides – in Sheffield or elsewhere

- Mental health issues of both perpetrator and victim
- Murder was possibly at point of separation
- Victim appears to have been an unidentified carer for perpetrator

Any other issues and information

- Both had mental health issues
- Betty was a social housing tenant

Equality and Diversity

- The Review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim and perpetrator.
- Both subjects were white British – no diversity issues identified

The review will consider any other information that is found to be relevant.

Time period

Adult A went to Citizens Advice Bureau as homeless in Jan 2017 – could be start of the couples' separation. Start date of 12 months before homicide - **20/12/2016.** Provisional end date of **23/12/2017** when adult A was imprisoned, anything further to be informed by disclosures made at criminal trial and agreed by panel.

Agencies required to contribute

- South Yorkshire Police
- Dept for Work & Pensions – Job Centre Plus
- Sheffield Clinical Commissioning Group – GPs
- Sheffield Health & Social Care NHS FT
- Sheffield Teaching Hospitals NHS FT – A & E
- Sheffield Council Housing Service
- Yorkshire Ambulance Service

Possibly required (more information to be sought):

- SCC Housing Solutions
- Opiates Service - SHSC
- Citizens Advice Bureau

Family members, friends, colleagues and employers

- Betty's family – brother, sister, son and daughter will be asked to contribute.
- The alleged perpetrator will be asked for consent and the chair & DHR co-ordinator will consider if he should be asked to contribute.

Interviews with family will be conducted by the chair & DHR co-ordinator, via the Police Family Liaison Officer.

Appendix B

Individual Management Report Recommendations

Sheffield Clinical Commissioning Group

1. Sheffield CCG to influence GPs to enquire about domestic abuse and substance misuse every time that a patient presents with mental health issues.
2. Sheffield CCG to encourage GPs to assess the risk of harm to others from those who have disclosed self-harm thoughts.
3. Sheffield CCG to influence GPs to recognise that those supporting people with mental health diagnoses are informal carers and should be offered support. The CCG will encourage GPs to document regular enquires about their patients care needs and caring responsibilities.
4. Sheffield CCG to encourage GPs to consider sharing information about caring responsibilities (and any potential risks to the carer) for patients who are being referred for Psychiatric assessments. If the carer is registered with a different GP practice then this could be done either with the patient's consent or without disclosing the potential perpetrator's details.
5. In cases of ongoing mental ill-health, good practice would be for a patient to be seen by the same General Practitioner.
6. In cases of ongoing low mood, and misuse of medication, talking therapies should always be offered by the General Practitioner.
7. The use of routine domestic abuse enquiries to be rolled out within all GP practices within Sheffield.

Sheffield Health and Social Care NHS Trust

1. When early intervention mental health services cease once a need for secondary mental health services is identified, consideration needs to be given to what will 'bridge the gap'.
2. Consideration should be given to selective domestic abuse enquires being made in cases of presenting acute mental illness within Liaison, for the patient and for any partner accompanying them.

Sheffield Community Safety Partnership

1. The Sheffield Safer and Sustainable Communities Partnership to seek assurance from SHSC NHS Foundation Trust with regard to the following:
    - future service redesign safeguards against any adverse impact upon service delivery
    - timely and robust processes for referrals made to CMHT which incorporates the learning from this DHR.
2. For the Sheffield City Council Public Health ACE workstream to consider the learning from this DHR
3. For the SSSCP to explore options for promoting local community awareness of domestic abuse and neighbourhood watch initiatives.

Sheffield Teaching Hospitals NHS Foundation Trust

1. Consideration should be given to selective domestic abuse enquires being made in cases of presenting acute mental illness within A&E, for the patient and for any partner accompanying them.