Leeds Safer Communities Partnership DHR 'I'

Overview Report

Chair & Independent Author

Steve Appleton
Managing Director
Contact Consulting (Oxford) Ltd

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Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected deaths of SL and RL on [redacted] 2014.

The DHR was commissioned by the Community Safety Partnership of Leeds City Council. At 21.57 on [redacted] 2014 RL contacted North Yorkshire Police via 101 on a mobile phone. He stated that he had committed a murder, his wife SL (sometimes known as LL) had been killed and she was at their home address in Leeds. RL refused to say how he committed the offence. He explained that he had left a holdall at Leeds train station which contained keys to their house and he provided the alarm code for the address. When questioned about his whereabouts he hung up.

At 22.22 Officers from West Yorkshire Police attended SL and RL's address in Leeds and forced entry. In the main bedroom the officers found the body of SL. She had severe injuries to the back of her head and was pronounced deceased at the scene by Paramedics. Two notes were located at the scene, a handwritten note addressed to LL and a typed note titled "confession and request". Both notes are apparently from RL.

Police attempted to locate RL. Telephone enquiries indicated that RL was in the [redacted] area of North Yorkshire. At 02.15 on [redacted] 2014 North Yorkshire Police Officers, discovered a body at [redacted]. The deceased was identified as RL.

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'*

Case Review

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 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.

Initial scoping took place during [redacted] 2014 and the first review panel was held in November 2014, following the appointment of an independent chair who is also the author of the Overview Report. Subsequent panel meetings were held in February and May 2015. This report was approved by the DHR panel prior to its submission to the Home Office.

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
Caroline Ablett	Leeds Teaching Hospitals
Luke Turnbull	NHS South and East Clinical Commissioning Group / NHS England North of England Regional Team
Richard Hattersley	LYPFT
Chris Maddison	Leeds Community Health
Elizabeth Ward	Leeds Adult Safeguarding Board
Madeleine Edwards	Housing Leeds

The Overview Report author

The independent chair and 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 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

SL (also known as LL)

White British female
Date of Birth [redacted]
Date of Death [redacted]/2014
Deceased was wife of RL

RL

White British male
Date of Birth [redacted]
Date of Death [redacted]/2014
Husband of SL

Family members

HM	Daughter of SL
SS	Daughter of SL

1.5 Terms of reference

The Terms of Reference were developed and agreed by the Review Panel and are set out below. Each agency IMR was required to follow these Terms of Reference.

1. Each agency's involvement with SL and RL between 1st March/May 2012 and [redacted] 2014. In addition, each agency should include any relevant events prior to 1st March/May 2012 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.

2. Whether, in relation to SL and RL, an improvement in any of the following might have led to a different outcome for SL:

   a. Communication between services
   b. Information sharing between services with regard to, care, treatment and support
   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,

4. The response of the relevant agencies to any referrals relating to SL and RL concerning domestic abuse, care, treatment and support (including emotional abuse and controlling behaviour) or other significant harm from 1st March/1st May 2012, 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 RL and SL

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 RL or SL were explored, shared appropriately and recorded.

6. Whether if there were issues, were the issues appropriately escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.

7. Whether organisations were aware of organisational change and if there was, did it have any impact over the period covered by the review. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively?

Adults at Risk 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 SL which would improve safeguarding practice in relation to domestic violence 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 SL and RL.

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 SL and RL.

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 SL and RL as well as summary reports and scoping information. 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
- West Yorkshire Police

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 SL and RL 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 and the action plan are accepted by the Community Safety Partnership.

1.9 Involvement with the family

The panel has sought to engage with family members. The panel wrote to HM and SS, the daughters of SL to advise them of the review and the chair also wrote to establish whether they wished to contribute to the process. No response was received from HM or SS. The chair also attempted to contact a family friend, a local minster of religion, but again no response was received.

[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

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 SL and RL. The report examines agency responses to and support given to the couple prior to the incident on [redacted] 2014.

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

- General Practitioner - primary care
- Leeds & York Partnership NHS Foundation Trust
- West Yorkshire Police

During the scoping process, contact was made with local housing services to establish their contact with the couple. This information has been incorporated into evidence gathered during the work of the panel.

None of the couple's contacts with the agencies prior to the incident were associated with a referral or subsequent assessment and case management associated with 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 SL or RL 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

SL and RL was a married couple who lived together in the northern area of Leeds.

At 21.57 on [redacted] 2014 RL contacted North Yorkshire Police via 101 on a mobile phone. He stated that he had committed a murder, his wife SL (sometimes known as LL) had been killed and she was at their home address in Leeds. RL refused to say how he committed the offence. He explained that he had left a holdall at Leeds train station which contained keys to their house and he provided the alarm code for the address. When questioned about his whereabouts he hung up.

At 22.22 Officers from West Yorkshire Police attended SL and RL's address in north Leeds and forced entry. In the main bedroom the officers found the body of SL. She had severe injuries to the back of her head and was pronounced deceased at the scene by Paramedics. Two notes were located at the scene, a handwritten note addressed to LL and a typed note titled "confession and request". Both notes are apparently from RL.

Police attempted to locate RL. Telephone enquiries indicated that RL was in the Gargrave area of North Yorkshire. At 02.15 on [redacted] 2014 North Yorkshire Police Officers, discovered a body at [redacted]. The deceased was identified as RL.

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 SL and RL, 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:

"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.

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

[4] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.

2.2.1 West Yorkshire Police (WYP)

West Yorkshire Police serve approximately 2.2 million people living in one of the five metropolitan districts of Bradford, Calderdale, Kirklees, Leeds and Wakefield. The area is policed by around 4,000 police officers and 3,600 support staff, including Police Community Support Officers. This makes the Force the fourth largest in the country.

WYP had a history of contact with and in relation to RL and SL:

On 2th March 2012 the police received a telephone call from a colleague of RL who stated that RL had employed him as an accountant and that RL owed him some money. The colleague had received two text messages from RL in which he had threatened to take his own life. The colleague provided an address and mobile phone number for RL and said that he believed the threats of suicide related to money concerns. Police officers attended the home of RL and spoke with him and SL. RL stated he had sent a 'random text' and that SL would keep an eye on him and sort out an appointment with his GP over the forthcoming weekend. No further action was taken by the Police.

On 24th August 2012 RL was arrested for criminal damage after he was observed by Police Officers kicking and damaging a public telephone box. RL spent time in WYP custody as a result of his arrest for criminal damage. He did not wish anyone to be notified of his arrest and declined to speak to a solicitor. During questioning the Police asked RL specific questions relating to his mental health during which he confirmed that he had once attempted self-harm. He also confirmed that he was taking medication, specifically Lansoprazole, which belongs to a group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach. It is used to treat and prevent stomach and intestinal ulcers. SL telephoned the Police asking if RL was with them and they confirmed he was and the reasons for his detention. She asked that RL be told of her call. RL was also seen in custody by a nurse and confirmed his one incident of self-harm some 30 years previously. He also stated that he was bankrupt. The nurse advised RL to see his GP on release. He was also referred to the mental health crisis service.

SL contacted the Police again on 24th August 2012 and reported that RL had left answerphone greetings on his mobile phone voicemail service stating "by the time you hear this I will be dead" These messages were corroborated by custody suite staff. SL stated her concerns about RL's mental health and said he was acting out of character.

RL was subsequently assessed as fit to be interviewed and it was agreed that the mental health crisis service would be contacted.

It was determined that RL would be bailed but given his mental state it was decided that the mental health crisis team would assess him while still in custody. Although reluctant to be assessed he did confirm that he was low in mood, did have suicidal ideation while intoxicated the previous night but denied feeling suicidal at the point of interview. He also stated that he had support from a private counsellor.

No further intervention was deemed necessary from the mental health crisis service and the Police believed RL to be able to leave custody on bail to return on 28th September 2012.

On 29th August 2012 at 23.06 SL reported RL as missing. She told Police that RL had gone for a meeting with his counsellor at 19.00, he normally returned two hours after the appointment but had not returned on this occasion. The police attempted to contact RL using mobile phone numbers SL provided. The Police re-contacted SL at 23.50 to advise of their actions. At 23.53 SL contacted the Police to advise that RL had returned home.

On 6th September 2012 SL was recorded by WYP as the complainant in a harassment warning issued to a former employee of RL. The calls were demanding £1,000 and SL reported that this person had been making threats since the start of the year. Although the Police had not been involved up to this point, SL believed the threats were now more serious and she was frightened. The former employee had apparently been to the couples' home and been abusive, including standing in their garden and shouting. SL said they did not owe him money but she was worried by the threat. A harassment warning was issued to the former employee but he refused to sign the warning notice.

On 28th September RL answered bail during which time he confirmed that he was suffering from depression and was awaiting an assessment. RL was charged and bailed to attend Leeds Magistrates Court on 11th October 2012.

On 11th October 2012 RL was convicted of criminal damage and was sentenced to a conditional discharge for six months and ordered to pay compensation of £126.66.

On 27/03/2014 SL reported to the Police that she had been receiving emails from a former employee demanding money that was owed to him. RL had received a text from the former employee stating that he knew where he worked and wanted money. This was the same former employee who was subject of the harassment warning on 6th September 2012. At SL's request, the Police Officer who attended and spoke to SL in relation to the former employee, attended at the ex-employee's address and advised/warned him to cease contacting SL and RL directly.

This was the last contact from WYP before the date of the incident, when they attended the couples' home and found SL deceased and later that day found RL deceased at [redacted]

Analysis of WYP involvement and lessons learned

The IMR describes a number of contacts between SL and RL, during 2012 and then in early 2014. These related principally to RLs arrest (and subsequent conviction) for criminal damage. Throughout those contacts WYP report no evidence of any incidence of domestic abuse or domestic violence.

During his time in Police custody RL was assessed by a Nurse, provided by SERCO who are contracted to deliver healthcare services. The treatment and support offered to RL whilst in police custody was appropriate and fully compliant with Approved Professional Practice (APP) and PACE 1984 Code C[5].

As part of the IMR process, WYP reviewed all internal management reports and these were also submitted to the Force's Professional Standards Department to ensure that all Police action is scrutinised for compliance with the Force standards of professional behaviour under the Police Conduct Regulations 2012. There were no concerns identified regarding any WYP contact, action or response in relation to SL or RL.

When RL entered into police custody on 24th August 2012 after being arrested for criminal damage, SL provided information relating to RL's mental health status and suicidal idealisation. This information provided a key opportunity for RL's mental health status to be assessed and resulted in the referral to the mental health Crisis Team. RL was also signposted to his GP by the SERCO nurse during his fit to detain and fit to interview assessments. This was appropriate good practice and in line with WYP protocols.

WYP conducted appropriate risk assessments of RL and paid particular attention to his mental health, given his expressed recent suicidal ideation when intoxicated, his prior incident of self harm (albeit 30 years previously) and recorded these in line with Police standard protocol. No risk assessments were conducted by WYP in relation to their contacts with SL.

In relation to the harassment of SL and RL, WYP took appropriate action in response to the allegations made by SL and RL.

[5] POLICE AND CRIMINAL EVIDENCE ACT 1984 (PACE) CODE C REVISED CODE OF PRACTICE FOR THE DETENTION, TREATMENT AND QUESTIONING OF PERSONS BY POLICE OFFICERS

During his time in custody, WYP ensured that information relating to his detention was communicated with SL and information about his wellbeing was shared with health professionals who were contacted in response to concerns about his mental state.

The IMR describes WYP's current policy and procedure in relation to responses to incidents of domestic abuse or violence. These policies and procedures have been updated since the incident, though not in direct response to it.

The IMR does not identify any lessons learned from review of contacts between SL and RL with WYP. No recommendations for action have been made

2.2.2 NHS England – General Practice

The NHS 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 Teams) who manage 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 NHS England Regional Teams.

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.[6]

Both RL and SL were registered at North Leeds Medical Practice with the same allocated GP, GP 1.

Contact with RL:

On 24 August 2012 RL was seen by GP 2. RL stated that he was depressed and said that 'he had been like this all of his life'. He stated that he wanted to leave his wife, his business had collapsed and he had been declared bankrupt. He was now setting up an accountancy business. He explained that he had poor concentration, and was sleeping and eating a lot. The previous evening RL said he was drinking and wanted to commit suicide by jumping into a lake. He then had blank memories and was picked up by the police (in relation to an incident of criminal damage). He explained that he regularly saw a private counsellor.

GP 2 and RL had a long conversation and RL's records state *"not keen on anti-depressants or Crisis Teams. Eventually agreed for me to phone them."* The notes record that RL had a moderate depression, which according to NICE Guidance could be treated with anti-depressants or by non-pharmacological methods such as counselling. It is clear that the GP did manage to convince RL to be referred to the Crisis Team. Later that day, GP 2 spoke to the Crisis Team.

On the 28 August 2012 GP 2 had a telephone consultation with SL who stated that RL was feeling calmer and was now receptive to the idea of treatment.

[6] Sheffield DHR Overview Report, Cantrill, Prof. Pat December 2011

RL had an appointment with GP 2 on 30 August 2012 when he seemed much brighter and had no suicidal intent. The PCMHT (Primary Care Mental Health Team) had been in touch to offer an assessment.

On 14 September 2012, RL had a further appointment with GP 2. He reported that he was continuing to do well and had no thoughts of self-harm. His records state that his PCMHT appointment was delayed until October and he was wondering whether he should still go. The GP records do not state why the appointment was delayed or the identity of the individual who requested the delay.

On 15 October 2012, correspondence in the GP records shows that PCMHT screened RL. The results were sent to the Practice in a letter dated 1 November 2012. The letter states:

"Thank you for your referral of this pleasant gentleman who presented with mainly symptoms of low mood and some anxiety symptoms. He also said he was currently seeing a counsellor named 'Pat'. After some thought RL decided to continue seeing his counsellor as he feels he is 'making some progress' so has been discharged back to your care. He knows this does not preclude him form (sic) accessing our service in the future should the need arise.

Additionally, RL had some questions regarding psychotropic medication so he was given some psychoeducation and a leaflet on this".

RL was seen by GP 2 on 18 October 2012. The record of this consultation states:

Doing really well, saw PCMHT, thought any CBT may conflict with current counselling. Finding it helpful, tackling past issues. Will cont. (sic) counseling"

On 13 January 2013, RL saw GP 2 as he had had blood in his sperm on a couple of occasions. He stated that it had now all settled and there was no increased urinary frequency but experienced some lower abdominal discomfort.

On 23 January 2013, RL's notes refer to two consultations, the first at 9.37 with GP 3 and the second with GP 4 at 10.34. It is not clear from the records why two GP's were involved in RL's care that day. However, given that the notes made by GP 3 do not include reference to an examination but include reference to the plan for treatment being an appointment, it is possible that the earlier consultation was in fact a telephone consultation.

The consultations both concern the same event, which was the fact that RL had experienced a strange sensory disturbance when his arms did not feel that they belonged to him and headaches. The possible diagnoses considered by GP 4 were migraine or Transient Ischaemic Attack.

RL also had an irregular pulse therefore a further possible cause may have been atrial fibrillation. Atrial fibrillation can cause Transient Ischaemic Attack. GP 4 discussed RL's history with PCAL (Primary Care Access Line) and he was sent to Leeds General Infirmary for an ECG (echocardiogram) and cardiology review. This is an appropriate response by RL's GP. RL was admitted to Leeds General Infirmary with atrial fibrillation.

On 24 January 2013, RL had an appointment with GP 2 and saw GP 1 on 25 January 2013.

The GP records contain an incomplete PHQ-9 Depression screening form[7] which is date stamped 26 January 2013. Question 9 on the form, 'Thoughts that you would be better off dead or of hurting yourself in some way' is given the highest score, 3, meaning 'nearly every day'. The IMR Author was unable to speak to the GP who requested the PHQ-9. However it must be assumed that this was a missed opportunity given that RL was experiencing thoughts of 'being better off dead' or 'hurting himself…' 'nearly every day'.

On 14 February 2013, GP 2 saw RL following his recent admission with atrial fibrillation. RL declined to be prescribed warfarin as he felt that he didn't want to have warfarin around with the temptation of taking an overdose. RL did not have any current thoughts of suicide and said he would contact the Crisis Team if he did.

On 21 June 2013, after noting minor irregularities in his liver function test, RL was referred for an MRI scan of his pelvis and asked to arrange a follow up appointment when the results of the scan were received. RL's GP suspected a fatty liver. The subsequent ultrasound scan revealed that he had a fatty liver.

RL saw GP 2 on 4 July 2013. It is stated that his haematospermia (blood in the sperm) had settled and he wondered whether this could have been an STI (sexually transmitted infection). He had had protected sexual intercourse with a known female partner, who was not his wife but had no discharge or urinary symptoms. A plan was made to complete an STI screen and await urology appointment and results. It is not clear from RL's records whether he was open to a discussion about his extra marital relationship at this time. The IMR states that unless RL had indicated to his GP that he was prepared to discuss this relationship and its potential impact, if any, upon his marriage, then it would have been difficult for his GP to explore this issue.

RL saw GP 2 on 15 October 2013. He took letters with him from cardiology stating he needed an antihypertensive (a medication to reduce blood pressure) in addition

[7] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression

to a beta blocker. During the appointment of 15 October 2013, RL received a prescription for Lisinopril 5mg tablets which is medication to assist with controlling blood pressure.

The final record in the GP notes on 12 February 2014 relates to the completion of paperwork by the GP to Aviva Insurance.

Contact with SL:

SL attended appointments with doctors and nurses at the Practice. The IMR author found that there were no entries or intimations that she was the victim of domestic violence or that she had any particular concerns in regard to her husband's behaviour.

SL attended an appointment with Nurse 1 at the Practice on 13 August 2012. The appointment appears to cover a range of issues, including depression screening, diabetic review, alcohol use and diet. There are no other records related to this appointment.

SL attended another appointment with Nurse 1 on 16 August 2012. The note in her GP records states that she was given lifestyle advice regarding exercise and referred for an exercise programme.

SL had a diabetes review on 19 June 2013. It is stated that her diabetes control was good and that she had been informed that a repeat diabetes review would be necessary in six months time.

SL underwent retinal screening at Leeds Retinal Screening Service on 19 August 2013. The results state that no lesions were found and that no further action was required.

On 29 October 2013 SL attended an appointment with GP 1 to discuss her diabetes blood test results.

SL underwent an ultrasound of her abdomen on 2 December 2013. The scan concluded that she had a fatty liver and it was noted to discuss this with her when she was next seen.

On 13 December 2013, SL had an appointment with GP 1. The notes state that she had decided to stop atorvastatin (medication used to treat high cholesterol and to lower the risk of stroke, heart attack, or other complications in people with type 2 diabetes, coronary heart disease or other risk factors) and she feels like a new woman. SL reported that she was not keen to try any other statins for the time being as she felt so good. It was noted that SL understood she had a high cardiovascular risk and that she should be on one but preferred not to be at the time. It was noted that SL was aware that she had a fatty liver, although there are no other notes detailing what was discussed in relation to her fatty liver. SL's sensitivity to statins was recorded.

Analysis of General Practice involvement and lessons learned

Although there is a record of RL stating that he was seeing a private counsellor, something repeated in the IMRs from LYPFT and WYP, there is no evidence of communication between the GP practice and the counsellor.

It has not been possible to establish the identity or contact details of the counselor. It is therefore not possible to form a judgment about whether communication with the counsellor took place. As the LYPFT IMR states, the mental health services were also unaware of the identity of the counselor. It is not known if this knowledge and potential communication with the counsellor would have had any bearing on treatment options and plans by the GP or other services.

GP services responded appropriately and swiftly in relation to RL and sought to address his physical and mental health concerns at all times.

There is no record of any other family involvement in consultations with the GP practice in relation to either RL or SL.

The IMR makes reference to an incidence of sexual contact between RL and a female who was not his wife. RL did not disclose the detail of this encounter in any detail and the GP did not probe RL for any information about the state of his marital relationship with SL.

The screening of RL's mental health was appropriate and used a recognised tool. The GP practice made appropriate referral to secondary services where they felt this to be necessary. None of the representations indicated the presence of severe mental illness and neither did they indicate any risk to SL in relation to domestic violence or abuse.

The GP practice did not have a Domestic Violence protocol in place at the time of the incident or in the period preceding them. GP1 was aware of the need to alert other agencies if such violence or abuse was suspected.

There is no evidence of any significant risk factors for domestic violence or abuse occurring, which could have been identified as an opportunity for assessment, decision-making and effective intervention in the care, or treatment of RL or SL.

There is an incomplete PHQ-9[8] assessment date stamped 26 January 2013. Best practice would have been for PHQ-9 to have been completed on 14 February 2013. It does not have to be completed in the presence of a health care professional and in certain circumstances a patient may be asked to complete one on a regular basis at home, weekly for example, whilst on a course of treatment. It is not best practice for the tool to remain incomplete but the IMR does state that it is not clear whether full completion would have had any bearing on the events that followed in August 2014.

There is no evidence of any missed opportunities in relation to SL. Her medical conditions were appropriately dealt with according to current accepted practice

The GP practice did not hold a 'Significant Event' meeting following the deaths of RL and SL. The issues were discussed at the Practice Clinical meeting on 27th January 2015. The learning to come from this was that a new process be put in place for the discussion of all deaths at those meetings in future.

The IMR makes one recommendation, which is set out in Section Four.

[8] The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV (Diagnostic and Statistical Manual Fourth Edition - he standard classification of mental disorders used by mental health professionals). This can help track a patients overall depression severity as well as the specific symptoms that are improving or not with treatment*. University of Washington – Psychiatry & Behavioural Science / NHS Choices*

2.2.3 Leeds and 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's involvement with RL was confined to his contact with Crisis Assessment Service (CAS) while he was detained in police custody in August 2012. LYPFT had no contact or involvement with SL.

RL was not detained under S136 of the Mental Health Act[9] but had been arrested following an incident of criminal damage. This meant that mental health services were not involved in a full mental health act assessment. The custody nurse (SERCO) had some concerns about RL's state of mind and was unsure whether he was at risk of self-harm given that when intoxicated RL had said he had suicidal thoughts.

CAS received a telephone call from the custody nurse seeking advice. RL had refused to be assessed (by mental health services) and wanted to be released from police custody. RL had altered his voicemail message so anyone hearing it would hear him threatening suicide. He was heavily intoxicated at the time he changed the outgoing message.

Subsequently RL denied any suicidal thoughts and said he had no intention of harming himself but described social and financial stressors. He said he was being supported by a private counselor, who he described being happy with and wanted no help from mental health services indicating that the counsellor's support was 'enough'.

The plan agreed was for RL to visit his GP the following day (he did so and was accompanied by his wife). Notes suggest the CAS service had a telephone conversation with the GP following RL's visit agreeing that '*there being no further risk at present but she (GP) would like him to be referred to CMHT for assessment in respect of his mental health.*

[9] **Section 136 - Mentally disordered persons found in public places.**
(1) If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135 above.
(2) A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional**]** and of making any necessary arrangements for his treatment or care.
(3) A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.
(4) A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.
Chapter 20 Mental Health Act 1983 (Amended 2007) HMSO

On the same day the CAS requested that the Community Mental Health Team (CMHT) duty worker contact RL to arrange follow up and gather more information. The CMHT duty worker rang RL to discuss follow up.

Clinical notes report '*RL feeling much better, he reports having had a crisis due to a build up of stress that he 'had started drinking and felt suicidal'*. RL said he was 'not now feeling suicidal' following the incident of criminal damage and that this did 'not happen regularly'. He denied any increase in alcohol use and said that drinking to excess was not a regular occurrence.

He said he had started to see a counsellor which he found helpful and was seeing his GP to commence an anti-depressant. RL 'unsure if he wants any further support'.

The plan agreed with RL was:

- RL given contact number for Primary Care Mental Health service. The PCMH (now known as 'IAPT') is a CBT (Cognitive Behavioural Therapy) based service offered in primary care for people suffering from 'lower level' common mental health problems. This was in relation to there being no evidence of mental illness of a severe or enduring nature.
- RL agreed to self refer to the PCMH if he felt he needed 'help' with dealing with his current stressors.
- RL was given crisis telephone numbers including out of hours number.
- No further follow up with CMHT.
- RL would continue to see the counsellor for support.

Analysis of LYPFT involvement and lessons learned

The involvement of LYPFT with RL was limited and centred on advice whilst he was detained in custody and telephone contact with his GP.

A full assessment was not carried out nor agreed to by RL. RL was within his rights to refuse an assessment because he was not detained under the Mental Health Act.

The advice given by LYPFT services was timely and in accordance with professional standards and procedures. The evidence suggests that the CAS and CMHT professionals reviewing the information to hand, made reasonable judgments in relation to offering secondary mental health care. There was no suggestion that RL did not have capacity nor was there any evidence to suggest that he was suffering from serious mental ill health. The advice given and the plan agreed were appropriate and reasonable in the circumstances.

The IMR makes two recommendations which can be found at Section Four.

2.3 Views of the family

The project officer at the Leeds City Council Domestic Violence Team has written to the daughters of SL to advise them of the DHR process. The panel chair has written to the daughters of SL to seek their views and input to the DHR process.

Neither of these approaches has received any response, therefore the panel has not been able to seek their views during the review and the writing of the overview report.

SL was a lay-preacher at a local church. The panel chair attempted to contact the Vicar at the church to see if he would be willing to provide any information. No response was received.

2.4 Other information gathered through scoping

In the course of the review the panel ascertained that on 30 October 2013, the Disciplinary Committee of ACCA (the Association of Chartered Certified Accountants) found allegations proved against RL who was a member of that professional body. The details are as follows:

Allegation 1

Pursuant to by-law 8(a)(viii) RL is liable to disciplinary action in that he failed to satisfy judgment debts ordered against him without reasonable excuse for a period of two months namely:

(a) Northampton County Court on 26 August 2010.
(b) Northampton County Court on 23 March 2011.
(c) Leeds County Court on 28 April 2011.
(d) Northampton County Court on 1 July 2011.
(e) Slough County Court on 27 January 2012.

Allegation 4

Pursuant to bye-law 8(a)(i) RL is guilty of misconduct having failed to inform ACCA that he has been made bankrupt, in breach of Regulation 12(2)(h)(iii) of The Chartered Certified Accountant's Global Practising Regulations 2003 (as applicable in 2012).

The Committee ordered that RL be severely reprimanded, pay a fine of £2,000, pay compensation of £500 to a client and pay costs of £3,000. The Committee also made an order that any future application by RL for any certificate or licence issued by the Association, or to conduct exempt regulated activities in accordance with the

Designated Professional Body Regulations, be referred to the Admissions and Licensing Committee.

ACCA's regulations required them to publish the Committee's findings and orders by way of a news release, as soon as the order became effective. The Committee had discretion with regards to which publications the news release should be sent to, and discretion in exceptional circumstances to direct that the relevant person not be named. The Committee ordered that a news release should be published on ACCA's website and to the local press, referring to RL by name.[10]

[10] ACCA News release 13th November 2013

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 draw 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 the panel has drawn the following conclusions:

- The couple were clearly dealing with some stressful life events, in particular RL's bankruptcy and harassment from a former employee who believed that the couple owed him money, something they both denied at the time.

- RL had been reprimanded by his professional body and ordered to pay a fine, following allegations of professional misconduct being proved in November 2013.

- RL experienced low mood and depression at times and had expressed thoughts of self-harm. These were most clearly expressed in the time preceding and following his arrest for criminal damage in 2012.

- The status of the couples' marriage remains unclear. Although there is evidence of one instance of infidelity by RL there is nothing to indicate that this was a pattern of behaviour and no information about the status of that '*relationship*' nor whether SL was aware of the instance of infidelity reported by RL to his GP.

- The interventions of WYP and LYPFT were appropriate, timely and met the professional standards that would be expected of them. In particular WYP conducted regular assessments of RL when he was in custody in 2012 in accordance with Police practice and a custody nurse was appropriately engaged to review RL. That nurse made appropriate approaches to LYPFT mental health services, who in turn responded swiftly.

- The interventions of the GP practice were also appropriate, timely and met the professional standards that would have been expected.

- The absence of a Domestic Violence protocol at the GP practice represents a deficit in their policy suite, but it does not appear that its absence contributed to the events that occurred in any way.

- The role of the private counsellor is unclear and their identity, contact details and intervention have not been possible to ascertain. There does not appear to have been any contact between the counsellor and the GP practice or with LYPFT. This is not in itself unusual as it was a private arrangement between the counsellor and RL.

- No information has been found from the IMRs to indicate that SL was at any risk of domestic violence or abuse from RL. No concerns were raised by any of the agencies that had contact with the couple and they were not regarded as vulnerable adults.

3.1.2 Predictability and preventability

The panel has considered whether the deaths of SL and RL 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 their deaths.

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

On the basis of 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

West Yorkshire Police

No recommendations made

NHS England - Primary Care

Recommendation:

The CCG should take the opportunity presented by these events to assess local GPs' awareness of domestic violence following a training programme, which is being delivered by the local CCG. It is likely that such an assessment could be conducted using questionnaires the outcome of which could demonstrate a lack of formal policies in place in local practices.

In order to ensure a high uptake of any questionnaire based audit it is suggested that any CPD points awarded for taking part in domestic abuse training are not issued until the questionnaire is complete. Such a questionnaire based audit could take place at the end of a training day or else using a tool such as "Survey Monkey".

The recommendation is expected to be completed within six months of the date of the IMR, thus by September 2015.

LYPFT

Recommendation One:

Ensure Crisis and CMHT services have information and awareness of what constitutes psychological abuse. Ensure up to date contact details for Domestic Violence support are readily available during crisis assessment.

Recommendation Two:

All CAS assessments to include question on Domestic Violence.

Recommendation One does not have a confirmed timescale for delivery.
Recommendation Two is expected to be completed by June 2015.

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 makes two overarching recommendations for action:

Recommendation One

We recommend that in line with the LYPFT IMR recommendation, that LYPFT ensure that all its mental health services, both in patient and community based have information regarding domestic violence and abuse and are able to inform them when conducting assessments and reviews.

Recommendation Two

We recommend a practice improvement in relation to the conducting and administration of the PHQ-9. The processes that GPs have in place for the use of PHQ-9s should be reviewed and if necessary amended to ensure that following completion PHQ-9's are reviewed and any appropriate action is taken.