Leeds Domestic Homicide Review G

OVERVIEW REPORT
Into the death of Karen Jordan[1]

Hilary McCollum, Independent Domestic Homicide Review Chair and Report Author

Report Completed: July 2016[2]

[1] Not her real name.

[2] The report was originally completed in July 2015 and agreed at a sign-off meeting. In March 2016, the review process was reopened. Further evidence was presented in April and May 2016 and an additional Panel meeting was held. As a result, a number of amendments were made to the report during April and May 2016. It was considered by Leeds Community Safety Partnership on 30 June 2016 and finalised following that meeting.

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Section One: PREFACE

1. This Domestic Homicide Review (DHR) report examines agency responses to Karen Jordan, her husband, Steven[3], and their sons, up to the point of Karen and Steven's deaths on 29 April 2014. The family was resident in a town within the Leeds City Council area although the elder son had started university outside the area approximately seven months prior to the deaths.

2. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The Act states that a DHR should be:

   'A review of the circumstances in which the death of a person aged 16 years or over has, or appears to have resulted from violence, abuse or neglect by –
   a) A person to whom (s)he was related or with whom (s)he was or had been in an intimate relationship or
   b) a member of the same household as himself/herself'

3. The key purposes for undertaking DHRs[4] are 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
   - Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

4. This review was initiated by the Chair of the Leeds Community Safety Partnership in compliance with the legislation. The review process followed the Home Office statutory guidance.

5. The Independent Chair and DHR Panel extend their thanks to everyone who has contributed to the deliberations of the Review. In particular, they thank Karen's family and friends and Steven's family for their participation.

6. The Chair of the Review thanks all of the members of the Review Panel and all review report authors for their contributions to the Review.

[3] Not his real name.
[4] Home Office, 2011, Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, p6, https://www.gov.uk/government/publications/statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

7. The Independent Chair and the DHR Panel members offer their deepest sympathy to all who have been affected by the deaths of Karen and Steven.

Section Two: INTRODUCTION

8. This Overview Report examines agency responses and support given to Karen Jordan, an adult resident of the Leeds area, her husband, Steven Jordan, also of the Leeds area, and their sons, David[5] and Mark[6]. The report focuses on the period between 1 January 2010 and the death of Karen Jordan on 29 April 2014. A number of earlier events are included where relevant.

9. The table below sets out the family members involved in this review.

Party	Name	Age (at the time of Karen's death)	Known addresses
Victim	Karen Jordan	47	Address 1
Suspect	Steven Jordan	48	Address 1
Child 1	David Jordan		University (from October 2013) Address 1
Child 2	Mark Jordan		Address 1

10. Address 1 is the privately owned house in Leeds where the family had lived for more than 15 years.

ABOUT LEEDS

11. The Jordans lived in a small, affluent town within the Leeds City Council area. Leeds is the third-largest city in Britain with a population of approximately 750,000. It is considered the cultural, financial and commercial heart of West Yorkshire and is the focus of public transport, rail and road communications networks in the region. Leeds has existed since the fifth century. Today it is the second largest legal centre in the UK and the leading UK city for telephone delivered banking and related financial services. Although unemployment is higher than the national average, Leeds is overall less deprived than other large UK cities. More than one in six (17.4%) residents are from a minority ethnic background.

12. The crime rate in Leeds is above the national average. In 2013/14, there were a total of 13,832 domestic violence reports recorded by the West Yorkshire Police in Leeds. Of these, 4,311 were recorded as crimes, 7,842 as non-crime domestic incidents and 925 as breaches of the peace. This was similar to the average for

[5] Not his real name.
[6] Not his real name.

West Yorkshire. In common with many local areas, Leeds has a MARAC and an IDVA service.

SUMMARY OF THE CASE

13. Karen Jordan was a white British woman, born in the Leeds area in 1967. At the time of her death she was a highly regarded, popular community figure who was universally well-liked. She was devoted to her two sons. She was described as warm, kind, friendly, dynamic and enthusiastic. One friend said: "A shining light has been lost from our life and the lives of everyone she came into contact with." Karen worked in the public sector.

14. Steven Jordan was a white British man born in the Leeds area in 1966. He was described as a "quiet and self-reserved" man who "barely spoke" to any of his neighbours. Steven worked in the IT industry.

15. Karen and Steven met at school and married in June 1989. In [redacted] Karen gave birth to the couple's first child, David. A second son, Mark, was born in [redacted] Ostensibly there were no major problems in the marriage but in the months before the homicide, Karen told a number of agencies (including Leeds and York Partnership NHS Foundation Trust, West Yorkshire Police, Leeds Adult Social Care and Leeds Women's Aid) that Steven had been controlling and emotionally abusive throughout the marriage.

16. The first indication that there may have been significant issues in the family was in November 2012, when [redacted] Personal matter Child 1

17. [redacted] Personal matter Child 1 He described a good relationship with his mother but said he did not have "the same relationship with his father." He said that Karen had told him that Steven could find situations awkward due to his upbringing. [redacted] Personal matter Child 1

18. In November 2013, Karen told her mother that she wanted to end the marriage. However she did not want to disrupt Mark's schooling as he was due to take his [redacted] exams in May/June 2014 and decided to delay telling Steven of her decision.

19. It appears that Steven became aware of her plans and on 22 March 2014 he made what appeared to be a suicide attempt using fumes from the car exhaust. *(Author's Note: Steven said it was a suicide attempt and health professionals regarded it as such but Karen and her parents did not believe this was a genuine suicide attempt.)* Steven was found by Mark and taken to A&E. Following an assessment by the Acute Liaison Psychiatric Service from Leeds & York Partnership NHS Foundation

Trust, he was informally admitted to the Becklin Centre (a psychiatric inpatient facility) and was subsequently formally detained under section 2 of the Mental Health Act for assessment[7]. He cited marital problems as the reason for his attempted suicide.

20. While in the Becklin Centre, Karen informed Steven that she wished to end the relationship and initiated divorce proceedings via a solicitor. She attended a drop-in run by Leeds Women's Aid and asked for advice on getting an Occupation Order. She also received advice from the police.

21. Karen was worried that Steven may become aggressive if he was discharged back to the family home and attempted to prevent him returning home. However she was unable to do so without an Occupation Order, which it seems she could not afford to pursue and which she had been advised she might not obtain anyway because of the lack of documented evidence of abuse. *(Author's Note: her parents offered to pay for the costs of attempting to obtain an order but Karen felt their help would be more useful later in the year when she would be setting up home without Steven.)* She agreed to his discharge from the Becklin Centre to Address 1 on 16 April 2014, on the condition that this was a temporary measure with Steven and Karen living separate lives whilst Steven found his own accommodation.

22. On returning home, Steven began to harass Karen. The police were called on Friday 18 April 2014 regarding Steven following Karen and her sons on a walk. Two hours after the call, the police had not attended and phoned Karen. The situation was calm and she said she did not wish to take any further action. On Friday 25 April 2014, Steven changed the Wi-Fi password and refused to tell Karen and Mark what it was. Karen took Mark to her parents' for the weekend. She called the police on Saturday 26 April 2014 and they met with her and her parents the following day. The police identified the report as a non-crime, non-domestic incident. They offered to talk to Steven but Karen was concerned that this could make the situation worse.

23. Karen's parents wanted her to stay with them but Karen and Mark returned to Address 1 on Monday 28 April 2014. Her father fitted locks on their doors in an attempt to stop Steven from harassing and spying on them.

24. Karen went to work on Tuesday 29 April 2014. Mark went to school and then to his

[7] The Mental Health Act 1983 makes provision for people to be admitted, detained and treated in hospital without their consent because they are considered by mental health professionals to be a risk to themselves and/or others. Admissions under the Act are referred to as 'formal' admissions. Individuals may also voluntarily agree to be admitted to psychiatric care. These are referred to as 'informal' admissions. The rights of people are different depending whether they have been admitted formally or informally. Less than half of people in psychiatric wards are formally detained. (MIND suggest about 25% of patients are formally detained http://www.mind.org.uk/information-support/legal-rights/mental-health-act-the- mind-guide/#.VCGC_ZRdWO0. Figures from the Health and Social Care Information Centre (2013 Bulletin) show that around 45% of patients whose records were in Mental Health Minimum Dataset returns were formally detained during the 2012/13 reporting year. http://www.hscic.gov.uk/catalogue/PUB12745). A summary of the Mental Health Act is set out at Appendix 5.

girlfriend's house. A row broke out between Karen and Steven on her return from work. He then stabbed her to death and set the house on fire.

25. At 18:32, a neighbour called 999 to report that Address 1 was on fire. Neighbours had heard arguing coming from the address followed by what was described as an explosion. Steven was set alight during the fire. Witnesses describe him coming out of the house engulfed in flames.

26. Fire and police responded to the call. On arrival of the first police officer at the scene, Steven was found in the back garden and the premises were fully alight. Together with members of the public, the officer used water from the garden pond to extinguish the flames on Steven and he was transported to hospital. He died later that evening of his injuries.

27. The fire service attended, put out the fire and discovered the body of Karen Jordan just inside the side entrance door. She had received multiple stab wounds. She was 47 years old.

28. The police investigation team is satisfied that Steven Jordan killed Karen before deliberately setting fire to their house using some form of accelerant. There will be no criminal proceedings but an inquest will be held to consider the circumstances of both deaths.

POST MORTEM

29. On 2 May 2014, a Home Office pathologist, Dr Kirsten Hope, conducted a post mortem examination on Karen's body at Pinderfields Hospital. The cause of death was multiple stabs wounds.

INQUEST

30. The inquest was opened and adjourned in May 2014 by Coroner David Hinchliff at Wakefield Coroners Court pending police inquiries. The Inquest is scheduled to resume in January 2017.

COURT DATES

31. As set out above, the police investigation team is satisfied that Karen's death was a homicide and that Steven set fire to Address 1. Steven died from injuries sustained in the fire. As a result, there was no criminal trial but an inquest will take place.

Section Three: THE REVIEW PROCESS

DECISION TO HOLD A REVIEW

32. When Leeds Community Safety Partnership was notified of Karen's death, records were immediately secured and, in consultation with partners, a decision was made to instigate a DHR. The Home Office was duly notified on 23 June 2014.

33. In July 2014, Hilary McCollum was appointed as the Independent Chair and Report Writer to conduct the review. She has worked for more than twenty-five years within the public and voluntary sectors on issues related to violence against women and girls. She does not have any connection with the agencies to which the report relates or with the families of the victim or perpetrator.

CONVENING THE PANEL

34. The first meeting of the review panel was held on 4 August 2014. The panel consisted of senior officers from statutory and non-statutory agencies as listed below. None of the members of the Panel have had any direct contact with Karen, Steven or their children.

Name	**Organisation**
Hilary McCollum	Independent Chair and Report writer
Area Community Safety Co-ordinator	Domestic violence team, Leeds City Council
Domestic Homicide Reviews Senior Officer	Domestic violence team, Leeds City Council
Superintendent	West Yorkshire Police
Head of Service	Leeds Adult Social Care
Head of Children's Social Work Service	Children's Social Work Services
Designated Nurse for Safeguarding Adults	NHS England / Leeds Clinical Commissioning Groups
Named Nurse for Safeguarding Children and Domestic Violence	Leeds and York Partnership NHS Foundation Trust
Head of Service, Children Looked After & Safeguarding	Leeds Community Healthcare NHS Trust
Lead Professional for	Leeds Teaching Hospital's Trust

Name	Organisation
Safeguarding Adults at Risk	
Named Professional for Safeguarding Adults	Yorkshire Ambulance Service NHS Trust
IDVA Service Manager	Leeds Domestic Violence Service
Head of Service Learning for Life	Schools and Learning, Leeds City Council

SCOPE AND TERMS OF REFERENCE

35. The first meeting considered the scope and Terms of Reference for the review. The first significant event that the Panel was aware of was David [redacted] in November 2012. However we decided to go back to the beginning of 2010 with the aim of capturing any significant events that would help the Panel understand what had happened and where there were opportunities to intervene differently. The permission of both sons was sought to be named parties to the review to ensure a fuller picture of the family.

36. The areas for the review to consider included:

- Each agency's involvement with family members between 1 January 2010 and the death of Karen Jordan on 29 April 2014;
- Communication and information sharing between services;
- Accessibility, availability and responsiveness of services;
- Compliance with policy, procedures, protocols and professional standards, particularly in relation to domestic violence, safeguarding children and safeguarding adults;
- Responses to any referrals;
- The quality of assessments and risk assessments;
- Thresholds for intervention;
- Whether adult-focused services ensured that the welfare of any children was promoted and safeguarded and vice-versa and how this was done;
- Whether services took account of the wishes and views of members of the family in decision-making and how this was done;
- Sensitivity and responsiveness of agencies to issues of identity and additional needs;
- Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner;

- The impact of organisational change;
- Whether there is any learning from this case which would improve safeguarding practice in relation to domestic violence and its impact on children.

37. The full terms of reference for the review are attached as Appendix 1.

INDIVIDUAL MANAGEMENT REPORTS AND CHRONOLOGIES

38. At the start of the review process, Leeds Community Safety Team contacted a range of organisations that potentially could have had contact with the victim, the suspect or their children. This included statutory organisations including the police, probation, health services and the local council as well as non-statutory organisations. All organisations were asked to make an initial return confirming whether or not they had had any contact and briefly outlining their involvement.

39. The first meeting of the Panel considered information from the initial returns. On the basis of this information and discussion at the meeting, the following agencies were asked to give chronological accounts of their contact with the victim and suspect prior to the homicide (see Section 4, Narrative Chronology which sets out relevant events) and to complete an Individual Management Review (IMR) in line with the format set out in the statutory guidance:

    - Leeds City Council Adult Social Care
    - Leeds City Council Children's Social Work Services
    - Leeds City Council Education and Early Years Safeguarding Team
    - Leeds Clinical Commissioning Group – GPs for all family members
    - Leeds and York Partnership NHS Foundation Trust
    - Leeds Community Healthcare NHS Trust – Child & Adolescent Mental Health Services and School Nursing Services
    - Leeds Teaching Hospitals Trust
    - West Yorkshire Police
    - Leeds Women's Aid and Leeds Domestic Violence Service
    - Yorkshire Ambulance Service

40. Chronologies and IMRs were prepared by all agencies from which they were requested. The Chair agreed to accept the Serious Incident Investigation report from Leeds & York Partnership NHS Foundation Trust (as this was already in preparation) instead of an IMR but asked for further information in a number of areas to ensure that the terms of reference of the DHR were addressed. Each of the reports covered the following:

    - A chronology of interaction with the victim, perpetrator and/or the children
    - What was done or agreed

- Whether internal procedures and policies were followed
- Whether staff have received sufficient training to enact their roles
- Analysis of the above using the terms of reference
- Lessons learned
- Recommendations

41. The IMRs and Serious Incident Investigation Report were scrutinised at meetings of the Panel meeting. In some instances, additional recommendations were made which have been included in the action plan at Appendix 2. A combined chronology was also produced and this was considered at the second panel meeting.

TIMESCALES

42. This review began on 4 August 2014. Eight meetings of the panel were held in the period August 2014-May 2015, with the final one being on 13 May 2015. The draft overview report went to a meeting in August 2015 where it the findings were presented.

43. Subsequent to this meeting, a number of agencies raised concerns about the report which resulted in the review process being reopened in March 2016. Comments on the overview report and further evidence were submitted by several agencies in April 2016 and an additional Panel meeting was held on 26 April 2016.

44. Following this, revised versions of the Overview Report and Summary were produced in May 2016 and considered in correspondence with members of the Panel. The revised Overview Report and Summary were considered at a meeting of Leeds Community Safety Partnership on 30 June 2016, along with a commentary prepared by Leeds and York Partnership Foundation Trust. LYPFT's commentary is attached as Appendix 3. Leeds Community Safety Partnership broadly accepted the findings of the Overview Report but decided to produce a statement which is attached as Appendix 4.

45. The review began within fourteen weeks of Karen's death and continued in parallel with the criminal investigation and the preparation of the police report for the coroner. The inquest was rescheduled in March 2016, pending the conclusion of the DHR process.

PARALLEL INVESTIGATIONS

46. There was no criminal trial due to Steven's death.

47. An inquest will take place and the police and other agencies have prepared reports for the Coroner.

48. Leeds & York Partnership NHS Foundation Trust conducted a Serious Incident Investigation reflecting the requirement to do so under the NHS Serious Incident Framework. The report of the Serious Incident Investigation was available to the Panel.

CONTRIBUTORS TO THE REVIEW

49. All Panel members regularly attended and contributed to Panel meetings.

50. The Chair interviewed Karen's parents, her younger son and two of her friends. The Chair interviewed Steven's parents and two sisters. Following the reopening of the review, two members of Safer Leeds met with Steven's parents, two sisters and brother-in-law. Notes of this meeting were shared with the Chair and key points fed back to the Panel. The Chair also interviewed a member of the extended schools team who had supported both David and Mark, knew Karen and had met Steven on one occasion.

INVOLVEMENT OF FAMILY AND FRIENDS

51. The Chair wrote to Karen's sons and her parents via the police Family Liaison Officer. Karen's parents and her younger son agreed to be involved in the review and the Chair conducted an interview with them.

52. The Chair wrote to Steven's parents via the police Family Liaison Officer and conducted an interview with them and two of Steven's sisters during the later stages of the review. As set out in paragraph 50, Steven's family also met with Safer Leeds when the review was reopened.

53. The author of the Serious Incident Investigation report had met with both families and shared information from those interviews with the Chair.

54. The Chair wrote to two friends of Karen's and both agreed to be interviewed. The Chair also interviewed a member of the extended schools team who knew Karen, had supported both David and Mark and had met Steven on one occasion.

DISSEMINATION

55. DHR Panel members (see list at paragraph 34), the families of Karen and Steven, Leeds City Council's Legal Department and the Chair of Leeds Community Safety Partnership have all received a copy of this report.

CONFIDENTIALITY

56. The findings of this review are confidential and all parties have been anonymised. For ease of reading, the victim and perpetrator and their children have been allocated alternative names.

57. Information has only been made available as described above. The report will not be published until permission has been given by the Home Office to do so.

INDEPENDENCE

58. This report was written on behalf of the DHR panel by the Independent Chair of the Review, Hilary McCollum. Hilary has worked for more than twenty-five years within the public and voluntary sectors on issues related to violence against women and girls. She has been a specialist adviser to the Cabinet Office and developed the draft London Violence against Women Strategy, *The Way Forward*, for the London Mayor. She was a member of the Metropolitan Police Force's Domestic Homicide Review Group, the London Domestic Violence Steering Group and the London Safeguarding Children Board. Hilary has also worked on hate crime and led the formal inquiry into disability harassment for the Equality and Human Rights Commission, including preparing the final report, *Hidden in Plain Sight*.

59. The Chair had no connection with the attending agencies.

60. This original report was written between February 2015 and July 2015 and was considered in detail at two Panel meetings. It was agreed at a sign-off meeting in August 2015. It was based on:

- the Individual Management Reviews undertaken by:
  - Leeds City Council Adult Social Care
  - Leeds City Council Children's Social Work Services
  - Leeds City Council Education
  - Leeds Clinical Commissioning Group
  - Leeds Community Healthcare NHS Trust
  - Leeds Teaching Hospitals Trust
  - West Yorkshire Police
  - Leeds Domestic Violence Service
  - Yorkshire Ambulance Service
- the Serious Incident Investigation Report and additional information provided by Leeds & York NHS Foundation Trust;
- interviews with:
  - Karen's parents and one of her sons
  - two friends of Karen's
  - Steven's parents, sisters and brother-in-law
  - a member of the school's extended services team

61. The IMR report writers and Serious Incident Investigation Report writer had not had any contact with the victim or perpetrator and were not line managed by anyone who did. Each of the reports was signed off by a senior manager within the organisation. DHR Panel members were similarly independent.

62. As set out in paragraphs 42-45 above, the review process was reopened in March 2016 and a number of agencies submitted comments on the Overview Report and additional evidence. The Chair of the Panel revised the Overview Report and Summary during April and May 2016 as a result. The revised Overview Report and

Summary were considered in correspondence with the Panel during May 2016 and at a meeting of the Leeds Community Safety Partnership on 30 June 2016. LYPFT submitted a commentary on the revised Overview Report and this is included as Appendix 3. Leeds Community Safety Partnership produced a statement and this is attached as Appendix 4.

ACKNOWLEDGMENTS

63. The Chair of the Review would like to thank all members of the Review Panel who contributed to the Review. The Chair also extends her thanks to the authors of the Individual Management Reviews (IMR) and Serious Incident Investigation. The Chair would like to thank all those who agreed to participate in this review, particularly the families of Karen and Steven and friends of Karen.

CONDOLENCES

64. The Panel wishes to express its condolences to all those affected by these deaths.

Section Four: THE FACTS

PEN PORTRAITS

Karen Jordan

65. Karen Jordan was a white British woman, who was born in 1967. She had one brother. She was a member of the Anglican Church. Karen worked in the public sector.

66. Karen was universally well liked and highly regarded. She was a popular woman who was described as warm, kind, friendly, dynamic and enthusiastic. One friend called her “a shining light”.

67. She met Steven when they were at school. A local councillor who knew her in the mid 1980s said that she was a quiet young woman at that time.

68. Karen and Steven married in June 1989. Steven’s controlling behaviour emerged even before they married and continued for the next 25 years. Her mother felt that Karen acquiesced to Steven to maintain the peace. Karen told her mother that on one occasion early in the marriage Steven had locked her in the house and hidden the key.

69. Karen gave birth to the couple’s first child in [redacted] and their second in [redacted]. She was described as absolutely dedicated to her children and her focus was their welfare. She had a good relationship with both boys. Their relationship with their father was not close. Karen explained to them that Steven struggled in his relationships due to difficulties in his own childhood. She tried to protect her children from unnecessary stress and did not discuss her marriage problems with either David or Mark until the point that Steven made his suicide attempt in March 2014. However it was not always possible to hide Steven’s behaviour from them. On one occasion when the boys were young, Karen fell on the kitchen floor following an argument with Steven and dislocated her knee. Steven refused to help her and encouraged his four-year-old son to touch Karen’s injured knee as if to cause her pain.

70. Karen appears to have tried to present a positive picture of her family to the outside world but in 2011 she confided in her mother that Steven was controlling, abusive and manipulative. She said that he would leave the house without telling anyone where he was going or for how long. He would sulk if he did not get his own way. On her birthday, he refused to give her the family presents saying she didn’t deserve them. Later in the day he said, “Have you been good enough to get your presents now?” He had slapped one of his sons across the face. He would decide whether he was going to attend a family outing by tossing a coin in front of the boys. Her mother felt Steven’s behaviour was chipping away at Karen’s self-esteem and confidence but Karen felt she needed to stay because of the children.

71. During the 2000s, Karen became increasingly active in her local community, working to improve the environment in her area. She was also a member of the Parent-Teacher Association of her boys’ school. Through her voluntary work she became involved in fundraising, organising events, writing articles and giving speeches. Her sons would help with practical work and Steven would also

contribute on occasion. Her parents felt that Karen's confidence, health and self-esteem improved as a result of her voluntary work.

72. In November 2013, Karen told her mother that she had decided to leave Steven but she did not want to tell him until after Mark's examinations in May/June 2014. Karen thought she could make a fresh start with the boys after selling the marital home and intended to tell her sons after Mark's exams. Karen started to remove things she valued such as family photo albums from the house. By early 2014, Karen confided in her mother that she felt different as a result of her decision and could see a light at the end of the tunnel.

73. Karen's mother supported her decision to leave Steven but warned her to be careful about revealing her intentions to Steven before that time. However it appears that Steven became aware of Karen's plan to leave him. On 22 March 2014, Steven's younger son, found him semi-conscious in the garage after what appeared to be a suicide attempt. He was taken by ambulance to A&E and then admitted for assessment to the Becklin Centre, a psychiatric unit run by Leeds & York Partnership NHS Foundation Trust. Karen told staff at the Becklin Centre that Steven was controlling and emotionally abusive and that she planned to divorce him. This was the first time that she had indicated to any agency that she was experiencing domestic abuse. Less than six weeks later, she was dead. In the intervening weeks she had disclosed domestic abuse to Leeds Adult Social Care, West Yorkshire Police and Leeds Women's Aid. She had initiated divorce proceedings and attempted to prevent Steven returning home. However she was unable to do so without an Occupation Order.

74. Steven was discharged home on 16 April 2014 with Karen's agreement. Shortly thereafter he began to stalk Karen. Police were called on two occasions, after he followed her and her sons on 18 April 2014 and after he changed the WiFi passwords on 25 April 2014 (she called police on 26 April 2014 and they attended the following day but concluded that they could take no further action). Karen took Mark to stay with her parents over the weekend of 25-27 April but returned home on Monday 28 April 2014. Her father fitted locks on the bedroom. The following day, Steven stabbed her to death after an argument. She was 47 years old.

Steven Jordan

75. Steven Jordan was born in Leeds in 1966, the third of four children. His ethnic background was white British. He met Karen at school and they married in June 1989.

76. Steven did well at school and was always well behaved although a family member reported that he had been vulnerable to bullying. He studied mathematics at university and went on to work in the IT industry. He was made redundant in 2010. He got another job but was made redundant again after 18 months. At the time of the homicide, he was working locally in an IT support role.

77. He was described as a "quiet and self-reserved" man who "barely spoke" to any of his neighbours. He was seen by one of Karen's friends as "a loner" who was "socially awkward" and, at times, rude. In interview for this review, one member of

his family described him as a closed book, a deep and introverted person who answered questions directly and had no sense of humour.

78. Steven was an avid cyclist and would spend much of his weekends cycling.

79. Steven did not attend parent teacher evenings or similar events at the boys' school. He was seen as uncommunicative within the family and his sons tended to turn to their mother for help. He did not tell his sons he loved them until the point at which Karen told him she wanted a divorce. He was described during the Mental Health Assessment in March 2014 as having "a certain coldness".

80. Karen and Steven lived in their own home in a commuter town within the Leeds Council area. Steven kept a tight rein on finances and expected Karen to account for any money she spent. He controlled the family's access to the Internet by setting additional firewalls limiting the sites that could be accessed.

81. Steven's family said he idolised Karen and never spoke badly of her. They acknowledge that he was likely to be controlling towards her but have suggested that she was also controlling towards him. For example, they said that she would not let him store his collections of Dr Who memorabilia and Lego in the downstairs rooms of their house and insisted that they were kept in the loft.

82. Steven himself did not tell any agency that Karen was controlling him. He did however tell staff at LYPFT that he could understand why she would want to leave him, that he was ashamed of how he had treated her and that he had been cruel to her.

83. Steven and Karen had been married for more than 24 years when Karen decided that she wanted a divorce. As mentioned above, when Steven became aware of this, it appears that he attempted suicide using carbon monoxide fumes from his car exhaust. He was found by his younger son and taken to A&E on 22 March 2014.

84. Steven requested that his wife and son be present during the initial psychiatric assessment. He was noted by hospital staff to be alert and very controlled. He said he had attempted to take his own life because he thought his marriage was ending. He agreed to an informal admission to the Becklin Centre and was subsequently formally detained under Section 2 of the Mental Health Act. He told staff that Karen had told him she didn't love him anymore. He said his relationship with Karen had been "alright" over the preceding 15 years but over the last few months he described feeling neglected and ignored and unwanted which had led to his suicide attempt. This contrasts with Karen's account of the relationship

85. During the period of Steven's admission he received letters from Karen's solicitor pursuing divorce. They began discussions, by letter, making future separate plans, including Steven moving out of the marital home and finding alternative accommodation. Steven got his own solicitor and was advised that Karen could not exclude him from the family home.

86. He returned home on 16 April 2014 on the agreement that they had separated, would live their own lives and he would look for his own accommodation. However he began stalking her. He stabbed her to death on Tuesday 29 April 2014 following an argument. He then set the house on fire using an accelerant. It is not clear whether he set himself alight deliberately. He emerged from the house into the

garden engulfed in flames. A police officer put the flames out with the help of neighbours. Steven was taken by ambulance to A&E. He resisted treatment en route and said he wanted to die. He died that evening of his injuries. He was 48.

NARRATIVE CHRONOLOGY

87. A comprehensive chronology of agency involvement was prepared and considered by the Review Panel. All relevant events are set out in the Narrative Chronology below.

1989 – 2009
Marriage and children

88. Steven and Karen married in June 1989.

89. Karen gave birth to their first child in [redacted] and their second in [redacted]

90. Both boys entered primary and secondary school as expected and there were no significant issues recorded.

2010-2013
Routine medical appointments; Steven's ongoing back problems; [redacted] and agency responses

91. On 4 and 9 August 2010 and 28 September 2010, Steven attended his GP review for an ongoing back problem.

92. In September 2010 (15 and 27 September 2010), Karen had two GP appointments regarding an injury to her left ring finger. She said that this had occurred following a fall from a bike.

93. On 3 February and 12 April 2011, Steven Jordan attended his GP for a review of his back pain, which was being treated with amitriptyline. There is an entry on the record of 12 April 2011 stating "no mood disturbance". It appears that this was linked to a practice of recording the mood of patients experiencing chronic pain, as pain and depression frequently co-exist. Steven had another back pain review on 1 August 2011 and reported a significant improvement.

94. On 28 November 2012, David was referred to the extended services team at his secondary school by a friend who had previously used the service. Private matter child 1 [redacted] his was good practice.

95. Private matter child 1 [redacted]

96. Private matter child 1 [redacted]

This was actioned with immediate effect, which was good practice. The Vice Principal wanted to arrange a meeting with David's parents to discuss the support plan. David explicitly said that he did not wish to tell his dad (Steven) how he was feeling or about t Private matter child 1 He did not want to go home to be with Steven on his own. The Family Support Worker agreed that she would stay with David until Karen came home from work.

97. Private matter child 1

98. The Family Support Worker took David home after 5pm. Karen brought her into the living room and Steven also joined them. The Family Support Worker explained the events of the day to David's parents. According to the Family Support Worker, "Karen did all the talking," while "Steven sat in a chair looking in a different direction and never said a word." Karen asked why the school had not contacted her straight away and accepted the explanation for the decision to wait.

99. Karen took David to A&E at Leeds General Infirmary that evening Private matter child 1 He was seen both on his own and with Karen. The assessment included some enquiry about home life but it is not recorded whether domestic violence was explored. David said "things are fine at home" and that the family was "close" and his parents were supportive. Private matter child 1

100. On 29 November 2012, the associate Vice Principal met with David and his parents to discuss the support plan. Private matter child 1 The Vice Principal noted that, "Steven made almost no contribution to the meeting at all."

101. Private matter child 1

104. Around 3 December 2012, Karen got the opportunity to meet a member of the royal family at the same time as David's [redacted] appointment on 5 December 2012. This was linked to her community work. She contacted [redacted] and tried to rearrange the appointment for later that day but that was not possible. Karen was clear that she would prefer to attend with David but he did not want his mother to miss the chance of meeting the royal family and said that this would cause him greater distress. According to [redacted] records, he did not want to attend with his father. The situation was resolved when the Family Support Worker offered to take David to his [redacted] appointment.

105. On 5 December 2012, David attended his [redacted] appointment, accompanied by the Family Support Worker. The appointment was with the same Senior House Officer that had spoken to him on the phone on 30 November 2012. [redacted] David explained why his mother had not attended with him. The [redacted] doctor asked David about his father. David said that he did not have "the same relationship with his father" and that his mother had explained to David that due to his father's upbringing, he found situations like these awkward. The opportunity to discuss family relationships and David's home life in more detail was not taken. David's presenting problems were recorded as being the same as for 30 November 2012 and another appointment was arranged.

106. [redacted]

107. David attended further [redacted] appointments on 24 and 31 December 2012, accompanied by Karen. On 31 December 2012, both David and his mother reported that things had gone well over the last seven days and that Christmas was a good distraction. David denied any strain in his relationship with his parents but said his father struggled to support him emotionally. It is unclear within the records whether this comment was when he was seen on his own or with his mother. [redacted]

109. The referral to [redacted] was made on 11 January 2013. [redacted]. There was also a reference to "family dynamics" but no further information about what prompted this was provided. [redacted]

110. Private matter child 1 [redacted]

111. In [redacted] David started university outside of the Leeds area and as a result no longer lived at home.

112. On 21 October 2013, Steven was seen at the GP practice. He reported headaches and a humming sensation in his head, which he had had for three months. He was advised to have his ears syringed, which he did on 28 October 2013. He was also advised to have his eyes tested.

113. On 26 February 2014, Steven saw the GP and reported a "constant pitch humming around my head". He was recorded as being anxious. This was discussed with the GP as part of this review who indicated that Steven showed some signs of "irritation, anxiety and a sense of dissatisfaction with the outcome of the consultation" and had a "demeanor of aggressiveness". The GP indicated that the aggression was not to an extent where she felt threatened or that Steven was a risk to others and that these assessments were very much retrospective. This was the last clinical contact between Steven and the GP practice.

114. On the morning of 22 March 2014, Mark went to fetch his bike from the garage and found Steven slumped next to his car following an apparent attempted suicide. The car engine was not on but a hosepipe had been fed through the car window. At 07:30, Yorkshire Ambulance Service received a 999 call from Karen reporting that, "My husband's tried to kill himself with carbon monoxide". Yorkshire Ambulance Service dispatched three Rapid Response Vehicles (RRV) and a Double Crewed Ambulance (DCA) immediately; one RRV was a specialist Hazardous Area Response Team (HART) trained paramedic.

115. The Yorkshire Ambulance Service call taker asked Karen to explain exactly what had happened. She said, "We just found him in the side of the car, with a pipe from the exhaust going into the car, with the car door open, he's conscious, but laid on the side of the garage floor". During the call, Karen was heard to ask Mark to fetch a blanket for Steven, as she was concerned he would be cold on the concrete floor. Karen repeatedly spoke to Steven to keep him alert.

116. The call was terminated when ambulance staff arrived on scene at 07:38. Steven did not demonstrate mental capacity or consent to treatment, which was documented on the patient report form (PRF). It was also noted on the PRF that Steven was "last seen at 02:00 and found by son at 07:30". Steven was given oxygen and taken by double-crewed ambulance to St. James's University Hospital where he was handed over to the emergency department.

117. At 07:32, Yorkshire Ambulance Service had informed West Yorkshire Police of the incident. Officers were dispatched a few minutes later, arriving at 07:39. No criminal offence or other matter requiring police response was identified.

118. At the hospital, Steven was seen by a staff nurse and a doctor and was assessed and treated for high levels of carbon monoxide in his body and for attempted suicide. There were high risk factors associated with his suicide attempt (i.e. circumstances, age range, non-smoker and the amount of carbon monoxide that was in Steven's body when Yorkshire Ambulance Service arrived at the scene). Staff on duty in A&E believed that Steven had made a definite attempt to take his own life and that he was aware that the result of his actions could have resulted in his death. *(Author's Note: Karen told her parents that she did not believe that this was a serious attempt and that Steven knew he would be found.)* A capacity assessment was completed and established that he had full capacity. His Glasgow Coma Scale (GCS)[8] was 15/15 (fully alert and orientated).

119. A staff nurse spoke with Steven about the circumstances surrounding the incident and his subsequent admission. Steven was noted to be alert and very controlled. He requested that Karen and Mark be present during the initial assessment, which was to establish basic history of the event and family situation and to identify any future on-going risk factors. He said he had attempted to take his own life because he thought his marriage was ending. He was very clear that he wanted Karen and Mark to be aware of his intentions. The staff nurse described Steven's non-verbal communication as very powerful and the atmosphere in the cubicle seemed intense at times. The staff nurse also said it had a feeling of a "dark situation".

120. As part of this review, the staff nurse reported that Karen was in shock and she expressed no emotion. She looked to be "a woman at the end of her tether". There was little interaction between Steven and Karen. Staff in the A&E department may not have thought this to be unusual behaviour given the circumstances that Steven had just attempted to take his own life at the family home; that Karen's [redacted]-year-old son had been the one to find Steven; and that this suicide attempt was associated with the fact that Karen was planning to divorce Steven. The staff nurse did make a point of speaking with Karen alone once the opportunity arose but did not ask directly whether there were any domestic abuse issues or risk factors at home. This should have happened.

121. Steven initially wished to self-discharge however he agreed to wait for an assessment that day from the Acute Liaison Psychiatry Service (ALPS) team from Leeds & York Partnership Foundation Trust. The referral to ALPS was made at 09:30 but he was not considered medically fit to be assessed at that time. At 11:27, A&E contacted ALPS again. Steven wanted to self-discharge. He said he was "fine" now. He had tickets to The Lion King at 14.30 and wanted to go home so that he could attend. Karen was reported by the Staff Nurse to look "tense" and "frightened". The ALPS worker thought that Steven should be assessed as it appeared to be a significant suicide attempt and suggested admitting him to the Clinical Decisions Unit and then asking for a Section 5(2) Mental Health Act to be implemented[9]. The treating doctor in A&E said Steven would be medically fit to assess at midday.

[8] The Glasgow Coma Scale indicates if the patient is alert and orientated.
[9] Section 5(2) of the Mental Health Act allows for short-term detention of patients who are seen to be at risk.

122. At 12:30, the staff nurse at St. James's University Hospital contacted the Local Authority Emergency Duty Team at Leeds City Council to inform them that Mark had found his father after an attempted suicide. The referral said that the "parents have relationship issues." Mark was said to be "resilient" but he and his mother were "dazed." That afternoon, a social worker from the Duty & Advice Team phoned Karen. She said that Mark was quite resilient and had support at school and that they did not need any help from Children's Social Work Services. The social worker contacted Karen again on 24 March 2014. She thanked them for their support but said they did not need anything at that time and that Mark was fine.

123. Steven was assessed by the ALPS team at 12:45. He reported that he had left no suicide notes and had not told anyone what he was going to do. He thought that everyone else was asleep and his chosen method would be quick and painless. He said that when it did not work after several hours, he could not cope with the physical symptoms so he switched off the engine. He climbed out of his car but passed out on the garage floor. He said that his problem stemmed from his wife reportedly telling him she didn't love him anymore. He said that his relationship with Karen had been "alright" over the preceding 15 years but over the last few months he described feeling neglected and ignored. He reported that his family made him feel unwanted which had led to his suicide attempt.

124. A FACE (Functional Analysis of Care Environments)[10] risk assessment was conducted as part of the ALPS Assessment. It recorded:

- Risk of suicide – 3 (serious apparent risk)
- Risk of deliberate self harm - 1 (low apparent risk)
- Risk of accidental self harm - 1 (low apparent risk)
- Risk of severe neglect - 0 (no apparent risk)
- Risk related to physical condition - 0 (no apparent risk)
- Risk of abuse/exploitation by others - 0 (no apparent risk)

[10] Under the FACE risk assessment system:
0 = no apparent risk. No history of warning signs indicative of risk.
1 = low apparent risk. No current behaviour indicative of risk but patient's history and/or warning signs indicate the possible presence of risk. The necessary level of screening/vigilance is covered by a standard care plan, i.e. no special risk prevention measures or plans are required.
2 = significant risk. Patient's history and condition indicate the presence of risk and this is considered to be a significant issue at present i.e. risk management plan is to be drawn up as part of the patient's care plan.
3 = serious apparent risk. Circumstances are such that a risk management plan should be/has been drawn up and implemented.
4 = serious and imminent risk. Patient's history and condition indicate the presence of risk and this is considered imminent (e.g. evidence of preparatory acts). Highest priority to be given to risk prevention.
9 = unknown risk.

- Risk of violence/harm to others – 9 (unknown risk).

125. The ALPS team recommended that Steven be informally admitted to the Becklin Centre, an inpatient mental health service, for assessment, which Steven agreed to. He had had no previous involvement with statutory mental health services. He denied any current suicidal ideation and said that he felt "silly and regretful" about his actions. He stated that he would not approach staff to request 1:1 support because he felt thoughts about harming himself would not return. He agreed to be nursed on 15-minute intermittent observations and escorted in the grounds to maintain his safety. Steven was allocated a primary and associate nurse who had regular 1:1 discussions with him. He was reviewed on the ward at least once a week by a multidisciplinary team (comprising of doctors and nurses).

126. During the admission process at the Becklin Centre, Steven was seen with Karen and a member of the nursing staff. He reported that for the previous one to two months he had felt unwanted and that nobody liked him. He said that he had tried to discuss this with Karen once but was not sure what happened. Regarding the suicide attempt, he reported "feeling silly, stupid and regretful". He had wanted to end his life at the time but no longer wished to do so and said that "[I have made] a fool of myself". He stated he had not previously attempted to end his life. He was not sure for how long he'd been planning suicide but thought it was possibly a day. He had not written a suicide note and did not leave a will. He had not told Karen about his plan to end his life. He said he got the idea of carbon monoxide poisoning from a TV programme. After the suicide attempt, he fell out of the car as he found it difficult to breathe.

127. Steven felt that his mood had been okay. He reported seeing the future as normal. He wished to go back to work and had last worked on the day of his suicide attempt. He did not hear any voices, there were no visual hallucinations, no paranoid thoughts or delusional beliefs and he had no periods of mania. He said that he had always had problems with his sleep because of back pain, but since starting on Amitriptyline he usually managed 7½ - 8 hours' sleep a night.

128. A mental state examination of Steven at that time noted that he made good eye contact but difficult rapport. Steven subjectively described his mood as good and objectively it was noted to be 'euthymic and reactive'.[11] There was no evidence of any formal thought disorder or any delusional beliefs. He reported no thoughts of deliberate self-harm or suicide. He was noted not to be responding to any hallucinations. He was orientated in time, place and person. Insight at that time was documented as unclear as he did not appear to appreciate the significance of the suicide attempt. The clinical impression was of a suicide attempt in response to relationship difficulties.

129. Karen was seen as part of the admission assessment, both together with Steven and then on her own. She said there had been difficulties in the marriage for some time and she was planning to leave Steven after Mark finished his [redacted] She said

[11] In layman's terms, an assessment of 'euthymic and reactive' means that his mood was normal and he reacted appropriately to changes and flows in conversation.

that Steven was emotionally abusive but denied that he was ever physically aggressive towards her or the children. She described him as being “unreasonable and controlling” in his behaviour towards her. She said that Steven had always been difficult to live with and had a poor relationship with his sons. She handed over a note that Steven had given to her which was a list of things for "an escape plan, such as a 20 metre length of rope, false ID and a hat pin". Karen was not referred to domestic violence services or given contact details of such services at this time. The admitting doctor advised that Steven was detainable if he tried to leave.

130. Steven’s parents visited him at the Becklin Centre the following day and on a number of subsequent occasions. His sister and a friend also visited him on occasion.

131. During a ward review on 24 March 2014, Steven appeared guarded but denied any suicidal thoughts. Nursing staff at that time reported that Karen was considering leaving Steven and wanted to tell him while he was in hospital. She was worried that Steven would go to the railway tracks behind their home. Nursing staff reported no signs of depressive symptoms.

132. During the ward round the background circumstances leading to Steven's admission were explored further. Steven reported feeling ignored and neglected by his family prior to his admission. He felt unwanted and that there had been little communication since Christmas 2013. He said that he had tried to hug Karen the Thursday before the admission but she pushed him away. On the following morning Karen told him that she did not love him anymore. Steven explained that he felt this had tipped him over the edge and following this he was thinking about taking his life. He was upset all day at work and did not feel he could confide in his colleagues. Prior to the Friday, he had no thoughts of ending his life. When asked about the suicide attempt Steven repeated that he felt very stupid and very ashamed. He was "regretful" and "glad to be alive". He stated that he now thought he could do without Karen and had no thoughts of ending his life. He still wanted to be with Karen but did not know her feelings at the time. He wished to go back to "normality", to go home and sort things out with his family. He wanted to get back to work, cycling and family life. When asked how he would cope if the relationship with Karen did not work out, Steven stated he would have to split up from his wife and that suicide was too painful. He reported no thoughts of harming others including his wife and children. He denied any auditory hallucinations, paranoid beliefs or other worrying thoughts.

133. Steven was against the idea of staying in hospital for a period of assessment. He stated that friends would provide support if needed. Although he showed no signs of mental illness, the clinical team took a cautious approach and detained him under Section 5(2) of the Mental Health Act at 17.00, allowing him to be held for up to 72 hours against his will. He continued to be nursed on 15-minute observations and was allowed escorted leave in the hospital grounds with nursing staff.

134. On 25 March 2014, the Becklin Centre made a referral to Leeds Adult Social Care for an Approved Mental Health Professional[12] to complete a Section 2 Mental Health Act assessment, which would allow Steven to be detained for 28 days. The case was allocated to a social worker who was an Approved Mental Health Professional (as required under the Mental Health Act) and a trainee Approved Mental Health Professional[13], who was shadowing the social worker. A Community Psychiatric Nurse phoned Steven's GP practice to ask if a doctor would be available to apply for detention of Steven Jordan under the Mental Health Act[14]. The nurse was advised to ask the on-call psychiatrist to do the assessment instead. It is not known whether the GP surgery declined to participate in assessing Steven because of other clinical commitments or whether the GP available lacked personal knowledge of Steven. This was not unusual practice.

135. At 16:00 on 25 March 2014, both Adult Social Care staff members interviewed Steven in a quiet meeting room at the Becklin Centre in the presence of a Section 12 approved doctor. Steven said he chose to commit suicide using exhaust gases because he was a coward and he thought this would be an almost painless method. He was shocked that his wife no longer loved him but having had time to reflect on this he thought he had got his head round it. Steven was unhappy with the prospect of remaining in hospital, as he thought he did not need any help. He minimised the severity of his suicide attempt.

136. The social worker telephoned Karen, as Steven's nearest relative, both before and after the Mental Health Assessment. She reported a difficult marriage and gave several examples of her husband being "unreasonable" and "controlling" in his behaviour towards her. She said Steven had been emotionally abusive but denied he had ever been physically aggressive. At times she was fearful that he might damage property. There is no record that she was given advice and information regarding domestic violence and she was not referred to domestic violence services.

137. Karen thought that Steven had become aware that her intention was to leave him and this led to his suicide attempt. She did not think that Steven's suicide attempt had been serious as he had not come to serious harm and she said he had done it in a way so that he would be found.

138. The Mental Health Assessment documented that Steven had no known contact with forensic services or criminal justice. It was considered appropriate for Steven to be

[12] The Approved Mental Health Professional (AMHP) role was established under the Mental Health Act 2007 and replaced the Approved Social Worker role. The AMHP decides if an individual should be compulsorily detained after assessment and consultation with two doctors, at least one of whom must be a Section 12 approved doctor. The other is usually a GP.

[13] Trainee AMHPs have already completed a professional qualification such as a social worker degree prior to undertaking training to become an AMHP.

[14] Under the Mental Health Act, a patient can only be detained for longer than 72 hours with the approval of two doctors. One doctor must be 'approved' under Section 12(2) of the Act (usually a consultant psychiatrist); the other should know the patient personally in a professional capacity. If this is not possible, the second doctor should also be 'approved'.

detained under Section 2 of the Mental Health Act, as he needed to have a period of assessment in an acute setting due to the risks associated with his attempted suicide, the level of planning involved and the seriousness of the attempt. Steven was not considered to be depressed or psychotic but, according to the trainee AHMP involved in the case, there was discussion between the Adult Social Care staff and the Section 12 doctor that Steven could have an undiagnosed personality disorder that could be properly assessed on the ward. There was a "certain coldness" in him and he could only see that he was affected by his suicide attempt and was not able to understand the impact on his son and wife. The possibility that Steven might have a personality disorder was not explicitly recorded as something to follow up within the Mental Health Assessment as it is not the role of the AMHP to suggest areas of mental disorder for clinical follow up. Nevertheless there was a reference to "Query Personality Traits" in recommendations for further work. As would be routine for all mental health admissions, Steven was assessed during the time of his admission in relation to whether he had a personality disorder and doctors concluded that this was not the case.

139. Under the risk section of the Mental Health Assessment (risk/safety to others), the trainee (who was completing the assessment under supervision by the AMHP) recorded the difficulties that Karen discussed with the social worker in relation to her marriage:

- She alleged emotional abuse from Steven and gave several examples of Steven being "unreasonable" and "controlling" in his behaviour towards her;
- She denied that he had ever been physically aggressive but said at times she was fearful that he may damage property.

140. Neither the examples of Steven's controlling behaviour nor the reasons for Karen fearing Steven might damage property were recorded in the assessment. In interview for this review, the trainee (now a qualified social worker) said that Karen did not actually use the words 'emotional abuse' but it was his opinion that she was experiencing psychological manipulation and emotional abuse from Steven. Karen said Steven could be petty and controlling, for example, if she turned on the lights he may turn them off and she said he had smashed ornaments. The trainee also said that at the time of the assessment, they did not consider that Karen was at risk given there was no previous history of concerns, there was no previous mental health history and there was no involvement from the police or forensic services. *(Author's note – Adult Social Care's approach to risk is considered in the Analysis section.)*

141. The Mental Health Assessment concluded that: "Steven presents as a potentially serious risk of harm to himself (suicide), which requires further assessment and treatment in an in-patient setting. The issues around his relationship were a significant contributing factor in his suicide attempt. There was some suggestion that his relationship/home life may become more volatile in the short term and may lead to an increased risk at current time."

142. At 17:30, the Section 2 Mental Health Act assessment was completed, enabling Steven to be detained for up to 28 days. The period in hospital involved a care plan centred on assessment of his mental health, observation and support. In interview

for this review, the trainee Approved Mental Health Professional recalled discussing the outcome of the assessment with Steven. Steven was very unhappy and tearful. The trainee discussed Steven's rights with him but Steven did not want an Independent Mental Health Advocate.

143. On the same day (25 March 2014), a FACE risk assessment was recorded. All the risk levels remained the same except Steven's risk of suicide, which was reduced from 3 (serious apparent risk) to 2 (significant risk).

144. Arising from the ward review, a Foundation Year 2 doctor telephoned Karen on 25 March 2014 to take a collateral history[15]. This is usual practice for newly admitted patients. Karen reported that Steven had made no previous suicide attempts. There was a background of Steven being moody and stroppy at times. She said that Steven was quite manipulative and got angry about small things. For example she reported that in the past he had told her to turn the lights off and when it did not happen he took the fuses out of the lights. She said that he had never been violent in the relationship. She said he had never been close to their sons. Karen reported that she had made the decision to leave Steven and thought he had picked up on her body language and her attitude changing towards him. She said that she still planned to leave Steven and asked whether it would be best to tell him that she wanted a divorce whilst he was still in hospital. The outcome of that conversation was that it was felt better that Karen told Steven whilst he was in hospital.

145. Karen said that Steven had asked her to bring items into the hospital that he could end his life with, such as a rope. In interview for the review Karen's family said that Steven found it ridiculous that he was in a psychiatric ward and had suggested 'joke' items to escape with including a file baked into a cake as well as a rope. On the same day, Steven was recorded by LYPFT as making jokes about his admission to the psychiatric ward. He said that he had a rope in his bag to escape with. He appeared to have minimal insight into his recent suicide attempt.

146. On 26 March 2014, Steven told his primary nurse that he was keen to have his 15-minute observation levels reduced as he found this was disturbing his sleep at night. He also asked to have unescorted leave in the hospital grounds. The nurse documented that Steven did not wish to end his life anymore and that he felt able to approach nursing staff if this changed. Steven was noted to appear bright and settled in mood with no evidence of low mood and no display of depressive symptoms, his eye contact was good and he was upbeat. He went to use activities such as the gym and ate a good diet.

147. On 26 March 2014, Karen rang Mark's school to inform the extended services team that Mark had found Steven on Saturday following a suicide attempt. She also said that Steven had been detained for 28 days and was staying at the Becklin Centre for treatment. Karen reported that Steven was very difficult to live with but not physically violent. She had made the decision to leave Steven but wanted to wait until Mark had finished his exams. Karen reported that she was going to arrange to leave Steven whilst he was detained and had support from staff at the Becklin

[15] Additional information and background from a source other than the patient

Centre. Steven was aware of her decision to leave and Karen believed that this was what brought on the attempted suicide. Karen reported that she could not let this affect her decision. She had had enough. Karen was particularly concerned how her decision would affect Mark at this point in his school life and asked the extended services team to support him. The Family Support Worker offered to see Mark on 28 March 2014.

148. The nursing notes of 27 March 2014 record that Steven was bright and reactive during 1:1 time and it was felt that there were no symptoms of depression. Steven described himself as being his normal self. He currently had no plans to harm himself and stated that he was positive about the future.

149. Karen visited Steven on the evening of 27 March and told him that she did not love him anymore and wanted a divorce. Nursing staff documented that they spent 1:1 time with Steven following the visit. Steven was noted to be very upset and he told staff that he had cried in private. He denied any suicidal thoughts or thoughts to harm himself in any way. There was no evidence of any psychotic symptoms. Steven told nursing staff he had plans for the future. For example, he said his cousin's brother had a spare room and could put him up for a time and he talked about what sort of accommodation he would be able to afford if they sold the house and split the proceeds.

150. Steven went to the gym the following morning. On return to the ward he said he felt better after the gym session and appeared brighter in mood. Whilst there were no specific concerns, he continued to be nursed on 15-minute observations. He reported no suicidal thoughts. Steven also spent 1:1 time with his primary nurse. He was quite upset about his wife wanting to end the relationship. Staff explored his feelings with him in detail and he reported no intention of harming himself again. Steven said that he would probably not return to the family home and did not envisage that housing would be an issue.

151. On 28 March 2014, the Family Support Worker received a message from Karen that Mark would not be in school. Karen had visited Steven in hospital and told him that she wanted a divorce. Steven had, in turn, telephoned both David and Mark and told them that Karen had requested a divorce. Whilst no further detail was forthcoming about the telephone calls made by Steven to the boys, the inference was that Mark was upset. David was at university at the time, however Karen reported he was so distressed by Steven’s telephone call that Karen and Mark collected him from university on the same day.

152. Mark did attend school later that day and saw the Family Support Worker and the school’s Pastoral Support Officer. He was hoping that the separation would be a move forward for his mother. Mark said that Karen had told him a lot of things that Steven had done over the years that Mark was finding hard to comprehend. He said that he understood Steven had had a difficult childhood and believed this was why Steven parented himself and his brother as he did. When Steven had rung him, for the first time ever that Mark could remember, Steven told Mark that he loved him. Mark said that Karen was the caring and supporting factor in their upbringing. He felt unsure about the possibility of his mum moving out of the family home. Mark did not want to leave his bedroom behind, as this was his sanctuary, yet he did not think

that he would be able to live with his dad. He said that he thought that Karen tried to protect him but he would prefer to know the truth and felt he was mature enough to hear it. He reported that his girlfriend was a great source of support.

153. Over the next few days, (29th – 31st March 2014), Steven's mood was noted to be bright. There was no evidence of low mood or any depressive symptoms. On 30 March 2014, he again asked for his 15-minute observations to be reviewed as these were disturbing his sleep. He continued to state that he felt well and had no thoughts of harming himself. He spent time with nursing staff on the morning of 31 March 2014. He denied any suicidal thoughts and described his mood as okay but complained of feeling tired. He was reactive and responsive to humour, warm and spontaneous and there was no evidence of any depressive symptoms.

154. At the multi-disciplinary team review at the Becklin Centre on 31 March 2014, Steven was reported to be struggling with Karen's decision but could see a future without her. He again denied any suicidal thoughts and there was no evidence of any depressive symptoms. He was noted to be eating and sleeping well and was bright in mood. He stated that he was not really an impulsive person, and usually tried to think things through. He denied any paranoid thoughts or hallucinations.

155. Steven spoke at the review about his marriage. He explained he had been discussing with his wife the possibility of him still returning home on discharge and that they may look at selling their house after his son had finished his [redacted] exams. He said he understood where his wife was coming from when she said she had grown away from him and that he could see why his wife wanted to split up from him. He said that he had "not been the best husband in the world" and that he was ashamed of his behaviour to his wife over the years. He described himself as having been 'cruel' to Karen. When asked for an example, he described an incident when they had had an argument and she had run and slipped on the kitchen floor, dislocating her knee. He had not helped her up and instead went upstairs and did not call an ambulance.

156. Steven's main risks were considered to be attempts on his own life in the future in response to stressful situations. He maintained at this time that he had no suicidal ideas and deeply regretted the attempt he had made on his life. He said he would seek help in the future should he ever feel like that again. His level of observations following the multi-disciplinary review were reduced from 15-minute observations to general observations (hourly) and he was granted unescorted leave in the hospital grounds.

157. On 1 April 2014, Karen spoke with a Foundation Year 2 doctor[16] over the telephone about practical issues surrounding the divorce such as whether Steven would be returning to the family home on discharge. During that conversation, Karen said that Steven planned to contest the divorce. She was very concerned about the risk of violence from Steven towards her and gave the example of Steven having previously thrown a bannister at her over a minor issue. The doctor explored this

[16] A doctor who had completed their initial medical degree and was in the second year of post graduate training

further with Karen who clarified that Steven had not made any threats during this admission or recently and there were no current threats of violence. In light of the concerns expressed by Karen, the doctor spoke to Steven's consultant psychiatrist straight after her conversation with Karen and explained that she sounded worried about a possible risk of violence. The consultant psychiatrist suggested that the doctor telephone Karen back to ask whether she would be agreeable to them making a vulnerable adults referral. The doctor therefore telephoned Karen back and Karen agreed to the referral being made.

158. The Foundation Year 2 doctor telephoned the Leeds Social Services contact centre that same afternoon and explained that the consultant had asked her to make a safeguarding referral in relation to a patient's wife. The doctor explained that they felt Karen was at risk of emotional abuse and that Steven had previously physically threatened her, although there were no current threats. The call taker at Leeds Social Services indicated that they would not be able to accept a referral in relation to Karen because she would not come within the criteria for a vulnerable adults safeguarding referral[17]. The call-taker gave the doctor a safeguarding helpline telephone number and a link to the safeguarding webpage and asked the doctor to pass the information on to Karen. The call taker also advised that if Karen did feel threatened she should call the police.

159. The Foundation Year 2 doctor telephoned Karen back straight away and passed on the safeguarding contact information including the telephone helpline number and website. The doctor explained to Karen that she should call the police if she felt threatened by Steven.

160. On 2 April 2014, the School Nursing Service was notified by Leeds Teaching Hospital Trust (via a phone call from a staff nurse in A&E) that Mark had attended A&E with Steven as a result of Steven having self-harmed on 22 March 2014. It is not known why there was a delay in the notification. The School Nursing service was also notified that a referral had been made to Leeds Children's Social Work Services. There was no further School Nursing involvement as a result of this notification and no recorded evidence of liaison with other professionals.

161. Also on 2 April 2014, Steven's risk of violence/harm to others was changed on the FACE risk assessment from 9 (unknown) to 1 (low apparent risk) and the primary

[17] At the time, the definition of a vulnerable adult was someone, "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation." This definition was taken from the *No Secrets* guidance (Department of Health (2000), *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. Page 8, paragraph 2.3). This has now changed with the Care Act 2014, which was enacted on 1 April 2015. Safeguarding duties now apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

nurse ticked the box to indicate that the patient's partner/spouse could potentially be at risk.

162. On 2 and 3 April 2014, Steven was noted to be bright in mood with no evidence of low mood or symptoms of depression. However on 4 April 2014, Steven told a ward nurse that he had received a letter from Karen's solicitor informing him that Karen was "taking everything" (Steven's words) and that he could have no contact with his sons. He was noted to be upset and tearful and the nurse explored his mental state. When asked directly whether this development had caused him to experience any suicidal ideas, he was clear that it had not. The letter indicated that he would not be allowed to return to the family home on discharge. The nurse advised Steven to discuss this with a solicitor. The letter from Karen's solicitor also referred to concerns about Mark's current ability to cope with Steven's recent suicide attempt, particularly the fact that he had found Steven after the attempt. The nurse discussed with Steven the issues raised about Mark and his needs. Steven gave his consent to the nurse contacting Karen about this. The nurse then telephoned Karen to inform her about The Willows, a service provided by Barnardo's for young carers of people with mental health problems. Having spoken to The Willows beforehand, the nurse made Karen aware that there was a waiting list for the service and confirmed that Karen had the website details for this.

163. Between 5 April and 8 April 2014, nursing staff noted that Steven had no depressive symptoms. On 7 April 2014 Steven wanted a copy of Karen's solicitor's letter to give to his own solicitor, which was provided. He appeared bright in mood with no symptoms of low mood. He was positive in his outlook and felt that he had support from his family regarding his current situation.

164. On 9 April 2014, Steven told a ward nurse that he had spoken with his solicitor who advised that legally he should be able to return back home as there was no injunction or legal proceedings or court order in place to prevent him doing so. He said that ideally he would like to return back home and live in separate rooms until he sought other accommodation, but was aware that he may need to find accommodation whilst in hospital and be discharged straight to a new address.

165. Steven was seen for a Care Programme Approach (CPA) review on 9 April 2014, which involved the consultant psychiatrist, nursing staff from the ward, a trainee doctor and the care co-ordinator from the community mental health team. The emphasis of the review was on making plans to support Steven for the future including discharge from hospital and on-going support. Steven contributed positively, talking about alternative housing, a graded return to work and follow up from community mental health services. There were on-going issues with divorce proceedings and whether he could return to the family home.

166. Steven reported that his mood was good and he had been trying to sort out the practicalities following the letter from Karen's solicitor. He explained that once discharged he planned to sell things he owned and then move out of the family home. He said that he had come to terms with the divorce and had no thoughts of harming anyone including his wife and children. The plan was for the clinical team to await feedback regarding his accommodation and to aim for discharge when the position on this was resolved. Steven was granted two hours of Section 17

unescorted leave outside the hospital per day to the local area or to view any potential housing. It was also planned that the consultant would speak with Karen regarding the history of alleged domestic abuse as it was felt that Steven minimised this, with a view to possibly contacting Police Safeguarding thereafter. Steven confirmed during the review that he was happy for the team to speak to Karen.

167. On 10 April 2014, the consultant psychiatrist spoke in detail with Karen by telephone about the history of domestic abuse. She said that Steven had mentally abused her since before they were married. The abuse was ongoing, making her marriage and life difficult. Karen reported that Steven had cut his face out of photos. She said that on one occasion while she was having breakfast in bed he had asked her where something was. When she replied "why do you need that now?" he had poured her coffee and cereal on the floor and she had to clean it all up. Steven could be triggered by any small thing and she had to walk on egg shells in case it triggered bad behaviour. She told the consultant that such 'incidents' occurred approximately once every 6 months. When the children were much younger he used to hit them with a slipper. She said he had never hit her but, many years ago, he destroyed an upstairs bannister and threatened to hit her after a minor argument. She did not report any recent threats of violence. She said he was very controlling. She was worried that if he had behaved like this to her for 20 years, then what would he be like if he returned to the family home, now she had told him she was pursuing divorce. She had planned to divorce him after her son had completed his [redacted] in the summer. Karen reiterated that she intended filing for divorce. She had not at that time spoken to the police but had seen a solicitor who advised her that an injunction could be made to prevent him returning to the family home. She reported that her [redacted]-year-old son was more settled now and thought that Steven could live with his parents or another relative. The consultant explained that Steven had no symptoms of acute mental illness such as depression. He said that Steven would be discharged either later that week or the early part of the following week and she would be notified of when Steven would be discharged.

168. They discussed Karen's welfare if Steven returned to the marital home. The psychiatrist advised Karen that what she was describing was domestic abuse. The consultant went through the Police Safeguarding website with Karen whilst they were on the telephone and, based on the information on that website, they discussed domestic abuse and how to get help. As Karen seemed uncertain about telephoning the Police Safeguarding Unit herself, the consultant offered to make this referral and she confirmed that she was happy for him to do so.

169. Immediately following the telephone discussion with Karen, the consultant psychiatrist rang the West Yorkshire Police Safeguarding Unit in line with the guidance on the police website, which stated that a referral could be made by telephone. The psychiatrist's call was received by a domestic abuse clerical officer in the Leeds Safeguarding Unit. The doctor provided the details of Karen's history of abuse from Steven and informed the clerical officer of Steven's suicide attempt, that he would soon be discharged and that he had psychologically abused his wife. The psychiatrist asked the police to contact Karen and provided her home and mobile phone numbers. The consultant left his name and contact number in the event that the Police Safeguarding Unit needed to speak to him again but the Safeguarding

Unit did not contact him at any point up to the events giving rise to this review. The consultant reasonably believed that he had made a referral, but although West Yorkshire Police contacted Karen, they did not consider that LYPFT had made a referral. This was not made clear to LYPFT.

170. The domestic abuse clerical officer phoned Karen later that day after checking police databases and finding no previous reports of domestic abuse. Karen stated that she had suffered mental abuse from Steven for most of her married life and that he could "flip" at anything. She said that their marriage was over and she intended to move on with her life. Karen indicated that she did not intend to move out of her current home because her son was sitting exams. She thought that Steven might be able to find somewhere else to stay. She had already contacted a solicitor. The Clerical Officer advised Karen to contact the police "if any incidents occurred" and gave her contact details for Leeds Domestic Violence Service.[18] She also said she would send Karen a pack providing information about services available to women in Leeds. She was advised to keep a log of Steven's behaviour. In interview for this review, the Clerical Officer described her impression of Karen as "switched on and strong". She recalled that Karen may have described some specific incidents but did not believe she had reported physical violence. She felt that Karen was satisfied with the advice and information given. No record was made of the conversation and no report was submitted. The Clerical Officer said that this is normal practice when telephone calls are received asking for general advice. *(Author's note: the police's categorisation of this as a call "for general advice" rather than as a follow up of a referral from the Becklin Centre will be considered further in the Analysis section.)*

171. Karen attended the Leeds Women's Aid Drop-In service[19] with her parents on Friday 11 April 2014. Her father was asked to wait outside, as this was a women only service, whilst Karen discussed her situation with the LWA Drop-In Worker and a volunteer. Karen disclosed a history of non-physical domestic abuse by Steven, his recent suicide attempt and his imminent release from the Becklin Centre. Earlier in the year, Karen had made a decision to leave Steven once Mark had completed his [redacted] (in June 2014). She believed Steven's suicide attempt had been in response to her change in behaviour following her decision to leave him. Karen had taken legal advice about obtaining an Occupation Order to prevent Steven from returning home and was told it would cost about £3,000. She had instructed her solicitor to write to Steven at the Becklin Centre to ask him to live with his own family on his release. She said his family had agreed to have him. Karen would not consider leaving the house herself until Mark's exams were finished. She thought it would be possible to live separately under the same roof if Steven insisted on returning home; Karen said it would be awkward but did not express any fear. The

[18] Leeds Domestic Violence Service is a consortium commissioned by Leeds City Council to deliver a range of support, advice and advocacy to female and male victims of domestic violence. The services are delivered by Leeds Women's Aid, Help Advice & Law Team and Behind Closed Doors.

[19] The Drop-In is not part of the Leeds Domestic Violence Service contracted by Leeds City Council

LWA volunteer recalls Karen expressly stating she wasn't frightened of Steven. Her mum did not express any concerns herself and did not contradict Karen's account.

172. As a result of the discussion, Karen was given information and LWA Drop-In contact numbers (office and LWA Worker mobile). Karen was unsure whether the Occupation Order would be successful. She was advised to ring Rights of Women for an opinion on the cost of an Occupation Order. She gave consent for a referral to the LDVS Outreach team (provided by Behind Closed Doors) for emotional support whilst she was going through the separation. The option to undertake a CAADA-DASH assessment was not taken as the volunteer and worker did not identify any significant risk issues. This was in line with the Drop-in Guidance Protocol and Risk Assessment Protocol for Drop-In in operation at the time. *(Author's note: the decision not to undertake a risk assessment is discussed in the Analysis section.)*

173. Later the same day, the LWA Drop-In worker sent the referral via email to the LWA Gateway Co-ordinator. The referral was processed on Monday 14 April 2014 and sent by secure email to the LDVS Outreach team. The referral was processed by the LDVS Outreach Team Leader on 15 April 2014. An initial assessment of the information provided did not indicate that this was a priority or high-risk case. The referral was placed in the 'client pending tray' awaiting the attention of an LDVS Outreach Duty Worker. At the point of Karen's death, contact had not been attempted. This was outside the required response time, which is to attempt initial contact with all newly referred clients (or the referrer if more appropriate) within three working days.

174. Also on 11 April nursing staff spoke with Steven regarding using his Section 17 leave (unaccompanied leave) for viewing properties. The nursing notes document that Steven was looking at some housing websites that day but was also still considering living with a family member on discharge. At this point there was a recognition that they may be looking at discharge sometime during the following week. He reported that his mood remained good, he had no suicidal thoughts and he continued to be positive about the future. He was waiting to hear back from his solicitor regarding being able to return to the family home.

175. Steven discussed his housing situation with a nurse on the ward on 13 April 2014. He said he had an emailed a landlord about a property. There were no concerns about his mental state and he did not display any symptoms of depression or low mood. Nursing staff documented that on 14 April 2014 he continued to look for accommodation and was aware that he would be looking at his discharge soon. He was bright and reactive and did not display any symptoms of depression or low mood.

176. On Wednesday 16 April 2014, Steven was reviewed in the ward round as planned, to discuss his discharge plans. There was no family/carer representative at the review. Steven's parents were considered to be his main source of support. Karen had not been invited due to the difficulties between the couple and because LYPFT believed Steven would not be returning to the family home. (*Author's note: this is discussed further in the Analysis section).* During his admission Steven had looked at alternative accommodation other than returning to the family home, including living with his parents and family members as well as looking at living independently

in rented accommodation. However, despite alternative accommodation options, Steven always wished to return back to the family home, which he felt he was entitled to do. The consultant understood that Steven had sought legal advice in this matter and was informed that he could return to the family home unless a court told him otherwise. Prior to the ward review that day, Steven informed nursing staff that Karen had contacted him to say that he could return back to the family home as long as he found alternative accommodation as soon as possible. Steven showed the nurse the text he had received from Karen, which stated that he could move back to the family home on a temporary basis as long as his behaviour was reasonable. This text message was discussed at the ward review and, reflecting the concerns previously expressed by Karen about Steven returning to the family home, the consultant asked a member of nursing team to contact Karen after the ward review to double-check the position.

177. At the ward review, Steven stated that he had no low mood or suicidal thoughts. He also displayed no psychotic symptoms. He said he had no thoughts of harming others. The consultant expressly asked questions in relation to how Steven felt about his wife and children and whether he had any negative feelings towards his family due to his separation and Steven indicated that he did not. Steven was removed from his section on the basis that he had been assessed on the ward for 25 days, the clinical team were confident he did not display any symptoms of mental illness and there were no grounds for the section to continue or be extended. Steven refused any input from the intensive community support services but agreed to meet the care coordinator. Steven said he was no longer suicidal and felt he would be able to approach staff either at the Becklin Centre or in the community should he feel that way again. The plan was for Steven to be discharged once accommodation arrangements had been confirmed, which would possibly be that day subject to confirming with Karen the position regarding her text. Steven was made aware that the Community Mental Health Team would contact him to arrange follow-up within three days, which he accepted. He said he had support from his friends and family to help him.

178. A member of the nursing team telephoned Karen following the ward review. She confirmed that she had agreed to Steven returning back home in the short term, although she said she was not sure whether there were any conditions via the solicitor that Steven would have to abide by. Karen did not express any concerns for her own welfare or that of anybody else during that conversation.

179. The FACE risk assessment was updated. The risk of suicide was reduced from 2 (significant) to 1 (low apparent risk). The risk of violence/harm to others remained at 1.

180. As part of the agreed discharge plan, the Becklin Centre phoned the Community Mental Health Team. A message was left with the administration staff asking the care co-ordinator/community mental health team worker to request follow up within three days.

181. Steven's GP received a psychiatric discharge letter on 16 April 2014. There was no request for practice follow up in this letter. On 22 April 2014, Steven's analgesia for back pain (which was on repeat) was reduced to weekly issue due to his overdose

risk. This is standard practice in any case where there has been an incident of self-harm.

182. Two days after Steven's discharge, at 7.38pm on Friday 18 April 2014, Karen contacted West Yorkshire Police. She reported that when she and her sons went out for a walk that evening, Steven had insisted on following them even though she had specifically told him not to. This call was made while they were still on the walk and Karen said that Steven had gone away when he saw her on the phone. The call taker logged the information that Steven had recently been sectioned and that the couple were now separated but living in the same house because Steven had nowhere else to go. Karen indicated that she had previously been in touch with the Leeds Safeguarding Unit at West Yorkshire Police. She said she did not know if the situation would escalate when she returned home. The call was initially logged as a domestic incident, standard response.

183. At 7.51pm the log was endorsed that there were no units available to send to the call (it was the Friday evening of the Easter Bank Holiday weekend). At 9.45pm, the police contacted Karen by telephone. Both Karen and Steven had returned home. She was in one room with her sons and Steven was in another room watching TV. The log was finalised that Karen wanted no further action taking and that the call had been made for information only. The incident was finalised as message rather than as domestic abuse. As a result, no follow up was required. *(Author's note: This was a potential harassment offence but was not dealt with as such.)*

184. Steven was contacted by phone by his care co-ordinator from the Community Mental Health Team (CMHT) a week later on 23 April 2014, following the Easter Bank Holiday. Although outside the three days requested by the Becklin Centre, this was within the seven days required by LYPFT's policy. The care co-ordinator explained that he was telephoning to find out how Steven was following his discharge from hospital and to arrange a time for them to meet. Steven reported that he was fine and explained that he was living back at the family home but in a separate room from his wife and that he was returning to work on a graded return basis. Steven was reluctant to meet up and asked the care co-ordinator whether their telephone call could constitute the follow-up. The care co-ordinator explained that he would like to see him face-to-face, which Steven reluctantly agreed to. The first date Steven said he could do was 2 May 2014, although he was offered earlier dates. The care co-ordinator told Steven what support was available to him should he feel he needed it.

185. On 23 April 2014, Mark met with the Family Support Worker. He said that Steven had returned to the family home and the atmosphere was strained. He discussed alternative places where he could go and study if the atmosphere was impacting on his concentration. Mark said that Steven appeared to be making no attempt to leave the home or find alternative accommodation. Both Steven and Karen had solicitors involved.

186. At 14:57 on Saturday 26 April 2014, police received a call from Karen. The log details the circumstances of Steven's suicide attempt, their separation and that Steven had been trying to control and harass Karen since his discharge. As well as following her and the children, he had changed the Wi-Fi codes at home to prevent

Karen and Mark from having Internet access. Karen and Mark were currently safe at her parents. The call was logged as a domestic incident, standard response. Later that evening an officer contacted Karen and made an appointment for officers to visit the following day.

187. At about 1pm on Sunday 27 April 2014, two police officers visited Karen at her parents' home. The officers remained there for approximately an hour and spoke with Karen and her mother and father. During that time Karen informed the officers about Steven's suicide attempt, his period under section, her separation from him although they were still living in the same house, the incident where he followed her when she and the children went for a walk and his changing of the Wi-Fi codes. She asked the police officers for advice about what to do next. They asked questions to establish if a substantive criminal offence could be identified, for example whether he had been violent or caused damage to property but Karen said he had not. *(Author's note: again, this was not investigated as a harassment offence).* One officer consulted with a sergeant from the address and determined that the circumstances did not constitute a domestic abuse report and that no domestic abuse niche occurrence report was required. No risk assessment was undertaken. *(Author's note: this should have been recognised as domestic abuse. This is considered further in the analysis section.)* Karen was advised to contact the police again if a domestic abuse incident did occur and to continue action through her solicitor. The officers offered to visit Steven and discuss his conduct with him but Karen declined this offer as she felt police attendance might make things more difficult when she returned home.

188. Steven attended a family meeting later that day at Karen's parents' house.

189. On 28 April 2014, Karen and Mark returned home. Karen's father fitted locks on their bedroom doors to prevent Steven from harassing them and intruding on their privacy.

190. On 29 April 2014, Mark met with the Family Support Worker. He reported that Steven had changed the Internet password and refused to let either Mark or Karen have the new one. Mark said that Steven had also hacked into both his and Karen's computers. This resulted in Mark and Karen going to stay at Karen's parents over the weekend. Mark said that this was not a sustainable arrangement due to the location of his grandparents' house. Karen and Mark had returned back home with locks on their bedroom doors. Steven was not accepting the spilt and was not sticking to the agreement to move out.

191. Mark went to his girlfriend's house later that afternoon. When Karen returned from work, Steven was at home. Neighbours reported hearing an argument. At 18:32, the first of several calls was made to emergency services reporting a house fire at Address 1. Some reports also referred to a man emerging from the house engulfed in flames and to the sound of an explosion. Police, fire and ambulance crews were dispatched.

192. The police arrived first, at 18:34, and found Steven alight in the back garden. Together with members of the public, the officer used water from the garden pond to extinguish the flames. Yorkshire Ambulance Service dispatched three Rapid Response Vehicles (RRV), two Double Crewed Ambulances and two members of

the Hazardous Area Response Team. The first RRV arrived at 18:41. The house was fully alight and very smoky and police and fire services were already on the scene. Steven was located towards the rear of the garden. He was very badly burned and in and out of consciousness. He was given oxygen treatment and taken by ambulance to Leeds General Infirmary. En route he became non-compliant, taking off his oxygen mask and pulling the airway out. He said he wanted to die and kept trying to get off the trolley. Steven was treated on arrival at Leeds General Infirmary but died that evening of his injuries.

193. Steven had used an accelerant to start the fire and the house was well alight. It took the fire service some time to bring it under control. Karen's body was found inside the side entrance door. She had been stabbed a number of times.

194. The police initiated a homicide inquiry. Following the investigation, they were satisfied that Steven killed Karen, before deliberately setting fire to their house using some form of accelerant.

Section Five: ANALYSIS OF INDIVIDUAL AGENCY RESPONSES

195. A comprehensive chronology of agency contacts was prepared and considered by the Review Panel. In the accounts that follow, agency involvement has been summarised to focus on those contacts of most significance to the DHR.

Leeds & York Partnership NHS Foundation Trust

Summary of involvement

196. Steven had contact with LYPFT as an A&E patient requiring a psychiatric assessment following a suicide attempt on 22 March 2014; as an inpatient at the Becklin Centre in Leeds under the care of a consultant psychiatrist between 22 March and 16 April 2014; and as a recipient of community mental health services following his discharge.

197. Steven was assessed by the Acute Liaison Psychiatry Service at St. James's University Hospital A&E on Saturday 22 March 2014 following a suicide attempt. He was informally admitted to the Becklin Centre, a psychiatric hospital, later the same day. This reflected a cautious approach to assessment and was good practice. On 24 March 2014, Steven was formally detained, initially under Section 5(2) and then, on 25 March 2014, under Section 2 of the Mental Health Act, after he said he wanted to leave the hospital. At the time that he was formally detained, he was considered to pose a risk to himself (suicide) but his risk to others was assessed to be unknown.

198. The period in hospital involved a care plan centred on assessment of his mental health, observation and support. Over the 25 days that Steven was in hospital he was assessed by multiple professionals, including doctors and nursing staff, at both regular review meetings and through observation. This included nursing observations every 15 minutes from 22 March 2014 until 31 March 2014. The conclusion of these assessments was that Steven was not suffering from any mental illness or disorder including a personality disorder.

199. On the first day of her contact with LYPFT, on 22 March 2014, Karen disclosed a history of emotional abuse and controlling behaviour to LYPFT staff. There is no evidence that she was provided with contact details for domestic abuse services, either on that day, or on 25 March 2014 when she again referred to a long history of domestic abuse.

200. However the issue of domestic abuse was explored with Karen on 1 April 2014 during a telephone call with a Foundation Year 2 doctor, and again on 10 April 2014, when a consultant psychiatrist contacted her by phone. With Karen's agreement, the doctor sought to refer her to the Safeguarding Unit at Adult Social Care on 1 April 2014 but the referral was not accepted as Karen did not meet the criteria for a vulnerable adults safeguarding referral. LYPFT should have considered making a referral to a specialist domestic abuse service at this time, or at least given Karen contact details for such a service.

201. The consultant psychiatrist recorded a chronological history of the abuse on 10 April 2014 and spent time going through the police safeguarding website with Karen. This was good practice. With Karen's agreement, the consultant psychiatrist contacted the West Yorkshire Police Safeguarding Unit the same day with the aim of referring Karen in relation to domestic abuse. The police did not accept the case as a referral but LYPFT were not aware of this.

202. Although they attempted to make two safeguarding referrals (one to Adult Social Care, one to the police), LYPFT assessed Steven to be at low risk of harming Karen. LYPFT have asserted that a number of factors pointed away from Karen being at significant risk of harm including:

- Steven told staff that he was coming to terms with the prospect of the separation;
- Steven seemed to be making positive plans for the future, including planning for his return to work, investigating alternative accommodation and planning ways he would cope with stressful situations (e.g. going for walks);
- Steven said he regretted the suicide attempt and that he was no longer experiencing thoughts of harming himself;
- Steven consistently denied that he was experiencing any thoughts of harming Karen or anybody else;
- Steven's mood and behaviour were stable and appropriate during his period of admission;
- No issues had arisen during Steven's Section 17 leave away from the unit;
- There was no evidence of any mental illness or disorder;
- There was no forensic history;
- There were no current or recent threats of physical violence and only one known incident of threatened physical violence against Karen in the past.

203. Nevertheless LYPFT were aware that:

- Karen had disclosed a long history of Steven's abusive and controlling behaviour;
- Steven's attempted suicide was linked to his fear that Karen was going to leave him;
- Karen was now separating from him (a recognised period of heightened risk of domestic abuse and domestic homicide[20]);

[20] A substantial proportion of domestic homicides where the perpetrator is male and the victim is their female (ex) partner, occur post-separation. See for example, Understanding Homicide by Fiona Brookman, Sage, 2005, p282-3; *Private Violence: up to 75% of abused women who are murdered are killed after they leave their partners*, http://www.theguardian.com/money/us-money-blog/2014/oct/20/domestic-private-violence-women-men-abuse-hbo-ray-rice

- Karen had initiated divorce proceedings and attempted to prevent him returning to the family home;
- Karen had told LYPFT on at least two occasions (1 and 10 April 2014) that she was concerned about what Steven might do to her.

204. The appropriateness of an assessment of low risk is discussed in Section Six, Risk Assessment.

205. During his time in the Becklin Centre, Steven's mood was generally assessed as bright, he said he regretted his suicide attempt and denied having suicidal thoughts or thoughts of harming anyone else and did not display psychotic symptoms. He was assessed as not having a mental illness. In reviews he said he had started accepting the relationship breakdown. Although he described feeling sad he was also talking positively about the future. He was assessed as making progress and as not having a mental illness. At the time of his discharge, LYPFT would have had little legal justification for continuing to compulsorily detain him.

206. Steven was discharged back to the family home, Address 1, on 16 April 2014. Karen was not invited to the ward review meeting where the discharge decision was made. LYPFT have said that this was because until the day of the discharge they believed that Steven was not returning home. However there were indicators that Steven might return to the marital home from at least a week before this with Steven saying on 9 April 2014 that he hoped to return home and that he was entitled to do so unless Karen obtained a court order. Staff took the time to contact Karen on 16 April 2014 to check that the text Steven had shown them saying she agreed to him returning home on a temporary basis was genuine. However there was no explicit plan for promoting her safety and it appears that staff believed that this would be addressed through the supposed referral to West Yorkshire Police, which, unbeknownst to LYPFT, had not been accepted as a referral.

207. Although Steven's risk of suicide and his risk of harming others were assessed during his admission and within the FACE risk assessment process on the day of discharge, homicide followed by suicide[21] was not explicitly considered as a potential risk. LYPFT maintain that there was no evidence to suggest that Steven presented such a risk - he had no previous forensic history and had not recently threatened Karen. *(Author's note: He had however been manipulative and controlling in the hospital ward immediately prior to admission. LYPFT noted as part of the initial referral from St James's hospital on 22 March 2014 that the hospital staff nurse reported that Steven's wife looked "tense" and "frightened.")*. LYPFT did not have a domestic violence policy in place at the time of Steven's admission and had not adopted the CAADA-DASH.

208. There was limited contact with the Community Mental Health Team after Steven's discharge, with only one phonecall in a period of almost two weeks and no face-to-

[21] There were at least fourteen homicide-suicides involving a male partner/ex-partner killing a female partner/ex-partner in England and Wales in 2014. This is more than one in ten of the domestic homicides involving a female victim where the perpetrator was a male partner/ex-partner. http://kareningalasmith.com/counting-dead-women/2014-2/

face contact. A home visit had been arranged for 2 May 2014. Attempts had been made to have face-to-face contact on an earlier date but Steven said he was not available and LYPFT could not compel him to have an earlier appointment.

Key events

209. Steven was informally admitted to the Becklin Centre via the Trust's Acute Liaison Psychiatric Service (ALPS), who assessed Steven in St. James's University Hospital following a suicide attempt. This reflected a cautious approach to dealing with Steven's presenting issues, demonstrating good practice at a time when there is frequently pressure on in-patient resources. He reported that his problem stemmed from his wife reportedly telling him she didn't love him anymore.

210. At the point of admission to the Becklin Centre it emerged that Karen was planning to separate from Steven. At the admission assessment on the afternoon of 22 March 2014, Karen reported that they had had difficulties for some time. She said he had subjected her to emotional abuse and described him as being "unreasonable and controlling" in his behaviour towards her. Karen was not referred for support in relation to domestic abuse at this time or provided with details of relevant support services.

211. A junior doctor spoke to Karen on 25 March 2014, and she reported that Steven had asked her to bring items that he could escape with into the hospital. These included a rope which he could have also used to attempt suicide. Although Steven passed this request off as a joke, it could be interpreted as an example of manipulative/controlling behaviour.

212. On 1 April 2014, Karen told a foundation year 2 doctor that she was concerned about a risk of violence towards her and disclosed previous abuse and threats. Following discussion with the consultant psychiatrist, and with Karen's agreement, the Foundation Year 2 doctor contacted the Leeds Social Services contact centre that day with the aim of making a safeguarding referral. Leeds Social Services explained that they would not accept this as a safeguarding referral because Karen did not come within the vulnerable adults criteria. (*Author's note: both the Serious Incident Investigation report and the consultant psychiatrist's report to the Coroner, describe this as a referral but LYPFT subsequently clarified that they were aware that this had not been accepted as a referral*). The doctor was given contact details of Adult Social Care's Safeguarding Unit, which she passed on to Karen. LYPFT should have referred Karen to a domestic abuse service or at least given Karen contact details for such a service at this time but did not.

213. Domestic abuse was also explored with Karen on the phone by the consultant psychiatrist on 10 April 2014. She reported that she had experienced extensive and ongoing mental abuse from Steven, including prior to the marriage. The consultant recorded a chronological history of the abuse and spent time going through the police safeguarding website with her. This was good practice. With Karen's agreement, the consultant psychiatrist contacted the West Yorkshire Police Safeguarding Unit the same day with the aim of referring Karen in relation to domestic abuse. He shared the history of abuse with the clerical officer who took the call and he provided contact details for Karen. The consultant assumed, with justification, that the police had accepted this contact as a referral. This was not the

case. Although the police called Karen to provide her with information and suggest she keep a log of Steven's behaviour, they did not in fact accept the case as a referral and treated it as a call for general advice. LYPFT were not aware that the Police Safeguarding Unit had not accepted the contact as a referral.

214. FACE (Functional Analysis of Care Environments)[22] risk assessments were conducted with Steven on a number of occasions during his contact with LYPFT. The first was conducted as part of the ALPS Assessment on 22 March 2014. It recorded:

- Risk of suicide – 3 (serious apparent risk)
- Risk of deliberate self harm - 1 (low apparent risk)
- Risk of accidental self harm - 1 (low apparent risk)
- Risk of severe neglect - 0 (no apparent risk)
- Risk related to physical condition - 0 (no apparent risk)
- Risk of abuse/exploitation by others - 0 (no apparent risk)
- Risk of violence/harm to others – 9 (unknown risk).

215. The only person recognised as at risk during the initial assessment was Steven himself. Further FACE risk assessments were recorded over the course of Steven's admission (on 25 March 2014, 2 April 2014, 11 April 2014, 16 April 2014). All the risk levels remained the same except:

- Risk of suicide – reduced from 3 to 2 (25 March 2014) and from 2 to 1 (16 April 2014);
- Risk of violence/harm to others – changed from 9 to 1 (2 April 2014)

216. In FACE risk assessments from 2 April 2014 onward, Steven was recognised as posing a risk to both himself and to Karen but the risk to Karen was viewed as low. The assessment on 2 April 2014 was the day after LYPFT had contacted Adult

[22] Under the FACE risk assessment system:
0 = no apparent risk. No history of warning signs indicative of risk.
1 = low apparent risk. No current behaviour indicative of risk but patient's history and/or warning signs indicate the possible presence of risk. The necessary level of screening/vigilance is covered by a standard care plan, i.e. no special risk prevention measures or plan are required.
2 = significant risk. Patient's history and condition indicate the presence of risk and this is considered to be a significant issue at present i.e. risk management plan is to be drawn up as part of the patient's care plan.
3 = serious apparent risk. Circumstances are such that a risk management plan should be/has been drawn up and implemented.
4 = serious and imminent risk. Patient's history and condition indicate the presence of risk and this is considered imminent (e.g. evidence of preparatory acts). Highest priority to be given to risk prevention.
9 = unknown risk.

Social Care with a view to making a safeguarding referral. Similarly the day after the consultant psychiatrist thought that he had referred Karen to West Yorkshire Police because of domestic abuse, the FACE assessment was that Steven was at low risk of harming her. The consultant psychiatrist recorded on 10 April 2014 that 'incidents' occurred approximately every 6 months, but it is clear that Karen described a relationship characterised by an ongoing dynamic of controlling behaviour from Steven to Karen. She described Steven as "very controlling" and the psychiatrist recorded that during the marriage, "She has had to walk on egg shells in case it triggers bad behaviour in him to her." The psychiatrist recognised that Karen had been experiencing domestic abuse for a considerable period of time. There is no clear rationale for the assessment of low risk of harm given the history of coercive control, the circumstances of Steven's attempted suicide and Karen's decision to initiate divorce proceedings.

217. In all FACE assessments, including at the point of his discharge, Steven's risk of relapse was recorded as high. LYPFT have stated that the box for 'high risk of relapse' on the FACE document was ticked 'yes' at the point of Steven's admission but that staff did not 'untick' this box as the admission progressed. LYPFT have stated that this should have happened. Other contemporaneous documentation reflects LYPFT's assessment that Steven was not considered to be at high risk of suicide at discharge. The issue of risk assessment is discussed further in Section Six: Risk Assessment.

218. The Mental Health Act Assessment conducted on 25 March 2014 referred to the possibility that Steven may have "personality traits" and recommended that he needed to develop coping strategies and ways to regulate his emotions. Leeds & York Partnership Foundation Trust addressed these issues under the Care Programme Approach. As is routine in any assessment of a patient's mental health, consideration was given to aspects of Steven's personality and whether he may meet the criteria for a personality disorder. During the 25-day in-patient admission Steven was regularly assessed and no evidence emerged that he had any mental disorder, including personality disorder. He showed no symptoms of depression or emotional instability during his admission. He received input from doctors and nurses in relation to exploring his emotions and coping strategies via multi-disciplinary ward reviews and regular 1:1 time with nursing staff. On discharge he was provided with information about services to contact if he needed support.

219. On 27 March 2014, Steven said he wanted to appeal against being compulsorily detained and was given a list of solicitors but by 30 March 2014 he had decided not to appeal.

220. Karen visited Steven on 27 March 2014 and told him that she wanted a divorce. He was upset about this and spoke to night staff on the ward. At the multi-disciplinary team review at the Becklin Centre on 31 March 2014, Steven was reported to be struggling with Karen's decision but could see a future without her. He described himself as having been cruel to Karen during the marriage and said he understood why she might want to leave him. A few days later, on 4 April 2014 he appeared distressed and said he did not know why his wife was stating that he had abused her, although only a few days earlier he had admitted being cruel to her. The primary worker said that emotional/mental abuse was often subjective. She did not

discuss with the clinical team whether there were referral options for Steven to address his behaviour as a perpetrator beyond seeking legal advice.

221. A Care Programme Approach meeting was held on 9 April 2014. Steven's Primary Worker said that should Steven have accommodation to go to then his current presentation would be able to be managed by the Intensive Community Service (ICS). Steven said he was going to stay at the family home upon discharge and that he may look for alternative accommodation in the future. He said he had come to terms with the divorce and had no thoughts of wanting to harm anyone, including his family**.** On Wednesday 16 April 2014, Steven was reviewed in the ward round as planned. Karen was not invited to the meeting. According to LYPFT, this was because the couple was separating and because the clinical team thought that Steven was not returning home. However, as set out above, on 9 April 2014 Steven had indicated that he still hoped to return home and that he had obtained legal advice that he was entitled to return unless Karen obtained an injunction or court order preventing him from doing so. Although Steven had been looking for alternative accommodation while on the ward, throughout his admission he had said his preference was to return home. On 10 April 2014, the consultant psychiatrist discussed Karen's welfare with her in the event that Steven returned to the marital home. This suggests that LYPFT should have been aware of the possibility that Steven was returning home before 16 April 2014 and that there was an opportunity to involve Karen more fully in discharge planning.

222. At the ward round on 16 April 2014, Steven said he had no specific needs other than housing. He showed the team a text message from Karen, which said that he could move back to Address 1 on a temporary basis as long as there was no bad behaviour. He was expected to stay in the spare room and find alternative accommodation as soon as possible. The team contacted Karen who confirmed she had agreed to the arrangement short term. This was good practice. However it appears that this call was not made until after Steven had already phoned his son to tell him he was coming home.

223. As part of the Serious Incident Investigation, Karen's family said that they understood that she had been told she would get 24 hours' notice of his discharge from hospital. The Serious Incident Investigation found no evidence from the records that 24-hour notice had been agreed and it would not be usual practice for LYPFT to give any such period of notice in relation to discharge. There is an entry on the 25 March 2014 that refers to *"24 hour release.*" LYPFT have advised that this was specifically in the context of Karen's query about when to tell Steven that she wanted a divorce and Steven being detained at that time under a temporary Mental Health Act holding power (Section 5(2)), with a decision not yet having been made as to whether he would be detained for assessment under the Mental Health Act or whether he would become an informal patient – and therefore free to leave hospital – within the next day or so. The consultant psychiatrist assured Karen on 10 April 2014 that she would be notified of his discharge, which he advised was likely within the next week. She was contacted on the day of the discharge, as set out previously. It is possible that Karen may have thought the 24-hour notice period extended to the duration of his stay at the Becklin Centre.

224. Steven was noted to have no depressive symptoms and said he had no thoughts about harming others. As set out above, the risk to Karen was underestimated in the FACE risk assessment, with no clear rationale as to why Steven was considered to be at low risk of harming her. He had displayed a pattern of controlling behaviour to Karen for the previous 25 years. She was now seeking to break that control by separating from him, a recognised period of heightened risk. The separating couple were going to be living in the same house, with the potential for a volatile, tense and stressful situation which could result in further abuse. The risk of homicide followed by suicide was not explicitly considered. This is considered further in the next Section.

225. Steven was removed from his section on the basis that he had been assessed continuously on the ward for 25 days, the clinical team were confident he did not display any symptoms of mental illness and there were no grounds for the section 2 to continue or for Steven to be detained under the provisions of section 3 of the Mental Health Act. As part of the agreed discharge plan, he was referred to the Community Mental Health Team. This was done via a message which was left with the administration staff asking the care co-ordinator at the Community Mental Health Team to follow up Steven within three days. Steven was not contacted by the Community Mental Health Team until 23 April 2014 (following Easter Bank Holiday), which was within LYPFT's seven-day standard, and agreed a home visit for 2 May 2014. Earlier dates for a face-to-face meeting were offered but Steven was free to make his own decisions about follow-up arrangements and LYPFT could not compel him to accept an earlier appointment. This was the only contact that Steven had with the Community Mental Health Team.

Leeds City Council Adult Social Care

Summary of involvement

226. Following a referral from Leeds & York Partnership Foundation Trust on 25 March 2014, an Approved Mental Health Professional[23] from Leeds Adult Social Care completed the Mental Health Assessment, which enabled Steven to be detained for up to 28 days under Section 2 of the Mental Health Act. A social worker, who was an Approved Mental Health Professional, and a trainee AMHP[24] interviewed Steven in the presence of a Section 12 doctor and agreed that he should be detained. The Approved Mental Health Professional spoke to Karen before and after the assessment and she disclosed domestic abuse and her plan to separate from Steven. Despite this, she was not assessed as being at risk from him and there is no record that she was offered any support in relation to domestic abuse.

[23] The Approved Mental Health Professional (AMHP) role was established under the Mental Health Act 2007 and replaced the Approved Social Worker role. The AMHP decides if an individual should be compulsorily detained after assessment and consultation with two doctors, at least one of whom must be a Section 12 approved doctor. The other is usually a GP.

[24] A trainee AMHP is a professionally qualified person with a minimum of two years' experience of practice.

227. Leeds & York Partnership Foundation Trust recorded that they had contacted the Safeguarding Unit at Leeds Adult Social Care on 1 April 2014 with a view to referring Karen because of domestic abuse. The call taker indicated that they would not be able to accept a safeguarding referral in relation to Karen because she would not come within the criteria for a vulnerable adults safeguarding referral. The call-taker provided contact details to pass on to Karen for her to contact the Safeguarding Unit herself. The call taker also advised that if Karen did feel threatened she should call the police.

Key events

228. On 25 March 2014, the Becklin Centre referred Steven to Adult Social Care, requesting completion of a Mental Health Assessment. The case was allocated to an Approved Mental Health Professional and a trainee who was shadowing him.

229. Steven was interviewed at the Becklin Centre in the presence of the Approved Mental Health Professional, the trainee and the Section 12 approved doctor. It was noted that the break down in his relationship was significant regarding his suicide attempt. Steven said he felt coerced regarding his hospital admission. He thought he did not need any help and he wanted to leave hospital. The trainee felt that Steven minimised the severity of his suicide attempt.

230. The Approved Mental Health Professional telephoned Karen both before and after the assessment interview. She said she thought Steven had become aware that she intended to leave him and this led to his suicide attempt. During this discussion she referred to a long history of emotional abuse from Steven and gave examples of his controlling behaviour.

231. Karen described a relationship that was characterised by coercive control. She also told Adult Social Care staff that she was separating from Steven, which is a high risk period for violence. The section of the Mental Health Assessment regarding recommendations for further work had no reference to her concerns and, there were no references to referral to any services that could support Karen in relation to domestic abuse or assess the level of risk to her. Given that homicide followed by suicide of the perpetrator is not an uncommon outcome in domestic homicides, Steven's risk to Karen should have been considered in more depth. In interview for this review, the trainee recalled that at the time of the assessment he and the social worker did not consider that Karen was at risk given there was no previous history of concerns, there was no previous mental health history and there was no involvement from the police or forensic services. This reflects a narrow understanding of risk and a privileging of physical violence over other forms of abusive and controlling behaviour. Leeds Adult Social Care has no domestic violence policy in relation to service provision (it does have a policy relating to employees).

232. The Mental Health Assessment was completed by the trainee AMHP under the supervision of the AMHP. The trainee participated in interviewing Steven and read the nursing and medical notes and the risk assessment completed by the Acute Liaison Psychiatry Service. Steven was not previously known to Mental Health Services and there was not much information about him. The trainee did not speak to Karen himself and relied on the AMHP's account of the phonecalls to her.

233. The trainee recorded within Steven's assessment that he had two sons, David (who was at university and Mark (who was studying for his It was noted that Mark had sought help when he found his father, 'passed out', following his suicide attempt and that the marital problems were causing strain in the family home. Steven referred to feeling unwanted by his family. David and Mark are not referred to within the risk section of the Mental Health Assessment and there is no reference to them in the 'recommendations' for further work section. The section titled 'Information relating to the possibility of children visiting' is blank. Given that it was Mark who found his father, the Approved Mental Health Professional should have contacted Children's Social Work Services to discuss the case and a recommendation regarding Mark's welfare should have been included in the assessment. In interview for this review, the trainee reported that he had discussed with the AMHP the impact on Mark of finding his father in the garage but they did not refer Mark to Children's Social Work Services as they thought he would not meet their criteria.

234. The three professionals did not think that Steven was depressed or psychotic but there was a discussion about the possibility that Steven could have an undiagnosed personality disorder given there was a "certain coldness in him", he could only see that he was affected by his suicide attempt and he was not able to understand the impact on his son and wife. Mental health diagnoses are a matter for the clinicians not the AMHP and it was anticipated that this would be explored further by the consultant psychiatrist on the ward or by the Community Mental Health team if Steven engaged with them. This was not made sufficiently clear and the recommendations section contained an ambiguous reference to "Query Personality Traits". Despite this, Steven was assessed in relation to personality disorder on the ward and clinicians concluded that he did not have a personality disorder.

235. The Mental Health Assessment confirmed that Steven would be detained under Section 2 of the Mental Health Act, as he needed to have a period of assessment in an acute setting. He was considered at serious risk of harm to himself (suicide) but the assessment noted that there was no evidence of risks to other people. This appears to disregard Karen's reports to both Adult Social Care and Leeds & York Partnership Foundation Trust that Steven was emotionally abusive, unreasonable and controlling. The Mental Health Assessment suggested that further work was needed regarding the possibility that Steven may have "personality traits" and that he needed to develop coping strategies and ways to regulate his emotions. As the recommendations related to the clinical assessment of Steven's mental health and risk factors regarding discharge planning, it was the responsibility of the Becklin Centre and Community Mental Health Team to address them. Upon completion of the Mental Health Assessment there was no other involvement from Adult Social Care staff in Steven's treatment.

236. Adult Social Care was approached by a Foundation Year 2 doctor from LYPFT in relation to Karen experiencing domestic abuse, as set out previously. The call was made to the Leeds Social Services contact centre but was not accepted as a referral as Karen did not meet the criteria for being regarded as a vulnerable adult.

West Yorkshire Police

Summary of involvement

237. West Yorkshire Police had contact with Karen and Steven on four occasions between 22 March and 26 April 2014:

- On 22 March 2014, the Yorkshire Ambulance Service reported Steven's suicide attempt and police attended Address 1;
- On 10 April 2014, a doctor at the Becklin Centre contacted the Leeds Safeguarding Unit to report that Steven had subjected Karen to a long history of domestic abuse and asked the police to contact Karen to offer help and advice;
- On 18 April 2014, Karen contacted the police to report that when she and her sons Mathew and Mark went out for a walk that evening Steven had insisted on following them even though she had specifically told him not to;
- On 26 April 2014, police received a call from Karen who reported that Steven was trying to control and harass her, having changed the Wi-Fi codes at home to prevent Internet access. This resulted in police officers meeting with Karen and her parents the following day.

238. In a period of only 16 days between 10 April 2014 and 26/27 April 2014, the police had three separate contacts with Karen in relation to domestic abuse, after no previous reported history of domestic abuse. This was not recognised as escalation. Steven's controlling behaviour reported on 26 April 2014 was not recorded as domestic abuse and was not recognised as potentially criminal behaviour under the Protection from Harassment Act.

239. There was a failure to recognise the contact with the Becklin Centre on 10 April 2014 as a referral. As a result, Karen was provided with generic advice by a clerical officer, she was not contacted by police officers and a risk assessment was not conducted. Karen's disclosure of a long history of domestic abuse was not recorded or risk assessed. She was advised to contact police if any incidents of domestic violence did occur. This may have created the impression that the behaviours that Karen was reporting were not serious or significant. Steven's pattern of coercively controlling behaviour was not recognised. Given Steven's attempted suicide, his detention in psychiatric care, the long abuse history and Karen's plans to divorce, this call should have been taken more seriously.

240. The incident of 18 April 2014 was finalised as a message. The incident of 26 April 2014 was defined as non-domestic, in contravention of West Yorkshire Police force domestic violence policy. As a result a risk assessment was not conducted. The possibility of issuing Steven with a harassment warning or pursuing a criminal charge under the Protection from Harassment Act was not explored on either occasion. Mark was not logged in either report and no referral was made to Children's Social Work Services.

Key events

241. On 22 March 2014, police attended Address 1 following a report from Ambulance Control of a man apparently attempting suicide. Three officers were dispatched.

Steven was transported to hospital by ambulance and, other than assisting at the scene, the police had no further role once it became apparent that this was not likely to be a fatal incident. Police had no role in Steven's admission to hospital and subsequent psychiatric detention. Other than the Command and Control Storm log no other report was recorded on police databases. No criminal offence was identified and Karen was not interviewed to ascertain the background to the incident. No risk assessment was required and none was conducted.

242. On 10 April 2014, a domestic abuse clerical officer[25] in the Leeds Safeguarding Unit received a phone call from a doctor at the Becklin Centre about Steven and Karen. The doctor's name and the date of this contact were not recorded by police but hospital records reviewed following Karen's death indicated that it was likely to have been 10 April 2014. In this conversation, the doctor informed the clerical officer of Steven's suicide attempt, that he would soon be discharged and that Steven had psychologically abused his wife over a period of many years. He asked that the police contact Karen to offer help and advice and left his name and contact number in the event that the Police Safeguarding Unit needed to speak to him again.

243. As a result, the Clerical Officer contacted Karen later that day by telephone after checking police databases and finding no previous reports of any domestic abuse. Karen reported mental abuse from Steven for most of her married life. She said that their marriage was over and she intended to move on with her life. It appears that Karen may have described some specific incidents of domestic abuse from the past but these were not recorded as they did not include physical violence. The Clerical Officer advised Karen to contact the police if "any incidents" occurred, which implies that she did not recognise the seriousness of the mental abuse that Karen was reporting.

244. The Clerical Officer gave Karen contact details for Leeds Domestic Violence Service and sent her information about services available to women in Leeds. She felt that Karen was satisfied with the advice and information given.

245. No record was made of the conversation or report submitted. In interview for this review, the clerical officer said that this is normal practice when telephone calls are received asking for general advice. As mentioned above, the contact with the Becklin Centre was not recognised as a referral. The seriousness of Karen's situation was not recognised despite a number of potential high-risk indicators - her disclosure of a long history of Steven's controlling behaviour, his suicide attempt, his mental health issues and the couple's separation.

[25] The Clerical Officer's duties include reviewing new domestic reports received in the safeguarding unit from attending officers, conducting research on police databases about previous incidents and the history of the involved parties, sending information packs and letters to victims and, on occasion, contacting victims by telephone. She routinely speaks with members of the public who call the Unit for advice about domestic abuse related issues. All non-crime medium and standard risk domestic abuse reports are reviewed and filed by the Unit's clerical officers who notify supervisors of those reports that require supervisory involvement.

246. On Friday 18 April 2014, Karen contacted police to report that when she and her sons went out for a walk that evening, Steven had followed them. This report was on the Friday evening of a Bank Holiday weekend. No units were available to send to the call and two hours later the police contacted Karen by telephone. She had returned home, Steven was watching TV in a separate room and Karen wanted no further action. The log was finalised that Karen wanted no further action taking and that the call had been made for information only. No other record was made of the incident and it was finalised as a message. This incident could have been finalised as domestic in nature and the possibility of addressing it as a potential crime under the Protection from Harassment Act could have been considered. This was only two days after Steven's discharge from psychiatric care but already he was demonstrating that he would not abide by the agreement not to behave badly. It is not clear if the police were aware of the agreement.

247. Just over a week later, on Saturday 26 April 2014 police received a call from Karen who said that Steven was trying to control and harass her, having changed the Wi-Fi codes at home to prevent Internet access. It noted that she was currently safe at her parents. Later that evening an officer contacted Karen and made an appointment for officers to visit the following day.

248. At about 1pm on Sunday 27 April 2014, two police constables visited Karen at the home address of her parents and spoke with her and her mother and father. The officers remained there for approximately an hour and Karen's parents felt they tried to explore her concerns. The officers considered there was no substantive criminal offence but did not explore the possibility of harassment offences. One officer consulted with a sergeant back at base and determined that this did not constitute a domestic abuse report and therefore no domestic abuse niche occurrence report or DASH risk assessment were required. This was incorrect.

249. Karen was advised to contact the police again if a domestic abuse incident did occur and to continue action through her solicitor. Again, this suggested that the officers did not recognise that Karen was experiencing domestic abuse and that officers privileged physical assaults over other forms of domestic abuse. The officers offered to visit Steven and discuss his conduct with him but Karen declined this offer as she felt police attendance might make things more difficult when she returned home.

250. Police had no further contact until attendance at the fatal house fire two days later.

251. Police initiated no direct communication with other services, particularly LYPFT, over the period of their involvement. Following police contact with Karen by telephone on 10, 18 and 26 April 2014 and the subsequent visit to her parents' address on 27 April 2014, no domestic abuse report was recorded and no onward referral made. During contact on 10 April 2014, Karen was provided with contact details for support services and advised to contact them herself.

252. The police should make a referral or notification to Children's Social Work Services where there is a report of domestic violence and a child in the household. There is no record that Mark was referred. This may be because he was not logged as being a member of the household and because the incidents were not recorded as domestic abuse.

Leeds Women's Aid and Leeds Domestic Violence Service (LDVS)

Summary of involvement

253. Karen attended a Leeds Women's Aid Drop-In[26] at the Together Women Project on Friday 11 April 2014. She disclosed a history of non-physical domestic abuse by Steven, his recent suicide attempt and his imminent release from the Becklin Centre. As a result of the discussion, Karen was provided with information and LWA Drop-In contact numbers (office and LWA Worker mobile). A CAADA-DASH risk assessment was not required under LWA's protocols and was not undertaken.

254. Karen gave consent for a referral to the LDVS Outreach team for emotional support whilst she was going through separation. The referral was made promptly on the same day, but was placed in the 'client pending tray' when it was processed by the leader of the Leeds Domestic Violence Service Outreach Team on 15 April 2014. It was assessed and was not considered to be high risk/high priority as Karen was requesting emotional support only and had indicated that she was not frightened of Steven. A number of potential high risk factors were indicated in the referral including Steven's attempted suicide and resulting detention in psychiatric care, Karen's interest in obtaining an Occupation Order, Steven's imminent release and the fact that the couple were separating. However these did not trigger concerns about the level of risk, perhaps because Karen said she was not frightened of Steven.

255. The LDVS Outreach team had not attempted to contact Karen at the time of her death. This did not meet expected service standards.

Key events

256. On Friday 11 April 2014, Karen attended a Leeds Women's Aid Drop-In and discussed her situation with the LWA Drop-In Worker and a volunteer. Her mother also attended the appointment. Karen disclosed a history of non-physical domestic abuse. She would not consider leaving the family home until Mark's exams were finished and had been advised by a solicitor that it would be expensive to try to obtain an Occupation Order to prevent Steven returning home and might not be successful. Karen said it would be awkward if Steven returned home but did not express any fear. The LWA Drop-In Worker and a volunteer discussed safety planning with Karen and her mother.

257. No formal CAADA-DASH risk assessment was undertaken. This was in line with LWA guidelines and protocols. The Drop-In service does not undertake a CAADA-DASH risk assessment as standard, due to the informal nature of the service. If information disclosed indicates a formal risk assessment is warranted and the client gives consent, then a CAADA-DASH risk assessment would be undertaken. The LWA worker and volunteer perceived the risk as low, based on the discussion held with Karen. However Karen had disclosed a number of potential high risk factors,

[26] Leeds Women's Aid operates Drop-In support services (outside of the contracted Leeds Domestic Violence Service) for women who have, or are, experiencing domestic abuse. These are based at two hospital locations. At the time of Karen accessing services, they also had a service at the Together Women Project (TWP) in Leeds City Centre.

and a formal risk assessment would have enabled a better understanding of her circumstances.

258. Karen was given information and LWA Drop-In contact numbers (office and LWA Worker mobile. She agreed to be referred to the LDVS Outreach team (provided by Behind Closed Doors) for emotional support whilst she was going through the separation. The LWA Drop-In Worker prepared the referral to LDVS Gateway on the same day, sharing information felt to be relevant. The following information was included:

Karen attended Leeds Women's Aid drop in service and disclosed ongoing domestic abuse from her husband. The incidents have not been physical but have been emotional, verbal and psychological over the years.

Karen decided a few months ago that she was going to leave him summer 2014 after her son had finished his [redacted] Steven obviously picked up on this and a few weeks ago attempted suicide by inhaling fumes from his car. He was found by his son. He was not successful and he then tried to discharge himself hours later from hospital. He was later sectioned for 28 days.

Karen has used this time to decide that she cannot take any more and wants a divorce. She has to pay for solicitors as she works and has been told an Occupation Order would cost her £3000. She is unsure whether she would even be successful as most of the abuse is historic. I have advised her to speak with Rights of Women in order to get a second opinion. We discussed safety, as he is due to return to the property when his section finishes in a few days.

Talked about long term impacts of domestic violence.

She would like emotional support whilst she is going through the separation.

259. The LWA Drop-In sits outside the LDVS contracted provision of services. LWA provide the LDVS Gateway and a triage function as part of the LDVS contract. The LDVS Gateway captures and processes referrals to any of the LDVS services. The triage role was established to further assess referrals, ensure information is up to date and make contact with the victim in order to decide which LDVS service is most appropriate for them. However this follow-up may not take place when the referral has been made by the LWA Drop-In to reduce confusion and duplication as the LWA Drop-in and the LDVS triage function may involve the same staff member.

260. LDVS Gateway processed the referral relating to Karen on Monday, 14 April 2014 and sent it through secure e-mail to the Outreach team that afternoon. LDVS Gateway noted that the referral referred to safety planning having taken place and that Karen "would like emotional support whilst she is going through the separation."

261. The referral was received and processed by the Outreach team (provided by Behind Closed Doors) on Tuesday 15 April 2014. The referral included information about a number of potential high risk factors, but the Outreach Team Leader assessed the referral as not presenting with significant risk warranting a priority response. The professional judgment may have been that the Drop-In had assessed risk sufficiently. The referral was printed off and copied. A copy was placed in a manual register and the original file placed in a Client Pending tray, awaiting contact from an

LDVS Outreach Duty Worker.

262. Contact should have been attempted within three days. At the point of Karen's death, contact had not been attempted. This was outside the expected response time. LDVS Outreach was experiencing reduced service capacity at the time due to a staff vacancy (which was filled a few weeks later) and to the fact that the referral was made in the run up to the Easter Bank Holiday weekend (18-21 April 2014), which resulted in reduced working hours.

Leeds City Council Education

Summary of involvement

263. David and Mark were educated in state primary and secondary schools within the Leeds area. The boys engaged well with school and there were no concerns until November 2012, when David accessed support through the extended services team[27] [redacted]. The service was very child-focused and responsive to David's needs, organising an urgent GP appointment and taking David to it, staying with him until his mother returned home, and subsequently accompanying David to a [redacted] appointment. David brought a thank you card for the service when their involvement came to an end.

264. As well as providing support through the extended services team, the school helped David [redacted] by developing an action plan to address his [redacted] and meeting with his parents to ensure that the right actions were in place.

265. Mark accessed extended school services at the request of his mother following Steven's attempted suicide in March 2014. Again, the service was child-focused and responsive.

266. The Family Support Worker from the extended services team had contact with both Steven and Karen. The contact with Steven was on one occasion only in November 2012 and he was uncommunicative.

267. The Family Support Worker had face-face, text and phone contact with Karen, in relation to her support of David and Mark. In November/December 2012, Karen and the Family Support Worker kept each other updated in relation to how David was doing and the Family Support Worker provided support which was both child-focused and addressed the family's needs. There appeared to be a good rapport between the Family Support worker and Karen.

268. In March 2014, Karen disclosed that she planned to divorce Steven and that he was very difficult to live with. It does not appear that the Family Support Worker explored what Karen meant by "difficult to live with" in detail. With hindsight, this might have been a missed opportunity to gain an understanding that Karen was experiencing domestic abuse and to refer her to specialist support. However, the discussion was

[27] The Extended School Service team includes Family Support Workers whose role is to offer practical help and advice to families in the area.

by phone and Karen was upset so it might not have been appropriate to probe further at this time.

269. On the day of the homicide, Mark told the Family Support Worker about Steven's controlling behaviour regarding the Wi-Fi and his disregard of the agreement to look for alternative accommodation. The Family Support Worker planned to discuss this disclosure with the school's lead for child protection. Even if this had been done that day, it would not have resulted in any action in time to prevent Karen's death a few hours later.

Key events

270. On 28 November 2012, David was referred to the extended services team by a friend who had previously accessed the service. He was feeling [redacted]. The Family Support Worker immediately sought medical attention for David by making an emergency GP appointment. She accompanied David to his GP and brought him back to school afterwards.

271. David did not want the school to contact his father. He was [redacted] years old at the time and his wishes were respected. David and the Family Support worker were concerned about the impact on Karen of being informed [redacted] by phone and the Family Support Worker offered to wait with David until his mother got home from work. This showed a note-worthy commitment to trying to meet the family's needs.

272. The Family Support Worker explained the situation to both David's parents but Steven was noted to be disengaged. Karen accompanied David to A&E that evening, as suggested by the GP [redacted], and texted the Family Support Worker to update her on the outcome. This suggests that the Family Support Worker had been effective in building up a rapport with Karen in a relatively short period of time.

273. The associate Vice Principal met with David and the Family Support Worker to discuss ways to [redacted] and other support. The support plan was actioned with immediate effect. The associate Vice Principal also met with David and his parents to discuss the support plan on 29 November 2012. Steven was noted to not contribute to the discussion.

274. David was referred to [redacted] following his A&E presentation. His first meeting was scheduled for 5 December 2012. Two days beforehand, Karen sought to change the appointment to avoid a clash with another commitment. This was not possible. Karen wanted to attend the [redacted] appointment with her son but David insisted she did not and that he would be more distressed if she missed the opportunity to meet a member of the royal family. The Family Support Worker offered to accompany David to the [redacted] appointment in order to avoid any further emotional stress on David. This was agreed by both David and Karen. This demonstrated a flexible approach to meeting the family's needs.

275. On 20 May 2013, David's case was closed by the extended services team. He called into the office with a thank you card for the Family Support Worker the following day.

276. On 26 March 2014, Karen contacted the extended services team requesting support for Mark following Steven's attempted suicide. She reported that Mark had found his father and that Steven had been compulsorily detained for 28 days and was staying at the Becklin Centre for treatment. Karen said that Steven was very difficult to live with but not violent. She had made the decision to leave Steven but had wanted to wait until Mark has finished his exams. Karen reported that she was planning to leave Steven whilst he was compulsorily detained and had support from staff at the Becklin Centre. As set out above, this phonecall was an opportunity to explore what Karen meant by "very difficult to live with" which might have resulted in a referral for specialist support. However, it may also have been inappropriate to probe further as the contact was by phone and Karen was upset and in such a situation, it is a judgment call for staff about how to respond.

277. On 28 March 2014, Karen contacted the Family Support Worker to say that Mark would not be in school. Karen had visited Steven in hospital and told him that she wanted a divorce and Steven had in turn telephoned both his sons. Mark attended school at lunchtime that day. He saw the Family Support Worker and Pastoral Support Officer and discussed his parents' relationship and his father's parenting. Mark did not disclose anything that would have suggested a child protection referral was required.

278. At a meeting on 23 April 2014, after the Easter holidays, Mark told the Family Support Worker that Steven had returned to the family home and the atmosphere was strained.

279. On 29 April 2014, Mark met with the Family Support Worker. As mentioned above, Mark reported that Steven had changed the Internet password and refused to let either Mark or Karen have the new one. Mark said that Steven had also hacked into both his and Karen's computers. This resulted in Mark and Karen going to stay at Karen's parents over the weekend but this was not a sustainable arrangement due to the location of his grandparents' house. Karen and Mark had returned back home with locks on the bedroom doors. Steven was not accepting the separation and not sticking to the agreement to move out. *(Author's note: Steven's abusive behaviour was escalating and becoming less hidden. It would have been appropriate to discuss the situation further with the school's lead for child protection and consider referring Karen to other services. This was planned but Karen was killed before it could take place. Even if this discussion had taken place on 29 April 2014, it would not have resulted in any action in time to prevent Karen's death later that day.)* Overall, the school and extended services team's work with the family was of high quality and responsive.

Leeds Community Healthcare NHS Trust – Child & Adolescent [redacted] Service and School Nursing Service

Summary of involvement

280. Leeds Community Healthcare NHS Trust provides a range of community based healthcare services for adults and children in the Leeds area.

281. Private matter - child 1 David appeared to find the contact supportive, there is little evidence that his home life and difficult relationship with his father were explored in any depth. This was a missed opportunity.

282. The School Nursing Service was informed by A&E of concerns about Mark on 2 April 2014 following Steven's suicide attempt. No actions were taken.

Key events

283. Private matter - child 1

284. Private matter - child 1 The assessment included some enquiry about home life but it is not recorded whether domestic violence was explored. David said "things are fine at home" and that the family was "close" and his parents were supportive. He wasdischarged into the care of his mother as she was felt to be a protective factor and was referred to

285. The majority of the contact was with a Senior House Officer (SHO). The Senior House Officer contacted the family by phone on 29 November 2012 and arranged a appointment for 10 December 2012. The arrangements were made with Steven who appeared vague when asked about how David had been since being reviewed in A&E.

286. The Senior House Officer spoke with both Karen and David by phone the following day, Friday 30 November 2012. A detailed assessment was performed but there is no record of questions being asked regarding his home life.

In interview for this review, the Senior House Officer said that these questions might have not been asked as this was her first contact with the family and was about making sense of the presenting problems. [redacted] It appeared to the Senior House Officer that David's presenting problems were not home-life based but the lack of exploration of his home life, and the fact that this was a first contact and was conducted by phone, means that this was not sufficiently tested. Subsequent contact was shaped by the belief that David's issues were not linked to his home life. Whilst it is clinically appropriate for [redacted] practitioners to discuss with service users the issues that the user wishes to discuss, this does not diminish the importance of exploring home-life.

287. In the contact on 30 November 2012, the Senior House Officer discussed a safety plan with both David and Karen, in line with expected practice. Karen requested an earlier appointment date for David, which was arranged for 5 December 2012.

288. At David's first [redacted] appointment on 5 December 2012, the Senior House Officer again used indirect questions to explore David's home life. His answers did not lead the Senior House Officer to suspect domestic violence in the family. More direct questioning might have elicited a different response. David said that he did not have the same relationship with his father. This was explored to some degree by the Senior House Officer but did not alter the focus of the work.

289. David's next appointment was on 13 December 2012. He was accompanied by his mother. As David was within a few months of his [redacted] birthday, a referral to [redacted] was agreed.

290. David attended further [redacted] appointments on 24 and 31 December 2012 and on 10 January 2013. On 31 December 2012, David denied any strain in his relationship with his parents but said that his father struggled to support him emotionally. It is unclear within the records whether this comment was when he was seen on his own or with his mother. It is likely that Karen's presence would have affected what David would have said but the Senior House Officer believes that he was on his own at the time.

291. A member of the [redacted] team was introduced to the family on 31 December 2012, which was good practice [redacted].

292. On 11 January 2013, David was referred by the Senior House Officer to [redacted] There was a reference to "family dynamics". No further information about what prompted this was provided and, in interview for this review, the Senior House Officer said she could not recall her intentions in making this reference. Relevant information should be clearly communicated in any referrals, which did not happen on this occasion.

293. David attended appointments with [redacted] on 25 January 2013 and 1 March 2013. He was accompanied by Karen to the first of these appointments but

there is no record of whether he was on his own or accompanied to the appointment on 1 March 2013. On both occasions he reported feeling much better and that he no longer felt he needed the support of , which had previously been agreed. David and the member of the team mutually agreed to close involvement on 1 March 2013. This ended David's contact with Leeds Community Healthcare.

294. On 2 April 2014, an A&E Nursing Sister phoned a School Staff Nurse at the School Nursing Service to notify Mark's attendance at A&E following Steven's suicide attempt and to inform the School Nursing Service that A&E had made a referral to Leeds Children's Social Work Service. There is no evidence on the electronic records system that the School Nursing Service was informed that Steven was subsequently admitted to the Becklin Centre.

295. It is not known why there was a delay in this notification but it appears that such delays are not unusual. It is not known whether it was the same A&E sister that had dealt with Mark at the time of his attendance. The School Nursing Service should have followed up the notification to check on whether Mark was in receipt of emotional support and to follow up on the actions of Children's Social Work Service but this did not happen. The rationale for the School Nursing Service not taking action was not recorded on the electronic records system.

296. The School Nursing Service is informed of a large number of children who have attended A&E. Notifications are often received in batches and the A&E practitioner handing over the information is often not the person who dealt with the child in A&E. The School Nursing Service plan to put in place a joint School Nursing Service and A&E Standard Operating procedure to improve communication between the services and ensure better follow up of referrals and notifications.[28]

Yorkshire Ambulance Service

Summary of involvement

297. Yorkshire Ambulance Service attended Address 1 on two occasions during the review period. On 22 March 2014, Yorkshire Ambulance Service conveyed Steven to St. James's University Hospital. This resulted from an emergency call after Mark found his father following a suicide attempt.

298. On 29 April 2014, Yorkshire Ambulance Service attended the scene of the house fire at Address 1 and conveyed Steven to hospital, where he later died. Ambulance crews did not treat Karen, as she was already dead when services were called.

[28] Recent changes and training at LCH have culminated in a new Standard Operating Procedure for the recording of significant safeguarding information on the electronic recording system (SystmOne) and is available within LCH to all practitioners working in children's services. Entries recorded on SystmOne within the new Safeguarding node will, in time, enhance practitioners decision making when dealing with both first-hand information and information shared by other agencies. This new system of recording became operational on 6 October 2014.

Key events

299. On 22 March 2014 at 07:30 Yorkshire Ambulance Service received a 999 call from Karen following Steven's suicide attempt. Yorkshire Ambulance Service dispatched three Rapid Response Vehicles (RRV) and a Double Crewed Ambulance (DCA) immediately. One RRV was a specialist Hazardous Area Response Team (HART) trained paramedic. This was appropriate. Yorkshire Ambulance Service Emergency Operation Centre informed West Yorkshire Police of the incident at 07:32 who also sent officers to the scene. This was good information sharing.

300. The first RRV arrived on scene at 07:38. This was within expected national guidance response times. The other ambulance services arrived at Address 1 at 07:42, 07:46 and 07:48. On arrival Steven did not demonstrate mental capacity or consent to treatment, which was documented on the associated patient report form (PRF). Due to his medical condition at the time, ambulance staff correctly conveyed Steven to hospital against his wishes and treated him en-route with oxygen in his 'best interest'.

301. The PRF recorded Steven "has been found by his son laid at side of car, unresponsive. Hosepipe connected to exhaust and through car window. ? Suicide attempt/Carbon Monoxide." The PRF stated Steven was "last seen at 02:00 and found by son at 07:30". Observations were taken from Steven at this time and he was given 100% oxygen therapy. His next of kin was recorded as "Wife Karen" and his ethnicity as British White. Past medical history was recorded as "back pain" and medication as "pain killers".

302. The DCA left the scene at 08:00 and arrived at St. James's University Hospital at 08:16. A clinical handover was given and responsibility handed over to the Emergency Department staff, who signed the PRF. This was in line with expected practice.

303. Yorkshire Ambulance Service was aware that Steven's son was present at the scene and he was mentioned on the PRF ("found by his son"). The documentation does not make clear which son was present and whether they were over 18 years of age. Under the Yorkshire Ambulance Service Safeguarding Children & Young People Policy (2013), staff should have recorded Mark's presence and age.

304. When attending incidents involving self-harm and (attempted) suicide by parents/carers, Yorkshire Ambulance Service staff should consider the impact on children and young people, especially where the events are witnessed. A referral should have been made to Leeds Children's Social Work Services but this did not happen.

305. Steven did not meet the threshold for being considered an "adult at risk" so Yorkshire Ambulance Service did not refer him to Adult Social Care. Since the time of this incident, a Yorkshire Ambulance Service Mental Health Pathway has been put in place. This was not available in March 2014 so Steven was not referred to it.

306. Yorkshire Ambulance Service Domestic Violence Guidance (2013), advises staff to ask direct questions about domestic abuse but, "this should always be done when the client is alone and only if it is safe to do so". Staff do not routinely ask about domestic abuse and did not document any concerns or disclosures of domestic

abuse. It is not recorded whether there was the opportunity to discuss this with Karen on her own.

307. On 29 April 2014 at 18:32, 18:33 and 18:34 Yorkshire Ambulance Service received three consecutive calls regarding a house fire at Address 1. The first was from a passer-by, the second call from West Yorkshire Fire and the third from West Yorkshire Police. Yorkshire Ambulance Service immediately dispatched three DCA's, three RRV's and two HART RRV's.

308. During the first 999 call, the Yorkshire Ambulance Service 999 call taker reassured the (unknown) female caller that help was on its way and tried to establish who the patient was and his condition. The caller was advised to remain at a safe distance. The call was terminated by Yorkshire Ambulance Service when the caller confirmed that Police had arrived on scene.

309. During the second call from West Yorkshire Fire, their operator stated, "We are going out to a house fire with persons reported". The address was confirmed by the Yorkshire Ambulance Service 999 call taker. The fire operator added they were not yet on scene so could not confirm the number of casualties but had been informed "someone had tried to set themselves on fire". The fire operator then realised that Yorkshire Ambulance Service had already rung this incident through to fire and this was a duplicate call.

310. During the third call from West Yorkshire Police Yorkshire Ambulance Service were requested to attend a "house fire". Police operators stated, "a male has jumped from a window" and "he appears deceased". The Police stated two houses were burning.

311. The Emergency Medical Dispatcher considered the scene unsafe from the beginning of the call and followed the correct protocol by asking the caller to not enter the burning building. Ambulance staff arriving on scene took advice regarding entering the house from the fire service. This was correct and followed established risk assessment processes. There was good information sharing between blue light services both before and after arrival at the scene.

312. The PRF for Steven recorded that, "On arrival Police & fire on scene. Directed by Fire *(Brigade)* to rear of property. House fully alight & very smoky. Found patient towards rear of garden. Not alert & patient not breathing. Very badly burned… Patient in and out of consciousness. GCS (Glasgow Coma Scale) up & down. Once patient on ambulance patient non-compliant… unable to get obs *(observations)* or IV access. En-route patient says wants to die, keeps trying to get off trolley." Ambulance staff conveyed him to hospital and continued to provide treatment for his injuries in his 'best interests'.

313. A pre-alert was documented as made en-route to Leeds General Infirmary. A clinical handover signature was obtained on the PRF to indicate a senior Yorkshire Ambulance Service clinician had provided a verbal and written handover to the receiving hospital staff in the Emergency Department (ED).

314. The PRF for Karen recorded, "Patient involved in house fire /explosion. Ambulance staff unable to enter premises at time of arrival. Fire service state patient is dead and not removing her as currently fire fighting. Once safe to enter house patient

deceased." All biographical and past medical history details were unknown at the time of recording. A senior Yorkshire Ambulance Service clinician on scene signed the PRF to state the patient was not being conveyed by Yorkshire Ambulance Service staff. A Recognition of Life Extinct (ROLE) form was completed by the attending staff for Karen. This documents that there are conditions unequivocally associated with death. The Yorkshire Ambulance Service staff member also documented, "Locality clinical supervisor to contact control re: safeguarding for [redacted] year old son of the patient". ROLE was confirmed at 21:08. YAS did not convey Karen's body to hospital at the request of Police and Fire services.

315. Yorkshire Ambulance Service made a safeguarding referral for Mark. This was appropriate.

Leeds Teaching Hospitals Trust

Summary of involvement

316. Steven attended A&E on three occasions during the scoping period:

- 19 February 2013 – treated at St. James's University Hospital with a chicken bone stuck in his throat. He was discharged the same day and no follow up was required;
- 22 March 2014 - Steven was brought by ambulance to A&E at St James's University Hospital. He had high levels of carbon monoxide in his body and was assessed and treated for attempted suicide. He was assessed by the A&E Department and Acute Liaison Psychiatry Service team (ALPS) and discharged under the care of ALPS to the Becklin Centre;
- 29 April 2014 - Steven was brought by ambulance to A&E at Leeds General Infirmary with burns following a fire at the family home. He refused treatments on arrival and told staff he wanted to die. He died later that day.

317. David attended A&E with his mum [redacted] and discharged the same day. Leeds Teaching Hospitals trust has no record of the [redacted] findings and plan. David also had a number of appointments with Leeds Teaching Hospitals Trust for an ongoing medical condition that he had had since childhood. These were not relevant to the review other than to say that he was accompanied by Karen to the appointments.

318. Neither Karen nor Mark was treated by Leeds Teaching Hospitals Trust although they both attended hospital with Steven after his suicide attempt.

Key events

319. David presented at Leeds General Infirmary A&E on 28 November 2012, escorted by his mother. He had seen his GP earlier that day. A document in the hospital medical notes cites a letter from David's GP informing A&E that this episode [redacted]

[redacted] a decision was made to discharge David into the care of his mother [redacted]. This was appropriate.

320. Steven attended A&E at St. James's University Hospital on 22 March 2014 following what appeared to be a failed suicide attempt. He was assessed by a staff nurse and seen by a doctor and treated with oxygen. There were high risk factors associated with Steven's suicide attempt (i.e. circumstances, age range, non-smoker and the amount of carbon monoxide that was in his body when Yorkshire Ambulance Service arrived at the scene). Given these contributing factors, staff on duty in A&E at the time of admission believed that Steven had made a definite attempt to take his own life and that he was aware that the result of his actions could have resulted in his death. A capacity assessment was completed and established that he had full capacity. Steven's Glasgow Coma Scale (GCS) was 15/15 indicating that he was highly alert and orientated. Following the initial assessment, a referral was made to the Acute Liaison Psychiatry Service (ALPS) team, which was appropriate.

321. A staff nurse spoke with Steven about the circumstances surrounding the incident and his subsequent admission. He requested that Karen and Mark be present during the initial assessment and it was not felt to be inappropriate to agree this. Steven made it clear that his suicide attempt was prompted by a concern that Karen planned to leave him. In interview for this review, the staff nurse said that there was nothing to suggest that she should be concerned for anyone's safety within the family unit. Mark looked well cared for and showed emotion and concern for his father. The only unusual factor was the lack of interaction between Steven and Karen. Steven had capacity, he was alert and very controlled, he knew why he wanted to attempt to take his own life and he was very clear that he wanted his wife and child to also be made aware of his intentions. It is not known why Steven wanted Mark to stay. The staff nurse described that Steven's non-verbal communication was very powerful in itself. The atmosphere in the cubicle seemed intense at times.

322. The staff nurse said that Karen was in shock and looked to be "a woman at the end of her tether". She made a point of speaking with Karen alone once the opportunity arose but did not ask directly whether there were any domestic abuse issues or risk factors at home. This may have been a missed opportunity to gather information and identify any risk factors. The Trust does not currently have an overarching Domestic Violence Policy. Abuse related to domestic violence is referenced in the Trust's Safeguarding Adults at Risk and Safeguarding Children's Policies and Procedures. A domestic violence task and finish group has been set up to look at LTHT's response in relation to whether a stand-alone domestic violence policy is required or alternatively whether current safeguarding policies need to be reviewed and strengthened and to incorporate the new Health and Social Care Act.

323. The staff nurse was unable to speak with Mark alone. There was no opportunity as Mark followed Steven's wishes and remained with him at his bedside throughout the stay in A&E. Mark later spoke with the ALPS team prior to Steven being admitted to the Becklin Centre. The staff team relied on ALPS to identify any concerning outcomes and recommendations in relation to Mark. ALPS advised staff in A&E to make a referral to Children's Social Work Services, which they did. However this information was not shared with LTHT Children's Safeguarding Team, which it

should have been. Leeds Teaching Hospital Trust's safeguarding policy has since been reviewed and now states that any referral to Children's Social Work Services should be copied to the named nurse in the hospital safeguarding team within 24 hours.

324. It is not clear whether A&E made a link between Steven's attendance and [redacted] Steven was assessed in A&E by the ALPS team. A&E communicated with ALPS prior to the assessment about Steven's medical condition. He was initially medically unfit for assessment and A&E indicated when he would be able to be seen. They contacted ALPS again when Steven indicated a wish to self-discharge. This indicated good management of the situation. Following the assessment, Steven was discharged under the care of LYPFT to Becklin Centre. He was identified as being a risk to himself.

325. Steven was brought to the A&E at Leeds General Infirmary on 29 April 2014 with burns following a fire at the family home. Steven refused treatments on arrival. He had capacity and informed staff he wanted to die. He had a Glasgow Coma Scale (GCS) of 15/15 however this was fluctuating during transfer into hospital. He was described as agitated and refusing monitoring. His injuries were incompatible with life and the multi-disciplinary team decided that treatment should be palliative. Following this decision, the A&E consultant informed the family of the prognosis. Steven was confirmed dead at 21:41.

Leeds City Council Children's Social Work Services

Summary of involvement

326. Children's Social Work Service had limited involvement with the family after Steven's attempted suicide in March 2014. The response was appropriate and proportionate.

Key events

327. A Staff Nurse at the Emergency Department of St. James's University Hospital referred Mark (who was aged [redacted] years at the time) to Children's Social Work Services after he found his father following an attempt to commit suicide by carbon monoxide poisoning. The referral was made on Saturday 22 March 2014 at 12:30.

328. At 16:24, a social worker from the Duty and Advice team phoned Mark's mother to discuss his welfare and whether he needed support and assistance. Karen set out how she had supported Mark and reported he was fine. She declined any help and said that they had previously accessed help from the extended services attached to the school.

329. The social worker making the call assessed that the family, including Mark, did not need assistance from Children's Social Work Services but called back on Monday 24 March 2014 to discuss further. Karen reiterated that she was fully aware of how to access support. Mark was reported to be in school and doing fine and Karen explained how she could access services locally if needed.

330. The social worker decided no further action was warranted. This decision was ratified by a manager and communicated to the referrer.

331. This was the total involvement of Children's Social Work Service until Mark's parents died.

Leeds Clinical Commissioning Group – GP services for all family members

Summary of involvement

332. All members of the family received GP services from the same local practice. The clinical and other relevant contact between Jordan family members and the GP Practice during the review period is summarised below.

Family Member	clinical contacts	other contacts
Karen	12	0
Steven	15	2 incoming letters
David	7	7 incoming letters
Mark	0	0

333. All adult appointments were separate i.e. Karen and Steven were not seen together.

334. The practice responded promptly to a request for an urgent appointment after David told the extended services team at school that [redacted] and provided a high quality of care.

335. Karen did not disclose domestic abuse to the practice and there was nothing in her presentation that would have prompted further enquiry. The practice does not appear to employ formal screening or routine and targeted enquiries to identify people who are experiencing domestic abuse. *(Author's note: there is a debate within health care about the use of screening and routine inquiry).*

336. Steven attended on two occasions reporting that he was hearing a buzzing noise in his head. It appears that this may have been an ear problem rather than an indication of psychosis.

337. The GP practice was asked to play a part in sectioning Steven but declined. They restricted his analgesia prescription to weekly after Steven was released from the Becklin Centre to prevent overdose.

Key events

338. In September 2010, Karen had two appointments following an injury to her left ring finger. She said she incurred the injury following a fall from a bike. The GP practice had no reason not to believe this account.

339. David attended the GP for review of a pre-existing condition in 2010 and an injury to his heel. On both occasions, Karen accompanied him.

340. On 28 November 2012, the extended schools service contacted the GP practice regarding concerns about David [redacted] The GP responded rapidly and appropriately, offering an appointment within half an hour, making a thorough assessment and referring for same day assessment (initially to

[redacted] and then to A&E) and ensuring that David was [redacted]. This was good and responsive practice.

341. The incident was discussed at a clinical meeting on 4 December 2012.

342. In October 2013, Steven attended the GP practice twice – initially with headaches and hearing disturbance, then for ear syringing. In February 2014, Steven reported a "humming sensation around my head" and was recorded as "being anxious". This consultation was discussed in detail in an interview with the GP for this review. The GP clarified that the entry did not indicate that Steven presented as feeling anxious but that he appeared anxious about the symptoms.

343. On 22 March 2014, the GP practice received a letter reporting Steven's attempted suicide and admission to hospital. Three days later, a Community Psychiatric Nurse requested that a doctor from the practice assist with applying for detention of Steven under the Mental Health Act. The Community Psychiatric Nurse was advised to ask the on-call psychiatrist to assess instead. The Practice's response may have been reasonable if other clinical commitments or lack of personal knowledge of Steven Jordan are factors.

344. Steven's attempted suicide was not reported as a significant event by the Practice and no clinical discussion took place. Attempted suicides are usually reported and discussed at practice clinical meetings. This should have happened on this occasion. The GP practice has changed its protocol to avoid any missed patient reviews in the future.

345. On 16 April 2014, Steven's psychiatric discharge letter was received by the Practice. Although there was no request for Practice follow-up in this letter, the Practice reduced Steven's analgesia for back pain (which was on repeat) to weekly issue due to the risk of overdose.

Section Six: ANALYSIS – KEY ISSUES

346. This section sets out the key issues identified by the panel in the course of the review, including consideration of the Terms of Reference. Key events for each agency are set out in the previous section.

Understanding of coercive control

347. As Evan Stark has said, "Not only is coercive control the most common context in which women are abused, it is also the most dangerous." Karen was killed after attempting to end a relationship with Steven that was characterised by coercive control. In the six weeks before her death, Karen reported a long history of Steven's controlling behaviour to a number of agencies. Although agencies did not record all of the examples of his controlling behaviour, the records include Steven:

- destroying possessions;
- controlling the environment (e.g. switching off lights when she had turned them on);
- threatening her;
- intimidating/frightening her (e.g. cutting his face out of family photos);
- depriving her of access to medical attention (e.g. Steven reported that after Karen had slipped on the kitchen floor, dislocating her knee, he had not helped her up and instead went upstairs and did not call an ambulance);
- manipulating her (e.g. insisting that she be present when he told A&E staff that he tried to kill himself because she was planning to leave him; asking her to bring items with which he could escape or kill himself into a psychiatric ward);
- following her;
- restricting her access to communication;
- monitoring her email.

348. Whilst some of Steven's behaviour might have seemed superficially trivial, its impact and intent was to take away Karen's freedom and reinforce his control. It contributed to a pattern of control that meant that Karen was "walking on eggshells" and had spent much of her married life altering her behaviour in order to try to keep the peace. She was now seeking to end his control of her. Some of the specific incidents of abuse recorded by agencies had occurred much earlier in the relationship. Rather than seeing these historic incidents as of limited relevance to whether Karen was at risk of harm from Steven, they suggest that Steven had established a pattern of control from the early stages of the relationship and that he might try to continue to maintain such control.

349. A number of agencies noted that there was no history of physical violence and this appears to have influenced their perceptions of the seriousness of the abuse and the degree of danger that Karen was facing. There was insufficient consideration that separation is a period of heightened risk in situations of domestic abuse.

350. From her first contact with LYPFT after Steven's reported suicide attempt (22 March 2014), Karen said that he was "unreasonable and controlling" in his treatment of her. She subsequently reported that Steven had asked her to bring in items such as a rope with which he could escape (25 March 2014), which could be viewed as manipulative behaviour, and later said that she was worried about what he might do to her (1 & 10 April 2014). She said he was very controlling and was worried that if he had behaved like this to her for twenty years, then what would he be like if he returned to the family home, now she had told him she was pursuing divorce.

351. Karen also told an Approved Mental Health Professional from Leeds Adult Social Care that Steven was "unreasonable and controlling" and reported a long history of emotional abuse. The AMHP noted that Steven was not "physically aggressive" but failed to record information disclosed by Karen about the nature of the abuse. Despite awareness of domestic abuse there is no record that Karen's safety was considered as part of the Mental Health Assessment. This should have happened. There is no record that she was referred to any domestic abuse service. Although the police provided Karen with contact details for Leeds Women's Aid on 10 April 2014, Leeds Adult Social Care had the opportunity to give her this information two weeks earlier. This would have given Karen more time to act on the basis of specialist advice before Steven's release.

352. Karen had contact with West Yorkshire Police on three separate occasions in the three weeks prior to her death. On two of these occasions (10 April 2014 and 27 April 2014), she reported a history of domestic abuse and on the other occasion (18 April 2014), the police initially recognised the report as a "domestic incident". On 10 April 2014, a domestic abuse clerical officer from the Police Safeguarding Unit called Karen at the request of LYPFT. Karen disclosed a history of mental abuse but no record was made of the conversation, no formal report was completed and no DASH risk assessment was undertaken. *(Author's note: a DASH risk assessment would normally be undertaken by police officers in person and would have required Karen to have been offered an appointment).* This was because the clerical officer considered that Karen was not making a report of a "domestic abuse incident" but was simply seeking advice about her options as she separated from her husband. The clerical officer advised Karen to contact the police "if any incidents occurred." This suggests a lack of understanding of domestic abuse as a pattern of behaviour and an ongoing dynamic within a relationship rather than a series of discrete "incidents". Such a response could suggest to a victim that mental abuse was not considered to be as serious or risky as physical violence.

353. At the time of Karen's contact with the clerical officer on 10 April 2014 there was limited scope for dealing with mental abuse through the criminal law[29]. The Protection from Harassment Act could have been explored as there was a "course of conduct" going back over a period of years but harassment offences can be

[29] The introduction of the offence of "Controlling or coercive behaviour in an intimate or family relationship" in the Serious Crime Act aims to provide the police and courts with a new tool for addressing mental abuse and controlling behaviour. The Act achieved Royal Assent on 3 March 2015 and is expected to come into force in late 2015.

difficult to prosecute. Nevertheless, the role of the police Safeguarding Unit goes beyond identifying offences and recognition of this contact with Karen as a report of domestic abuse would have resulted in a formal risk assessment, which could have led to actions aimed at protecting Karen. Karen was referred to Leeds Women's Aid for specialist support, which was appropriate.

354. Eight days later (18 April 2014), Karen reported to police that Steven was following her despite being asked not to. This was initially recognised and logged as a domestic incident. This call came at a high demand time for police and officers were not able to attend promptly. When contacted two hours later, Karen said that she no longer wished police to attend and the call was finalised as Code 126 'Message' with the text 'Caller does not want any further action. Reported information only'. As a result, no domestic abuse incident report or risk assessment was required. The police operator would not have been aware of the previous contact with the Safeguarding Unit as it had not been recorded and reported. This incident happened only two days after Steven's release from the Becklin Centre and indicated that Steven intended to continue to attempt to control Karen. However the police operator was not aware of this context. Had the police been able to attend, there would have been the opportunity to explore the background and discuss the use of the Protection from Harassment Act as a way of addressing Steven's behaviour. This incident could have been identified as either the start of a "course of conduct" or as a continuation of previous harassment if the previous history of mental abuse supported this. It is possible that a 'harassment warning' could have been issued and the incident recorded as a 'domestic – harassment warning' occurrence.

355. Karen Jordan contacted police again on 26 April 2014 to report that Steven had been trying to control and harass her. This call was identified as a domestic incident. The initial call taker noted that no violence had been used or threatened. An appointment was made for the following day. The two attending officers were aware of the call of 18 April 2014 as a result of a search on police systems. They spent approximately an hour discussing the circumstances of the report with Karen and her parents. Karen outlined that Steven had changed the Wi-Fi password and refused to tell her what it was and that she believed he had 'hacked' her email. She also reported a history of emotional abuse and Steven's suicide attempt. The police officers discussed whether any of the reported incidents constituted a criminal offence and determined that they did not. Steven paid the bill for the Internet and was entitled to change the codes. The officers did not identify Steven's behaviour as potentially constituting acts of harassment. Had the officers identified Steven's behaviour as harassment and spoken with him it is likely that the outcome would have been a 'harassment warning' rather than an arrest.

356. Following liaison with their Sergeant, the two officers determined that the circumstances as reported did not amount to a domestic incident. This demonstrates a lack of understanding of coercive control even though it forms part of the police's definition of domestic abuse. Although Karen described Steven's behaviour as 'childish', she was clearly concerned about it given that she had called the police and gone to her parents for the weekend. Removing Karen's access to the Wi-Fi should have been identified by the police as a way of controlling her

access to communication, information and services. This is a recognised aspect of coercive control, yet all three officers involved failed to identify it as such.

357. The call was finalised as “non-domestic, non-crime.” As a result, the officers did not complete a domestic abuse incident report and did not complete a DASH risk assessment. The attendance of police officers on this occasion offered the clearest opportunity for the police to undertake a DASH assessment. As no DASH assessment was completed, it is not possible to say how the risk to Karen would have been graded as we do not how she would have answered many of the questions within it. Even if the DASH had been completed on 27 April 2014 and Karen been assessed as high risk, her case would not have been heard at MARAC in time for agencies to put in place measures to prevent Karen’s death. However it is possible that exploration of risk through the DASH assessment might have influenced Karen’s own perceptions, such as whether to return to the family home and/or to reconsider trying to obtain an Occupation Order. This is not to blame Karen for her death, but to highlight that a DASH assessment can influence not just the actions of agencies but also the actions of victims.

358. Karen disclosed a history of non-physical domestic abuse and controlling behaviour to a Leeds Women’s Aid Drop-In Worker and Volunteer at a Leeds Women’s Aid Drop-In on 11 April 2014. As a result of the discussion, a safety plan was developed with her, she was given information and contact numbers and referred to the Leeds Domestic Violence Service (LDVS) Outreach team for emotional support whilst she was going through separation. No DASH risk assessment was conducted. This was in line with the LWA protocol for drop-ins, which does not require workers and volunteers to undertake a DASH risk assessment due to the informal nature of the service. Workers and volunteers do have the scope to undertake a DASH risk assessment if they consider they may be dealing with a high-risk victim. In Karen’s case, the worker and volunteer did not consider that the information that Karen was disclosing was potentially indicative of high risk. However a number of high risk factors were reported including Steven’s suicide attempt and admission to psychiatric care, Karen’s decision to end the relationship and attempts to exclude him from the family home and Steven’s history of controlling behaviour. A risk assessment would have been justified.

359. Later the same day, LWA Drop-In referred Karen to LDVS Outreach via the LDVS Gateway. The referral was processed by the LDVS Outreach Team Leader who did not identify the presenting issues as indicating potential high risk.

360. There is no record that Karen told the school Family Support Worker that Steven was controlling although she did say that he was very difficult to live with. Again, it was noted that he was not “physically violent” which may have influenced perceptions of risk.

361. Karen’s disclosures of abuse were all made within the six weeks preceding her death but referred to a period spanning her entire marriage. The disclosures were triggered by Steven’s attempted suicide, which was linked to Karen’s decision to end the relationship. Staff at Leeds Teaching Hospital Trust and LYPFT believed that Steven may have been making a genuine attempt on his life. This assessment may have been correct but Karen told her family that she did not believe it was a

serious attempt. Steven was found at a time when his son regularly retrieved his bike from the garage and Steven had already switched off the car engine that was the source of the carbon monoxide. It seems at least possible that this was another manipulation and another attempt at control. Steven was described as very controlled when he insisted at A&E that Karen and Mark be present when he disclosed that he had attempted suicide because he thought his marriage was over and that no-one in the family cared about him. This certainly appears to be manipulative behaviour. The staff nurse noted that there was a "dark atmosphere" and that Karen appeared at "the end of her tether" but did not explore domestic abuse with her.

362. As part of this review, Karen's friends identified ways in which Steven had isolated and controlled her. One friend reported that she had stopped phoning Karen at home because Steven was rude and unpleasant to her. The friend also reported that Steven controlled the family's finances, making Karen account for expenditure including in front of her friends. Although agencies were not aware of this information, it is possible that Karen might have disclosed it had any agency conducted a risk assessment with her.

363. After Steven was admitted to the Becklin Centre, Karen brought forward her plans to divorce him. He had intimidated her in the past and she was clearly concerned about what he might do in the future. She had sought to prevent him returning to Address 1 and her solicitor sent him a letter while he was in the Becklin Centre informing him that she wanted a divorce and asking him not to return home. She explored the option of seeking an Occupation Order prohibiting Steven from returning to the family home but discovered it would be difficult and expensive to do so. Although Steven had made some effort to find alternative accommodation while he was in the Becklin Centre, he had not identified anywhere else to go when he was due to be discharged. Karen sent Steven a text confirming he could return to the family home on the understanding that they would live separate lives and he would find alternative accommodation as soon as possible. This was confirmed by nursing staff in a conversation with Karen.

364. Within two days of Steven's discharge from the Becklin Centre, he was following Karen and soon after he was restricting her access to the Internet. She believed that he had been entering her room without her permission and had been attempting to intercept her email. These behaviours should have been regarded as stalking[30], especially given the fact that they occurred in a post-separation context and followed

[30] According to Crown Prosecution Service guidance, "Whilst there is no strict legal definition of 'stalking', section 2A (3) of the Protection from Harassment Act 1997 sets out examples of acts or omissions which, in particular circumstances, are ones associated with stalking. For example, following a person, watching or spying on them or forcing contact with the victim through any means, including social media… In many cases, the conduct might appear innocent (if it were to be taken in isolation), but when carried out repeatedly so as to amount to a course of conduct, it may then cause significant alarm, harassment or distress to the victim." http://www.cps.gov.uk/legal/s_to_u/stalking_and_harassment/#a02b

a long history of controlling behaviour. At the least, they should have been seen as harassment but this was not explored by the police.

365. A greater understanding of the long standing patterns of coercive control exerted by Steven might have helped agencies recognise that the absence of physical violence in the past could not be relied upon as a predictor of future violence in a situation where Karen was challenging his control. This in turn might have prompted agencies to consider what, if any, measures they could put in place to safeguard her and to help Karen to explore and understand the risks that she was facing and enable her to safeguard herself.

Risk assessment

366. The lack of recognition of the seriousness of Steven's controlling behaviour appears to have influenced the approach that agencies took to risk assessment, with risk assessments either not carried out (West Yorkshire Police and Leeds Women's Aid) or underestimating and/or not addressing the risks to Karen (Leeds & York Partnership Foundation Trust and Leeds Adult Social Care). Several agencies, including West Yorkshire Police, Leeds Adult Social Care and the school extended services team, noted that there was not a history of physical violence. This appears to have influenced perceptions of risk rather than encouraging a full exploration of Steven's controlling behaviour.

367. LYPFT carried out at least five risk assessments during the course of their contact with Steven between 22 March 2014 and 16 April 2014, using the FACE (Functional Analysis of Care Environments)[31] tool. The only person recognised as at risk during the initial risk assessment by the ALPS team on 22 March 2014 was Steven himself. Over the course of Steven's admission his risk of suicide reduced from 3 (serious apparent risk) to 2 (significant risk) on 25 March 2014 and to 1 (low apparent risk) on 16 April 2014, the day that Steven was discharged.

368. Subsequent events demonstrated that Steven was not in fact a low risk in relation to either himself or his wife. Within two weeks of his discharge both Steven and Karen were dead. Clearly the review has the benefit of hindsight. Indeed a key purpose of

[31] Under the FACE risk assessment system:
0 = no apparent risk. No history of warning signs indicative of risk.
1 = low apparent risk. No current behaviour indicative of risk but patient's history and/or warning signs indicate the possible presence of risk. The necessary level of screening/vigilance is covered by a standard care plan, i.e. no special risk prevention measures or plans are required.
2 = significant risk. Patient's history and condition indicate the presence of risk and this is considered to be a significant issue at present i.e. risk management plan is to be drawn up as part of the patient's care plan.
3 = serious apparent risk. Circumstances are such that a risk management plan should be/has been drawn up and implemented.
4 = serious and imminent risk. Patient's history and condition indicate the presence of risk and this is considered imminent (e.g. evidence of preparatory acts). Highest priority to be given to risk prevention.

domestic homicide reviews is to use 'hindsight' to consider whether there is anything to be learned that could prevent future homicides.

369. A pilot study about risk assessment prior to suicide and homicide found that, "risk is often reported by clinicians as having been 'low' before a suicide or a homicide occurs."[32] The issue for this review is to consider what might have assisted clinicians in identifying a higher level of risk and how this might influence future practice.

370. Karen disclosed Steven's history of controlling behaviour from the point of his admission on 22 March 2014 but his risk to others was categorised as unknown during the risk assessments of 22 and 25 March 2014. The risk assessments from 2 April 2014 onward (2, 11 and 16 April 2014) did identify that Steven posed a risk to Karen but this risk was viewed as low. LYPFT were aware of a number of risk factors including:

- a long history of abusive and controlling behaviour;
- Steven's admission that he had been cruel to Karen;
- his suicide attempt had been triggered by a fear that Karen was planning to leave him;
- Karen had initiated divorce proceedings and separation is a recognised high risk period for violence including homicide.

371. Karen was not LYPFT's patient and it is understandable that Steven was their primary concern. Nevertheless LYPFT staff did make efforts to explore the issue of domestic abuse with her. This was good practice. A Foundation Year 2 doctor discussed the history of Steven's abusive and controlling behaviour with Karen on 1 April 2014. There was sufficient concern about Karen's disclosures on 1 April 2014 for LYPFT to attempt making a safeguarding referral to Adult Social Care on the same day (which was not accepted as Karen did not meet the criteria). The FACE assessment was updated on 2 April 2014 to indicate for the first time that Karen was considered to be at risk of harm from Steven. Despite attempting to make a safeguarding referral to Adult Social Care the previous day, the risk to Karen was assessed as low. This appears to be somewhat contradictory.

372. The consultant psychiatrist spent time taking a history of abuse from Karen on 10 April 2014 and talking her through the police safeguarding website and was sufficiently concerned to contact West Yorkshire Police to make a referral on the same day (which was not accepted as a referral although this was not made clear to LYPFT). However, when the FACE risk assessment was reviewed the following day, the assessment of risk to Karen was still considered to be low. Again this appears to be contradictory.

373. LYPFT recognised that Steven's suicide attempt had been triggered by his belief that Karen was planning to leave him and explored this with him during his in-patient

[32] Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study, 2013 http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/RiskAssessmentfullreport2013.pdf

admission. Steven repeatedly said that he regretted the suicide attempt. Initially he said that he wanted to return home and get back to “normality”. Following Karen informing him that she wanted a divorce, he continued to state that he wanted to return home, which he eventually did, although he also did make some efforts to find alternative accommodation. On 31 March 2014, Steven described himself as having been cruel to Karen during the marriage and understanding why she might want to leave him. However on 4 April 2014, he told his primary worker that he didn't know why his wife was stating that he had abused her. He asked the primary worker’s opinion on abuse. She suggested that emotional/mental abuse is “often subjective”.

374. LYPFT believed that Steven was coming to terms with the divorce proceedings and separation and wished to move on with his life. However his behaviour to Karen on discharge suggests this was not the case. Only two days after being discharged he insisted on following her on a walk even though she had told him not to come. She reported to police that he said, “‘Well I’m coming anyway, you can’t stop me”. The following week, he blocked her access to the internet and appears to have been monitoring her emails. This would appear to be a continuation of the controlling behaviour that Karen had told LYPFT about.

375. Whilst LYPFT were not aware of these post-discharge incidents, the issue is whether it is reasonable for them to have considered that he was at low risk of harming her. Controlling behaviour is a form of abuse and should reasonably be considered to be a form of harm. LYPFT have suggested that a history of controlling behaviour would not automatically justify a score of 2 on the FACE risk assessment in terms of risk towards others. In Steven’s case, the history of controlling behaviour was combined with a recent suicide attempt that was attributed to his fears that Karen was planning to leave him. Since that attempt, she had confirmed that she did plan to leave him and had initiated divorce proceedings. Separation is a recognised period of heightened risk of domestic abuse, including of domestic homicide.

376. From 9 April 2014, LYPFT were aware that Steven may be returning to the family home in a post-separation situation. On 16 April 2014, this was confirmed when Karen agreed that Steven could return home. Steven was returning to a home situation where he had been abusive to Karen for a very long period of time and was used to having her under his control. LYPFT would not have been expected to undertake specific work with Steven to address his behaviour as a perpetrator of domestic abuse during his period of admission. In the absence of such work, it would seem reasonable to expect that Steven may well continue to try to control Karen, especially in a situation where she was trying to break his control. Karen had initiated divorce proceedings, which should have been considered as potentially heightening the risk of further abuse. This would suggest that an assessment of significant risk rather than low risk would have been justified.

377. LYPFT used the FACE risk assessment system to assess Steven’s risk to himself and others. This is a generic tool used in mental health settings. It is not a specific domestic abuse risk assessment tool. This reflects the fact that mental health patients present with a range of issues which may or may not include domestic abuse and clinicians need a tool that will deal with the range of presenting issues. Although the CAADA-DASH risk assessment tool was available on the LYPFT intranet it had not been formally adopted and clinical staff were not trained in its use.

LYPFT have since adopted the CAADA-DASH and added it to their electronic medical records system in December 2015. As well as a FACE risk assessment, LYPFT should carry out a DASH risk assessment if there is domestic abuse and should review practice in relation to risk assessment and discharge planning to ensure that the risks to victims of domestic abuse are considered and addressed, both for their own clients who may be victims of domestic abuse and for partners of clients who may be perpetrators of domestic abuse. They should ensure that their responses to domestic abuse incorporate the NICE guidance[33] including managing those who perpetrate it.

378. Leeds Adult Social Care completed a Mental Health Act Assessment on Steven at the request of LYPFT on 25 March 2014. The assessment identified Steven as at serious risk of harm to himself (suicide) but noted that there was no evidence of risks to other people. As part of the assessment, Karen had disclosed a long history of mental abuse and controlling behavior to the Approved Mental Health Professional. This appears to have been disregarded. The Approved Mental Health Professional was also aware that the suicide attempt had been prompted by Steven's belief that Karen was planning to leave him. Disproportionate weight appears to have been placed on the fact that there was not a history of physical violence. This reflects a narrow understanding of risk and underestimates the impact of coercive control. There was no reference to addressing Steven's abusive behaviour in the 'recommendations' for further work section.

379. As with LYPFT, Leeds Adult Social Care did not make use of the CAADA-DASH risk assessment tool within the assessment process. Leeds Adult Social Care should ensure that risk assessment is carried out with victims of domestic abuse and that any risks are reflected in Mental Health Assessments and in recommendations for further action.

380. Karen attended the Drop-In Service provided by Leeds Women's Aid on 11 April 2014. She disclosed a history of non-physical domestic abuse by Steven and discussed his recent suicide attempt, his imminent release from the Becklin Centre and her attempts to exclude him from the family home. As set out above, no risk assessment was undertaken. Although the Drop-In service does not routinely undertake a CAADA-DASH risk assessment, assessments are offered to clients if staff consider that the information disclosed warrants it. The Women's Aid worker and volunteer who interviewed Karen perceived her risk as low. This appears to be linked to the fact that she said she was not fearful. However, Karen had disclosed a number of potential high risk factors, which would have justified consideration of a formal assessment. These included:

- a long history of abusive and controlling behaviour;

[33] *Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively*, 2014, https://www.nice.org.uk/guidance/ph50/resources/guidance-domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-can-respond-effectively-pdf

- Steven's suicide attempt, detention under the Mental Health Act and imminent release;
- Karen's decision to end the relationship and initiate divorce proceedings.

381. Leeds Women's Aid referred Karen to Leeds Domestic Violence Service. The referral included information about the possible high risk factors set out above, but the Outreach Team Leader assessed the referral as not presenting with significant risk warranting a priority response.

382. West Yorkshire Police are required to complete a DASH risk assessment at all domestic abuse incidents they attend. The form should be endorsed with the identified risk level (Standard, Medium or High).[34] Officers are required to discuss their assessment with a supervisor who must approve the risk assessment.

383. As set out previously, West Yorkshire Police had contact with Karen in relation to domestic abuse on 10, 18 and 26/27 April 2014. A DASH risk assessment was not carried out on any of these occasions. As set out above, the domestic abuse clerical officer who contacted Karen on 10 April 2014 considered that the call was for advice only and was not a report of domestic abuse. As a result, the domestic abuse incident report and accompanying DASH risk assessment was not completed (*Author's note: this would have required police officers to have made an appointment with Karen to carry out the risk assessment face-to-face*). On 18 April 2014, police officers were not able to attend promptly due to demand from other calls. Karen later decided that she did not want officers to attend so it was not feasible to conduct a risk assessment on this occasion.

384. The clearest opportunity to conduct a risk assessment was on 27 April 2014, when police officers met with Karen. However the two attending officers and their supervising sergeant failed to recognise Karen's account of Steven's ongoing harassment and long history of controlling behaviour as domestic abuse. This is discussed above.

385. In interview for this review, the attending officers stated that they explored the issues which the DASH process covers without undertaking the actual process, for example whether Karen was very frightened of Steven and if she believed she was at risk of serious harm from him. They both felt that she did not believe this to be the case and that she did not disclose any significant risk indicators.

386. The issue of separation was explored with the officers. It is widely recognised that separation, and particularly the actual point of separation, is a key trigger moment for violence in intimate relationships and a common feature in domestic violence homicides. Steven's refusal to accept this separation may have been an indicator of

[34] DASH risk assessment categories are:
Standard: No significant indicators of risk of serious harm;
Medium: There are identifiable indicators of risk of serious harm. Offenders likely to cause serious harm if a change in circumstances, i.e. a failure to take medication, relationship breakdown, substance misuse, if bailed after Court appearance etc.
High: There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

significant risk but was not considered. In relation to his suicide attempt, the officers stated that Karen told them that this was not a serious attempt and had been done to get her attention and cause her to notice him again. It was not explored whether this attempt was potentially a means of emotional control to make Karen feel guilty and blame herself for it and as a threat to her that if she continued to end their marriage he would really kill himself. They did not consider the possibility that if he was prepared to end his own life he might be prepared to end hers. They did not consider the changing of the Wi-Fi codes as a potential attempt to isolate Karen and prevent her having wider contacts, or his persistence in following her and her children on a walk, until she called the police, as an example of obsession and attempted control (one officer stating that she told him to go away and he did). There was no assessment of these events as potentially significant risk factors and the officers did not believe Karen to be at risk of harm.

387. There were missed opportunities across agencies to undertake a thorough risk assessment. We do not know what that risk assessment would have indicated. The CAADA-DASH consists of 27 questions and the records that we have do not provide enough information to help us guess what answers Karen might have given if she had been asked them.

388. A thorough risk assessment would have provided agencies with the possibility of considering whether there were any actions they could put in place to safeguard Karen. It would also have provided Karen with the chance to consider her own risk in a structured manner. Victims of domestic abuse have a range of coping mechanisms to help them deal with the situation that they are in and enable them to try to carry on with their lives. This can include minimising the risks/impact of the behaviour that they are experiencing.

389. Karen had spent her married life “walking on eggshells” as Steven could “flip” at the smallest thing. Her sons were growing up and she was finally taking action to end the relationship. She had told LYPFT that she was worried that Steven might be violent to her as a result. She had disclosed a long history of controlling behaviour to a number of agencies, all of whom responded by identifying that she was at low risk of harm. Professionals with whom she had contact minimised the risks, and it is understandable that Karen may have done the same. She may not have wanted to appear to be “a victim” who was upset or frightened by what seemed on the surface to be Steven’s “childish” behaviour. Although agencies should be aware that separation is a high-risk period for violence, including domestic homicide, Karen may not have been. Agencies should also be aware of the risk of homicide-suicide (see below) but again, Karen may not have been. Had agencies helped her to think about the risk Steven posed to her, perhaps she would have made different decisions herself such as resisting Steven’s discharge to the family home or taking a loan to try to obtain an Occupation Order.

390. This is not meant in any way to blame Karen for what happened to her but to try to learn from her death to help other victims of domestic abuse. Karen was perceived as at low risk by agencies. But as events proved, she was not at low risk. Agency interventions are increasingly directed primarily at victims who are assessed as high risk. All victims should be supported to recognise the risks that they are facing and offered safety planning to help address them.

Homicide-Suicide Risk

391. Although homicide followed by suicide (homicide-suicide) is rare in comparison with the number of cases of attempted suicides that occur each year, it is not an uncommon outcome in domestic homicides. In 2014, when Karen was killed, there were at least fourteen homicide-suicides involving a male partner/ex-partner killing a female partner/ex-partner in England and Wales.[35] This is more than one in ten of the domestic homicides involving a female victim where the perpetrator was a male partner/ex-partner. As such, agencies need to consider how to identify potential homicide-suicides, especially in situations where a domestic abuse perpetrator has attempted suicide.

392. There is no record that any agency explicitly considered the risk of homicide-suicide. LYPFT and Adult Social Care recognised that Steven's attempted suicide had been triggered by his belief that Karen was going to leave him. Steven was admitted informally to the Becklin Centre and then formally detained under the Mental Health Act because of his suicide risk. LYPFT were also aware that Karen had initiated divorce proceedings following his admission to the Becklin Centre. LYPFT explored Steven's risk of suicide and his risk of harming Karen within the FACE risk assessment process but, as set out above, this process did not sufficiently recognise the risk that he would continue trying to control her. Homicide-suicide risk was not explicitly considered. LYPFT should ensure that homicide-suicide risk is considered when discharging an alleged perpetrator of domestic abuse who has previously attempted suicide or is considered a suicide risk.

393. Likewise, Leeds Adult Social Care should ensure that homicide-suicide risk is considered when making an assessment under the Mental Health Act of someone who is considered a suicide risk who is also alleged to be a perpetrator of domestic abuse. This should be addressed within the recommendations section of the assessment.

394. Had West Yorkshire Police completed a DASH risk assessment, Steven's suicide attempt would have been considered as part of it.

Think Family

395. The Think Family approach aims to ensure that support provided by different services is co-ordinated and focused on problems affecting the whole family. However, [redacted] contact with David in 2012/13 and Leeds Adult Social Care's contact with Steven in 2014 did not display such a joined up approach.

396. The first contact that suggested that there might have been issues within the family came in November 2012 when David told the Extended School Service that [redacted]. As a result he was referred to his GP and then to [redacted]. There was limited exploration of David's home life in the initial contacts with [redacted]

[35] http://kareningalasmith.com/counting-dead-women/2014-2/

. Subsequent contact was shaped by the belief that David's issues were not linked to his home life.

397. At the first appointment on 5 December 2012, the Senior House Officer used indirect questions to explore David's home life. David reported a positive relationship with his mother but said that he did not have the same relationship with his father. This was explored to some degree by the Senior House Officer but did not alter the focus of the work. At a subsequent appointment, he said that his father struggled to support him emotionally. Again, this did not alter the focus of the work and did not trigger exploration of family dynamics with Karen. A referral to the team in January 2013 made reference to "family dynamics" but provided no further information.

398. Whilst it is clinically appropriate for practitioners to discuss with service users the issues that the user wishes to discuss, this does not diminish the importance of exploring home-life and of following up comments that might suggest difficulties at home. A different approach by professionals would have given David and Karen the opportunity to discuss Steven's controlling behaviour and its impact on the family. This might have prompted a referral of Karen to a specialist domestic violence service before the crisis period prompted by Steven's attempted suicide 16 months later.

399. Steven was informally admitted to the Becklin Centre on 22 March 2014 and subsequently formally detained from 25 March 2014 to 16 April 2014. LYPFT staff were aware that a referral to Children's Social Work services had been made in A&E at the point Steven was admitted to LYPFT services following his suicide attempt and as such staff did not consider a further referral was necessary. The assessment of Steven made by Leeds Adult Social Care under the Mental Health Act recorded that he had two sons ( ). It noted that Mark had sought help when he found his father following his suicide attempt and that the marital problems were causing strain in the family home. However there is no consideration of either David and Mark in the rest of the assessment and the section titled 'Information relating to the possibility of children visiting' was blank.

400. On 1 April 2014, Karen told a Foundation Year 2 doctor at LYPFT that David and Mark did not want to see their father. Steven showed a nurse at the Becklin Centre a letter from Karen's solicitor, which said that there were concerns about Mark's ability to cope with his dad's recent suicide attempt, particularly the fact that he found him after the attempt. With Steven's agreement, LYPFT gave Karen contact details for a service that supports young carers of adults with mental health issues. On 10 April 2014, Karen told a psychiatrist from LYPFT that her solicitor had written to Steven to say that, in the interests of Mark, he should not return to the family home.

401. Leeds Teaching Hospitals Trust made a prompt referral of Mark to Leeds Children's Social Care following Steven's suicide attempt. This was appropriate. However there was a delay in sharing information about the suicide attempt with the School Nursing Service. The reasons for this delay are not known.

Referral pathways

402. When Karen first disclosed domestic abuse to LYPFT on 22 March 2014, and again to LYPFT and Adult Social Care on 25 March 2014, she was not referred to a specialist domestic violence service or given contact details for such a service. LYPFT did pass on safeguarding helpline and website details provided by Leeds Adult Social Care on 1 April 2014.

403. At the request of a consultant psychiatrist, a Foundation Year 2 doctor from LYPFT attempted to refer Karen to Leeds Adult Social Care on 1 April 2014 due to safeguarding concerns. Adult Social Care advised the doctor that Karen did not meet the criteria for a vulnerable adults safeguarding referral. It would have been more appropriate to refer her to a specialist domestic abuse service, such as Leeds Domestic Violence Service, directly.

404. A consultant psychiatrist at LYPFT believed that he had referred Karen to the West Yorkshire Police Safeguarding Unit on 10 April 2014. The Police Safeguarding Unit deals with a wider range of victims than Adult Social Care and this was an appropriate referral. The psychiatrist asked the Safeguarding Unit to contact Karen due to concerns about domestic abuse. This call was made to the police by the clinician treating Steven, who was compulsorily detained at the time. The psychiatrist should have been viewed as a credible third party and the police should have treated this as a report of domestic abuse, formally recorded the contact with Karen that resulted from it and informed LYPFT of the outcome. Instead, a domestic abuse clerical officer called Karen to provide her with information and general advice but did not make a formal report. Had this been accepted as a referral, police officers would have been expected to meet with Karen face-to-face and to conduct a DASH risk assessment. It would have also provided context for Karen's phonecall to the police on 18 April 2014, which might have led to it being recorded as a domestic abuse incident. The consultant had left his contact details but the police did not make any follow-up contact with LYPFT.

405. Agencies need to agree what constitutes a referral and the process for making one. The development of the Front Door Safeguarding Hub, which aims to provide a faster, more co-ordinated and consistent response to domestic violence cases, should help in this regard (see paragraph 426).

Access to Occupation Orders

406. Karen did not want Steven to return to the family home when he was discharged from the Becklin Centre. She did not wish to leave Address 1 herself until after Mark's exams were finished in June 2014. Her solicitor wrote to Steven on 4 April 2014 during his detention, initiating divorce proceedings, advising him not to return to Address 1 and suggesting that he find alternative accommodation. Steven got his own solicitor and on 9 April 2014 he told staff at LYPFT that his solicitor had advised him that Karen could not exclude him from the family home.

407. On 11 April 2014, Karen told Leeds Women's Aid that she had been advised by her solicitor that it would cost £3,000 to obtain an Occupation Order to prevent Steven from returning home. She was unsure whether she would even be successful as most of the abuse was historic. Leeds Women's Aid advised her to get a second

opinion from Rights of Women and provided her with contact details. It is not known whether she contacted them.

408. Karen agreed to Steven being discharged to Address 1 when it became clear that she could not prevent him without an Occupation Order. The Chair of this DHR wrote to Karen's solicitors requesting information about the contact they had with Karen regarding obtaining an Occupation Order but they would not disclose this citing the need for authorisation from Karen's family. This authorisation was subsequently provided by the family but the solicitors did not provide the requested information.

Additional Issues Arising from Analysis Against the Terms of Reference

409. The key issues are set out above. In addition the following issues have been identified in the analysis against the terms of reference

Communication and information sharing between (and within) services

410. There were examples of good communication and information sharing between services including:

- Prompt referral of David to his GP when he reported that [redacted] to the Extended School Services team;
- Prompt referral of David to [redacted] by his GP;
- Prompt referral of Mark to Leeds Children's Social Care by LTHT after Steven's suicide attempt;
- Good information sharing between blue light services at the time of the callouts relating to Steven's suicide attempt in March 2014 and the fatal stabbing and house fire in May 2014.

411. There were also examples of good communication with Karen, including from Children's Social Care regarding Mark after Steven's suicide attempt and contact with staff at LYPFT during Steven's admission.

412. There were also gaps in communication, notably:

- Difficulties in referral processes between LYPFT and West Yorkshire Police (see previously);
- Karen was not invited to the ward review meeting that agreed Steven's discharge on 16 April 2014, as detailed previously. It appears that she was not aware that 24-hour notice of his discharge only applied to his initial period of detention although she was aware that his release was imminent as a result of her discussions with the consultant on 10 April 2014.

Delivery of services

Service Standards

413. As a result of Karen's attendance at the Leeds Women's Aid drop-in on 11 April 2014, she was referred to Leeds Domestic Violence Service for support. The referral was processed on 14 April 2014, but at the time of Karen's death on 29 April 2014

contact had still not been made with her. This did not meet expected service standards and was linked to staff shortages.

Domestic Violence Policy & Procedures

414. The lack of understanding of coercive control, which is discussed above, affected risk assessments, discharge planning and post-discharge decision-making. This undermined effective service delivery.

415. Leeds Adult Social Care did not give sufficient consideration to the needs of Karen as a victim of domestic abuse during the Mental Health Assessment. Leeds Adult Social Care has no domestic violence policy in relation to service provision (it does have a policy relating to employees).

416. LYPFT did not have a domestic violence policy in place at the time and had not adopted the CAADA-DASH. Both are now in place and staff are being trained in using the CAAADA-DASH.

417. LYPFT have the capacity to place a domestic violence flag on a patient's records if they are either a victim or perpetrator of domestic abuse. This is currently only applied to MARAC cases.

418. West Yorkshire Police opened Karen's calls of 18 April 2014 and 26/27 April 2014 as domestic incidents but they were closed as 'message' and 'non-domestic' respectively. In the case of the call out of 26/27 April 2014, failure to record the call as a domestic incident was contrary to the Force's domestic violence policy.

419. At the time, Domestic Violence Protection Notices (DVPN) and Orders (DVPO) were not available to West Yorkshire Police. These Orders effectively provide a victim with a temporary non-molestation/restraining order and give them a 'breathing space' in which to receive support and consider their situation without the presence of the perpetrator in the household. However they require an incident of violence or threat of violence to have been made. This was not the case on either 18 April 2014 or 26/27 April 2014 and even if the option of an order had been live at the time it is unlikely that one could have been obtained.

Safeguarding Children policy, procedures and protocols

420. As set out previously, Mark was referred promptly to Children's Social Care by Leeds Teaching Hospital Trust after Steven's suicide attempt. This was good practice.

421. Children's Social Care followed up the referrals quickly and offered Karen and Mark support. This was good practice. The decision to close the case when this support was declined was appropriate and proportionate.

422. Leeds Adult Social Care did not give consideration to Mark in the Mental Health Act assessment and did not contact Children's Social Work Services to discuss the case. This should have happened.

Safeguarding Adults policy, procedures and protocols

423. As set out previously, LYPFT attempted to make a safeguarding adults alert in relation to Karen but this was not accepted by Leeds Adult Social Care. As set out previously (paragraph 158), Karen did not meet the definition of a vulnerable adult

that would have been required for a safeguarding alert to have been acted upon. A referral to a specialist domestic abuse service would have been more appropriate.

Assessments and Referrals

424. As set out previously, risk assessments were either not carried out or did not sufficiently recognise the risks to Karen. The risk of homicide-suicide was not explicitly considered.

425. Leeds Teaching Hospitals Trust promptly referred Mark to Children's Social Care after he found Steven following the suicide attempt. This met expected practice.

426. As set out previously, referral pathways between LYPFT and West Yorkshire Police were unclear. Leeds is now piloting the Front Door Safeguarding Hub, which aims to provide a faster, more co-ordinated and consistent response to domestic violence cases. The Front Door brings together partners from a range of organisations, including police, children's social work services, health, substance misuse services, housing services, domestic violence support services, probation, adult social care, fire and rescue, Leeds Anti-Social Behaviour Team and the Youth Offending Service. It aims to build on existing arrangements for the safeguarding of children affected by domestic violence. Implementation is still at an early stage but the Front Door should ensure better referral processes for victims. Key features of the new arrangements include improved information sharing, tasking and accountability. Daily partnership discussions allow for better understanding and management of risk and the co-ordination of appropriate support. Duplication and multiple contacts to victims should be minimised. Clear action plans are set relating to victims, children and perpetrators.

427. David's home circumstances were not sufficiently explored by [redacted] in 2012/13, either with David himself or with Karen. A more thorough examination might have led to disclosure of Steven's controlling and abusive behaviour and a referral to domestic abuse services before the crisis period of March/April 2014.

Wishes and views of members of the family

428. The extended school services team were responsive to David's expressed views, for example, waiting until Karen was home before contacting his parents.

429. As mentioned previously, Karen's family told the Serious Incident Investigation that they understood that Karen had been told she would get 24 hours' notice of Steven's discharge from hospital. The Trust's Serious Incident Investigation reported that there was no evidence that this had been agreed. However there is a reference on 25 March 2014 relating to 24-hour release and the consultant psychiatrist assured Karen on 10 April 2014 that she would be notified of his discharge. He advised her that this would take place either that week or the following week. Karen was notified of discharge on the day that it was agreed. LYPFT have said that it is not routine practice to give 24-hour notice and believe that Karen may have mistakenly believed that the 24-hour notice mentioned in relation to whether he was going to be formally detained applied to his entire admission. Confirmation of discharge on the same day that Steven was discharged resulted in last minute negotiations between Karen's solicitor and Steven's. It also put Mark in the difficult

position of taking a call from his father to say he was coming home and Mark having to contact his mother at work to make her aware of this.

430. Karen's parents said that Karen felt that LYPFT were not interested in her views about Steven's behaviour when he was in the Becklin Centre. She felt that staff saw his behaviour on the ward (such as inappropriate jokes and making light of what he had done) as odd and wouldn't listen to her when she said this was how he normally behaved, However, it is documented in the clinical records that Karen had told staff that this was how he normally behaved so they were aware of this and took this into account.

431. Karen's parents appreciated the time that police officers spent with the family on 27 April 2014. Officers offered to talk to Steven but Karen felt this would make the situation worse.

432. During an interview for this review, Karen's dad said that agencies did not give sufficient consideration to the fact that Karen was separating from Steven. He felt that agencies should not have based their assessments of future risk of physical violence on the fact that he had not been physically violent to Karen in the past. She had previously acquiesced to his demands but now she was challenging his previous long-established patterns of control within the relationship. There were "a new set of ground rules" and Steven needed "new ways of being in charge".

Thresholds for intervention

433. On 27 April 2014, police officers should have identified that they were dealing with domestic abuse and stalking, undertaken a risk assessment and considered making a MARAC referral if she was assessed as high risk. This was not an issue of the thresholds themselves being incorrect, rather that the thresholds were not appropriately applied.

434. As set out in the section on risk assessment, LYPFT assessed Steven's potential risk of harming Karen as low. Steven had been controlling and abusive to Karen for 25 years. There is no clear rationale for LYPFT's assessment that there was a low risk that he would continue to be so. The fact that the couple was separating and Karen had initiated divorce proceedings was likely to increase rather than reduce the risk that he would be abusive. Too great a reliance was placed on Steven's own account of whether he intended to harm Karen.

435. Risk to others is part of the FACE tool used by LYPFT but it does not explicitly reference domestic abuse and does not prompt consideration of the heightened risk of violence at the point of separation. Although LYPFT were signed up to MARAC arrangements, they had not adopted the CAADA-DASH tool, a risk assessment tool devised specifically for assessing risk in situations of domestic abuse, and clinicians were not trained in its use. Nevertheless, clinicians did discuss domestic abuse with Karen on 1 and 10 April 2014. The consultant psychiatrist believed that he had successfully referred Karen to West Yorkshire Police on 10 April 2014 and that this would help to manage any risk to her. As set out previously, unfortunately, the police did not accept the contact between the agencies as a referral although LYPFT were not aware of this. Whilst LYPFT could argue that Steven did not pose a risk to Karen

while he was formally detained, this was not the case when he was discharged. Had the risk been rated as 2, significant risk, rather than 1, low risk, a risk management plan would have been drawn up as part of the discharge process. This might have resulted in further contact with West Yorkshire Police, revealing that the previous attempt at referral had not been accepted and triggering a re-referral, which would have been expected to lead to the police undertaking a DASH risk assessment. This would have given the police a greater understanding of the context for Karen's call when Steven began stalking her two days after discharge.

436. LYPFT should incorporate the use of CAADA-DASH into risk assessment in situations of domestic abuse and use this to inform discharge planning. Where the patient is alleged to be a domestic abuse perpetrator, mental health services should explicitly consider the risk to both the alleged perpetrator and the victim of domestic abuse continuing post discharge and address this in the discharge planning process.

Identity and diversity issues

437. All nine protected characteristics in the 2010 Equality Act were considered by both IMR authors and the DHR Panel. Two of these had particular relevance to this DHR:

Sex: women are more likely to experience coercive control[36] than men and to be fearful where they are victims of domestic violence. Around one third of all female homicide victims are killed by a male partner or former partner.[37]

Disability: Steven had been detained under the Mental Health Act less than six weeks before he killed Karen.

438. The Panel also believed that class and financial status was relevant. Karen was an employed woman and did not have access to legal aid for help. However she was not wealthy and did not feel she could afford the cost of trying to obtain an Occupation Order to prevent Steven from returning home after his time in the Becklin Centre.

Escalation to senior management or other organisations/professionals

439. The review did not identify any failure to escalate issues to senior management. However, when the police officers sought advice from a sergeant on 27 April 2014, the sergeant should have advised them that they were dealing with a situation of domestic abuse and potentially stalking and harassment and instructed them to carry out a DASH risk assessment. Instead, officers were advised to code it as a non-crime, non-domestic requiring no risk assessment.

[36] Stark, E. 2009, *Coercive Control: How Men Entrap Women in Personal Life*

[37] Coleman and Osborne, 2010; Povey, ed. 2004, 2005; Home Office, 1999; Department of Health, 2005

440. As set out previously, referral processes between LYPFT and the police were unclear. It is hoped that these will improve as a result of the Front Door initiative discussed earlier.

The impact of organisational change

441. Leeds Domestic Violence Service were short of staff in the period when Karen was referred for support. This contributed to the failure to contact her within the timescales required.

442. There have been widespread concerns about the availability of inpatient psychiatric care across England and Wales in recent years.[38] However, these do not appear to have significantly impacted on Steven's care by LYPFT. He was initially informally admitted and subsequently detained formally with a bed being available locally. He was released from the section before it had expired as his behaviour on the ward did not justify continued detention.

443. There is no evidence that organisational change over the period covered by the review impacted on the ability of any other agency to respond effectively.

Lessons regarding the children

444. As set out previously, [redacted] should have done more to explore David's home life during their contact with him in 2012/13.

445. Leeds Adult Social Care should have given greater consideration to the needs of David and Mark as part of their Mental Health Act assessment of Steven. Agencies need to work harder on implementing their Think Family approach.

[38] The Royal College of Psychiatrists launched an independent Commission in February 2015 to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland.
https://www.rcpsych.ac.uk/mediacentre/pressreleases2015/independentcommissionlaunch.aspx

Section Seven: CONCLUSIONS

Lessons Learnt

446. A number of overarching issues emerge from the analysis:

- There was a lack of understanding of the dynamics of coercive control. Domestic abuse in an intimate partner relationship is best understood as a pattern of actions and behaviours used to intentionally control or dominate the victim. Where control can be achieved without the use of physical violence, physical violence may not be present. However, if the victim seeks to break the pattern of control, for example by threatening to leave the perpetrator, physical violence may be used in an attempt to re-exert control. In this case, the limited level of physical violence during the relationship appears to have affected perceptions of the risk of future physical violence.
- The risk that someone who had behaved in a controlling and abusive manner for 25 years would continue to be controlling and abusive was underestimated. The heightened risk of abuse and violence at separation was also underestimated. The risk of homicide-suicide was not explicitly considered;
- As a result, the degree of risk that Steven posed to Karen was not properly recognised, assessed and managed by agencies and Karen was not helped to understand and assess the risks herself.

Contributory Factors

447. The following contributory factors were identified:

- There was a lack of focus on managing Steven as a potential perpetrator;
- Karen was not signposted to specialist domestic violence services when she first disclosed abuse, delaying her access to specialist advice;
- Risk assessments were either not done or underestimated the level of risk;
- There was a lack of understanding of coercive control and a failure to recognise Steven's post-discharge behaviour as stalking.
- Referral processes were unclear, with LYPFT believing they had made a referral to the police but the police not treating the contact as a referral.

448. These issues have been considered in the report and are addressed within the recommendations and action plan.

Section Eight: WAS THIS HOMICIDE PREVENTABLE?

449. When considering homicide prevention it is helpful to think about harm prevention more broadly. Homicide is at the extreme end of a continuum of harm that can result from domestic abuse. Agencies may not always be able to precisely predict homicide but they should be able to assess whether harm is likely and consider the degree to which they have a role in preventing or reducing it. Considering harm more broadly also ties into concepts underlying the FACE risk assessment, a relevant feature of this case, which aims to assess the risks to mental health patients including both the risk of self-harm and harm to others; the MARAC approach, which aims to reduce serious harm in situations of domestic abuse; and a number of other harm reduction approaches in place across health and social care agencies.

450. Steven Jordan had been manipulative, controlling and abusive throughout his 25-year marriage to Karen. Karen sought to present a positive image of her family to the outside world and only told her mother how difficult the marriage was three years before her death. She felt that she should stay with Steven for the sake of her children, whom she was devoted to.

451. Karen was increasingly building her own life outside the marriage after spending many years trying to appease Steven. In November 2013, she told her mother that she planned to leave Steven in summer 2014 after her younger son had taken his [redacted] It appears that Steven became aware of her plans, leading to a suicide attempt in March 2014 that brought the couple into contact with a range of agencies. No agency was aware of domestic abuse until 22 March 2014. Less than six weeks later, Karen was dead. The review considered whether there were opportunities to do things differently that might have changed the outcome.

<u>Signposting</u>

452. Karen's first disclosure of domestic abuse was to LYPFT staff on 22 March 2014, when Steven was admitted to the Becklin Centre. She was not given information about specialist domestic violence services.

453. On 25 March 20014, she disclosed a long history of Steven's controlling and abusive behaviour to Leeds Adult Social Care. Again she was not given information about specialist domestic violence services.

454. On 1 April 2014, Karen again told LYPFT about the history of abuse. A Foundation Year 2 doctor made contact with Adult Social Care with a view to referring Karen but was told that she did not meet the criteria for a vulnerable adult. The doctor passed on information to Karen relating to the safeguarding website and helpline but it does not appear that information about specialist domestic violence services was provided at this time.

455. On 10 April 2014, the consultant psychiatrist recorded a history of abuse from Karen, talked her through the police safeguarding website, which includes information about domestic abuse, and made contact with Leeds Police Safeguarding Unit on Karen’s behalf. A clerical officer from the Police

Safeguarding Unit called Karen the same day and provided information about available services including Leeds Domestic Violence Service. Karen accessed the Leeds Women's Aid drop-in the following day where she talked in particular about trying to obtain an Occupation Order.

456. It appears that 10 April 2014 was the first time Karen had been given information about and had access to specialist domestic violence services, almost three weeks after her first disclosure. Had she received information at the earliest points of disclosure – to LYPFT on 22 March 2014 and to Adult Social Care on 25 March 2014 - she might have accessed specialist help more than two weeks earlier than she did. The day after receiving information about Leeds Women's Aid from West Yorkshire Police, Karen accessed the Leeds Women's Aid drop-in (on 11 April 2014). One of the issues that she discussed was whether she could obtain an Occupation Order. Although Karen had discussed an Occupation Order with her solicitor, she was concerned about the cost (£3000) that the solicitor had quoted to her. Leeds Women's Aid recommended that she contact the specialist Rights of Women family law helpline for a second opinion and provided her with contact details. The helpline currently operates on Tuesday 7pm – 9pm, Wednesday 7pm – 9pm, Thursday 7pm – 9pm, Friday 12pm – 2pm. It is not known whether Karen did contact Rights of Women but if the operating hours were the same in April 2014 as they are currently, she would have had, at most, two chances (Friday 11 April 2014 and Tuesday 15 April 2014) to do so before Steven's discharge. Earlier contact with specialist domestic abuse services would have given her more time to consider whether to try to obtain an Occupation Order to prevent Steven returning home in the light of specialist advice, whether to seek alternative accommodation herself or whether there were any other options open to her.

<u>Risk assessment</u>

457. Karen reported an extensive history of Steven's controlling and abusive behaviour to the AMHP as part of the Mental Health assessment process on 25 March 2014. However the Mental Health Assessment noted that there was no evidence that Steven posed a risk to other people and the opportunity to make recommendations within the Mental Health Assessment to address the risk of further domestic abuse to Karen was not taken.

458. LYPFT's FACE risk assessment underestimated the potential for Steven to continue abusing Karen. His risk to others was considered unknown until 2 April 2014, despite Karen disclosing domestic abuse on both 22 and 25 March 2014. From 2 April 2014 onwards, Steven was assessed as posing a low risk to Karen. This was in spite of LYPFT being aware that:

- he had a long history of controlling her;
- he had recently attempted suicide because he feared she was going to leave him;
- she had now confirmed that she was leaving him, which is a recognised period of heightened risk of domestic violence including domestic homicide;

- on 1 and 10 April 2014, she said she was frightened about what he might do to her; and
- he reported having been cruel to her in the past on 31 March 2014.

459. On 2 April 2014, LYPFT considered Steven's main risks to be attempts on his own life in the future in response to stressful situations. Similarly on 11 April 2014, LYPFT noted that, "His future risks may be that he attempts to end his life in response to stressful situations." LYPFT explored possible strategies for coping with stress with Steven during his admission and offered him the support of the Community Mental Health Team going forward. The discharge meeting on 16 April 2014 noted that it could be stressful for Steven either to be returning to the family home or to be living alone.

460. Despite the history of abuse, the circumstances prompting Steven's admission, the context of separation, and the fact that Steven was returning to the family home, putting the separating couple in close proximity in a situation that was potentially volatile and stressful, on the day of discharge LYPFT assessed Steven's risk of harming Karen to be low. Whilst it may not have been possible to predict that Steven was going to kill Karen, it does seem possible to have predicted that he was at risk of continuing trying to control her (a form of harm) and that there was a risk he would use violence to do so if other tactics failed.

461. As a result of the assessment of Steven being at low risk of harming Karen, a formal risk management plan was not required. LYPFT had previously attempted to address the risk to Karen through the referral to West Yorkshire Police but were unaware that this had not been accepted. If a formal risk management plan had been required when Steven was discharged, it might have led to further contact with West Yorkshire Police, revealing the failed referral. This could have prompted West Yorkshire Police to reconsider their approach, accept a referral and undertake a DASH risk assessment with Karen.

462. The CAADA-DASH tool was developed to help agencies assess risk in situations of domestic abuse, with the aim of better managing risk in order to reduce serious harm, including homicide. A CAADA-DASH risk assessment was never undertaken with Karen. The CAADA-DASH tool had not been adopted by LYPFT at the time of their contact with Karen but it was in use by West Yorkshire Police and police officers were required to undertake a DASH risk assessment in domestic abuse cases. Had the contact from LYPFT on 10 April 2014 been properly recognised as a referral, it is reasonable to expect that West Yorkshire Police would have interviewed Karen and completed a DASH with her on 10 April 2014.

463. Although it is possible to speculate about Karen's answers to some parts of the DASH, the panel had no information about many parts of the DASH and it is impossible to say what the assessment would have revealed and what, if any, actions agencies would have taken as a result.

464. Even if the DASH assessment had not identified Karen as high risk on 10 April 2014, its completion would have informed the subsequent reactions of the

police to the call outs on 18 and 26/27 April 2014. It would have made it more likely that the 18 April 2014 contact would have been finalised as a domestic incident rather than a message, resulting in officers visiting to assess the situation and conduct a DASH. It would have also made it more likely that the third contact, on 26/27 April 2014, could have been more easily identified as escalation.

465. A DASH should have been undertaken on 27 April 2014 in any event. Even if the police had done so, and assessed Karen as at high risk, her case would not have been heard at MARAC in time for agencies to put any actions in place to protect her. However the process may have affected Karen's own decisions (see below).

466. The other agency that was aware that Karen had reported a history of domestic abuse was Leeds Women's Aid. LWA had the option of undertaking a CAADA-DASH risk assessment but this was not a requirement, reflecting the informal setting of the drop-in service. LWA has since amended its policy and offers women the chance to undergo the DASH risk assessment if they wish to. LWA did undertake safety planning with Karen during the drop in session.

467. The purpose of risk assessment is to identify and manage risks in order to reduce harm. As set out elsewhere in this report, risk assessments were either not done, or underestimated the risk. As a result risks were not identified and managed by agencies as well as they could have been.

468. Beyond the potential impact of better risk assessment on what agencies did and didn't do, better risk assessment might have influenced what Karen did and didn't do. Even as late as 27 April 2014, the process of going through a structured risk assessment might have influenced Karen's own perceptions of her risk and influenced her decision to return to the family home and/or to reconsider attempting to obtain an Occupation Order. This is not meant to blame Karen for her death. However, interventions are increasingly targeted primarily at victims who have been assessed as high risk. For victims assessed as medium and standard risk, the risk assessment process has the potential to help them understand their situation and make decisions about their own lives.

<u>Sharing the family home post separation</u>

469. Karen did not want Steven to return to the family home and sought to prevent it through a letter to him from her solicitor. On 9 April 2014, Steven's solicitor advised him that Karen could not exclude him from the family home without a court order. She considered obtaining an Occupation Order but was concerned about the difficulty and expense of doing so. She was not entitled to legal aid.

470. Karen reluctantly agreed to Steven returning home and confirmed this in a text to him. LYPFT checked with Karen that the text was genuine when Steven showed it to them at the discharge meeting on 16 April 2014. This was good practice.

471. At the point of his discharge, Steven was not displaying signs of mental disorder or suicidal ideation and LYPFT could not justify continuing to detain

him. Without an Occupation Order, Karen could not exclude him from home and LYPFT had no grounds in law to influence where he chose to live.

472. Steven's return home ensured a greater level of contact with Karen than would have been the case if he had been living elsewhere. It gave him opportunities to seek to control her and to monitor her behaviour. It also put the separating couple in close contact with significant potential for conflict. As set out above, LYPFT had no power to prevent this, but a different score in the risk assessment would have ensured a written management plan.

473. It is possible, though not certain, that Karen could have obtained an Occupation Order to prevent Steven returning to the home. As mentioned previously, earlier access to specialist domestic violence services might have helped her explore the feasibility of obtaining such an order.

Stalking and escalation

474. Two days after Steven was discharged, Karen contacted West Yorkshire Police as Steven was following her. This was not recognised as potentially stalking behaviour. A further contact with the police on 26 April 2014 after Steven removed Karen and Mark's access to Wi-Fi, which resulted in a police visit on 27 April 2014, was not recognised as stalking or even recorded as domestic abuse.

475. Had police recognised that Karen was being stalked, it should have prompted a risk assessment to be conducted. It is also possible that they could have issued Steven with a harassment warning, which might have assisted Karen in obtaining an Occupation Order after Steven had already been discharged.

Conclusion

476. As set out above, there were several points where either agencies could have done things differently themselves or where they could have supported Karen to understand the risk she was facing differently so that she could have made different decisions. On this basis, it is at least possible that the overall outcome might have been different and that Karen's death could have been prevented.

477. The Panel wishes to express its condolences to all those affected by these deaths.

Section Nine: RECOMMENDATIONS

STRATEGIC RECOMMENDATIONS

449. The following strategic recommendations have been identified:

1. Improving understanding of coercive control

- All statutory agencies will ensure that they have policies and procedures in place for responding to domestic abuse including explicitly addressing coercive control.
- The Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership will ensure that all member agencies develop plans for skilling up workers to understand coercive control.
- All statutory agencies will ensure that they provide information about coercive control on their websites and other material about domestic abuse aimed at the public.
- Safer Leeds will request that the West Yorkshire Domestic Violence Sub Group consider conducting a public awareness campaign about domestic abuse, including coercive control.

2. Improving management of perpetrators

- Safer Leeds will map current services for managing domestic abuse perpetrators across all statutory agencies involved in the Safer Leeds partnership including ensuring that:
    - agencies outside the criminal justice system recognise that they have a responsibility to manage perpetrators;
    - the needs of victims are considered by agencies working with perpetrators.
- Safer Leeds will consider raising the impact on domestic abuse victim of legal aid changes through the Leeds Domestic Violence & Abuse Board.
- All statutory health agencies in Leeds will develop a plan for implementing the NICE guidance on domestic abuse, including responding to perpetrators.

3. Improving assessment and risk assessment across agencies

- Leeds & York Partnership Foundation Trust, Leeds Adult Social Care, Leeds Women's Aid and West Yorkshire Police will ensure that all staff understand when a DASH risk assessment should be conducted and will ensure that staff are either trained to do a DASH assessment or are aware of the referral pathways to follow to ensure a DASH assessment is done.
- Leeds & York Partnership Foundation Trust and Leeds Adult Social Care will ensure that where domestic abuse is a known issue, the victim will be offered a DASH risk assessment, where possible, either directly or through referral to another agency.
- LYPFT will increase the number of front-line practitioners able to conduct such an assessment.

- Leeds Adult Social Care will ensure that domestic abuse is explicitly addressed within the recommendations section where it is a known issue within a Mental Health Act Assessment.
- West Yorkshire Police will ensure that DASH risk assessments are carried out for all confirmed reported domestic incidents.

4. Improving safety planning

- Leeds Adult Social Care will ensure that the safety of the victim and any children or adults at risk within the household is explicitly considered within the Mental Health Act Assessment where domestic abuse is a known issue.
- Leeds & York Partnership Foundation Trust will ensure that the safety of the victim and any children or adults at risk within the household is explicitly considered as part of discharge planning where domestic abuse is a known issue.
- The Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership will review the support available to help victims assess their own risk and plan for their safety.
- The Chair of the Community Safety Partnership shall write to Resolution, the Solicitors Regulation Authority and the Law Society in order to invite the relevant organisations to raise awareness amongst their members as to the definition of domestic abuse and the potential consequences of controlling and coercive behaviour in domestic abuse situations, particularly in the light of the recent changes to the criminal, legislative definition

5. Improving referral processes

- Leeds Adult Social Care will ensure that actions to address domestic abuse are included within the recommendations section of a Mental Health Act Assessment where domestic abuse is a known issue.
- Leeds & York Partnership Foundation Trust will ensure that all relevant key issues from the Mental Health Act Assessment are highlighted on the electronic records of patients and addressed within the period of detention.

AGENCY RECOMMENDATIONS

Leeds Adult Social Care

To consider how immediate recommendations discussed by the Approved Mental Health Professional and the section 12 Doctor are shared and recorded with the ward staff to ensure there is appropriate follow up.

For the Approved Mental Health Professional Assessment template to be reviewed:

- in the ‘Assessment Conclusion’ section to have mandatory boxes to confirm if referrals are needed for Children’s Social Services, Adult Social Care, Adult

Safeguarding and MARAC for the service user and anyone impacted/at risk from the service user. To record if any further follow up is needed and who will complete the follow up.

- to have a section which has to be signed by the Mental Health Duty Team Manager to confirm they have read the assessment and to record any additional risk factors and recommendations which they think need addressing.
- For the AMPH to alert the duty manager if any specific recommendations would need signing off by the duty manager.

The new recording system which will be used by Adult Social Care (CIS) to link recommendations identified within the AMHP assessment with evidence that actions have been completed.

For the AMHP training programme and continual professional development training to include specific reference to risks for others who may be affected by the mental health service user. To include reference to children's services and safeguarding, adults safeguarding and domestic violence, including the MARAC process

For the Leeds Safeguarding Partnership Website to have more explicit information for members of the public about alternative sources of help regarding domestic violence.

For the mandatory safeguarding training for Leeds Adult Social Care staff to include written information about MARAC and links about organisations that could help victims of domestic violence who may be experiencing lower level risks of domestic violence and may not meet the criteria for MARAC.

For Adult Social Care and the Adult Safeguarding Board to be explicitly referred to within Leeds City Council's Domestic Violence and Abuse Scrutiny Board's recommendations.

For Senior Adult Social Care Staff to consider developing a Domestic Violence policy/guidelines in relation to service users and their families.

Leeds Children's Social Work Services

There are no recommendations from this review.

Leeds Clinical Commissioning Group

Provide feedback to GP Practice

Clinicians in Primary Care assessing mental health presentations are advised to routinely assess and record:

- risk to self
- risk to others
- perceived risk from others

GP practices are advised to ensure that, where staff recognise risks to self/others or risk from others information is recorded, shared and accessible to clinical colleagues and other practice staff who need to be aware of these issues.

Leeds Community Healthcare

To implement core questions of routine and selective enquiry into domestic violence into the assessment undertaken by CAMHS practitioners.

To implement a SNS review of acting on information shared with the service from A&E departments.

Leeds Education

There are no recommendations from this review.

Leeds Teaching Hospitals Trust

To consider developing training needs analysis on domestic violence issues, prioritising this review of current arrangements and pathways in high volume patient areas.

To explore how relevant clinical information held by mental health services such as mental health assessments and risk assessments can be communicated to and recorded by LTHT.

The domestic violence task and finish group to consider whether current safeguarding policies can be reviewed and strengthened or alternatively whether a stand-alone domestic violence policy is required.

Leeds Women's Aid and Leeds Domestic Violence Service

LWA to prepare a more detailed Protocol for the Drop-In service which codifies and explicitly states appropriate processes and actions to be implemented depending on a range of presenting client circumstances, including notes and record keeping.

LWA Risk Assessment protocol for drop-in and telephone services to be revised which codifies and explicitly states appropriate processes and actions to be implemented relating to risk assessment.

Review of the Referral Form for LDVS support services used by all referring sources. Specific focus on enhancing the information obtained from the client and/or referring agent with specific questions relating to actual and perception of risk and the welfare of children & young people in the home.

LDVS Lead and Service Managers include 'Changes to Policies, Procedures and Protocols' as a standard agenda item at all LDVS Management meetings. Review and Revision actions and outcomes to be monitored in meeting minutes. This will help to ensure all LDVS partners aware of revisions and to highlight those which are due for review.

Introduction of a referral alert monitoring system within LDVS Outreach. This will ensure contact is attempted with all clients referred for support within the prescribed timescale to improve client outcomes and enable potential problems in meeting this

performance measure to be identified and escalated to Senior Management in a timely manner.

Leeds & York Partnership Foundation Trust

Where a patient is being discharged from hospital clear information should be shared with the community service

In patient wards should have clear contact information for community services

The Trust policy for 7 day follow up should be reviewed to include any locally agreed standards

Where carers are involved, ward staff should ensure that they are invited to key clinical meetings to ensure their involvement.

West Yorkshire Police

That West Yorkshire Police review its training in respective of domestic abuse to ensure that concepts of coercion and control are fully embedded and officers recognise behaviours which meet the Force definition and follow procedures accordingly.

That West Yorkshire Police remind Safeguarding Unit staff of the importance of formally recording third party concerns that a victim is subject to abuse.

Yorkshire Ambulance Service

Within 3 months YAS will put a bulletin in Operational Update to remind staff of the impact on children and young people witnessing or affected by Deliberate Self-Harm/Para-suicide or suicide. The age & relationship of the child or young person must be documented and a referral to Children's Social Care must be made.

APPENDIX 1 Terms of Reference

Overarching aim

The over-arching intention of this review is to increase safety for potential and actual victims by learning lessons from the death in order to change future practice. It will be conducted in an open and consultative fashion bearing in mind the need to retain confidentiality and not apportion blame. Agencies will seek to discover what they could do differently in the future and how they can work more effectively with other partners.

Principles of the Review

1. Objective, independent & evidence-based
2. Guided by humanity, compassion and empathy, with the victim's voice at the heart of the process
3. Asking questions to prevent future harm, learn lessons and not blame individuals or organisations
4. Respecting equality and diversity
5. Openness and transparency whilst safeguarding confidential information where possible

Family Details

Summary of details of victim, alleged perpetrator and any children.

Party	Name	Age	Known and previous addresses
Victim	Karen Jordan	47	Address 1
Suspect	Steven Jordan	48	Address 1
Child 1	David Jordan	[redacted]	[redacted] Address 1
Child 2	Mark Jordan	[redacted]	Address 1

Incident Summary

At 18:32 on Tuesday 29 April 2014 a neighbour called 999 to report that Address 1 was on fire. Neighbours had heard arguing coming from the address followed by what was described as an explosion. Witnesses then describe Steven Jordan, coming out of the house via the patio doors from the kitchen area, engulfed in flames.

Fire and police responded to the call. On arrival of the first officer at the scene, Steven Jordan was found in the back garden of the premises fully alight. Together with members of the public, the officer used water from the garden pond to extinguish the flames. Steven Jordan was transported to hospital but died later that evening of his injuries.

The fire service attended, put out the fire and discovered the body of Karen Jordan just inside the side entrance door. She had received multiple stab wounds.

Karen had recently asked Steven for a divorce. Steven had tried to kill himself on 22 March 2014, citing their marital problems as the reason. He was sectioned afterwards and had spent some time at the Becklin Centre, Leeds.
The police investigation team are satisfied at this time that Steven Jordan killed his wife, Karen, before deliberately setting fire to their house using some form of accelerant. In light of this there w
submitted to HM Coroner and an inquest will be held at a date to be fixed.

Specific areas of enquiry

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

1. Each agency's involvement with the following family members between 1 January 2010 and the death of Karen Jordan on 29 April 2014:

   a. Karen Jordan

   b. Steven Jordan

   c. David Jordan

   d. Mark Jordan

   In addition, each agency should include any relevant events prior to 1 January 2010 and a summary of any contacts prior to 2010 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 the family members listed above, an improvement in any of the following might have led to a different outcome for Karen Jordan:

   a. Communication between services

   b. Information sharing between services with regard to both domestic violence and to the safeguarding of children

   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, including MARAC (Multi-Agency Risk Assessment Conference)

   c. Safeguarding children policy, procedures and protocols

d. Safeguarding adults policy, procedures and protocols

4. The response of the relevant agencies to any referrals relating to Karen Jordan, Steven Jordan, David Jordan and Mark Jordan concerning domestic abuse (including emotional abuse and controlling behaviour) or other significant harm from 01/01/10. 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 Karen Jordan, Steven Jordan, David Jordan and Mark Jordan.

5. Whether adult-focused services ensured that the welfare of any children was promoted and safeguarded and vice-versa and how this was done.

6. Whether services took account of the wishes and views of members of the family in decision-making and how this was done.

7. Whether thresholds for intervention were appropriately set and correctly applied in this case.

8. 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 of the parents or the children were explored, shared appropriately and recorded.

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

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

Child's Element of the Domestic Homicide Review

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

11. Whether there is any learning from this case in relation to David and Mark which would improve safeguarding practice in relation to domestic violence and its impact on children, particularly in the areas of:
    a. communication
    b. information sharing
    c. risk assessment

Panel Membership

Name	Organisation
Hilary McCollum	Independent Chair and Report writer
Area Community Safety Co-ordinator	Domestic violence team, Leeds City Council
Domestic Homicide Reviews Senior Officer	Domestic violence team, Leeds City Council
Superintendent	West Yorkshire Police
Head of Service	Leeds Adult Social Care
Head of Children's Social Work Service	Children's Social Work Services
Designated Nurse for Safeguarding Adults	NHS England / Leeds Clinical Commissioning Groups
Named Nurse for Safeguarding Children and Domestic Violence	Leeds and York Partnership NHS Foundation Trust
Head of Service, Children Looked After & Safeguarding	Leeds Community Healthcare NHS Trust
Lead Professional for Safeguarding Adults at Risk	Leeds Teaching Hospital's Trust
Named Professional for Safeguarding Adults	Yorkshire Ambulance Service NHS Trust
IDVA Service Manager	Leeds Domestic Violence Service
Head of Service Learning for Life	Schools and Learning, Leeds City Council

Family involvement and Confidentiality

The review will seek to involve the family of both the victim and the perpetrator in the review process, taking account of who the family wish to have involved as lead members and to identify other people they think relevant to the review process.

We will seek consent of the sons to be named parties in the review and will inform them of our intention to secure information from their records.

We will seek to agree a communication strategy that keeps the families informed, if they so wish, throughout the process. We will be sensitive to their wishes, their need for support and any existing arrangements that are in place to do this.

We will identify the timescale and process and ensure that the family is able to respond to this review endeavoring to avoid duplication of effort and without undue pressure.

Disclosure & Confidentiality

- Confidentiality should be maintained by organisations whilst undertaking their IMR. However, the achievement of confidentiality and transparency must be balanced against the legal requirements surrounding disclosure.
- The independent chair, on receipt of an IMR, may wish to review an organisation's case records and internal reports personally, or meet with review participants.
- A criminal trial will not take place.
- Any lessons learned will be taken forward immediately and not wait for the completion and publication of the Overview Report.
- Individuals will be granted anonymity within the Overview Report and Executive Summary and will be referred to by an alias or by initials.
- Where consent to share information is not forthcoming, agencies should consider whether the information can be said in the public interest.

IMRs and Chronologies

The first meeting of the DHR Panel agreed that Individual Management Reviews (IMRs) would be requested from the following organisations:

- Leeds City Council Adult Social Care
- Leeds City Council Children's Social Work Services
- Leeds City Council Education – Secondary School
- Leeds Clinical Commissioning Group – GPs for all family members
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust – Child & Adolescent Mental Health Services and School Nursing Service
- Leeds Teaching Hospitals Trust
- West Yorkshire Police
- Leeds Domestic Violence Service
- Yorkshire Ambulance Service

Additional agencies may be asked to submit IMRs in the light of further information received and the progress of the Review.

Review Panel members will take steps to ensure that their agency's IMR and chronology are completed within the agreed timescales set out below. Organisations will commit adequate resources to ensure this happens.

Review Panel members will read all the circulated management reports and chronologies prior to the panel meetings and will consider whether any additional information may be required and whether the findings and recommendations are appropriate.

Advice on how to complete IMRs and Chronologies will be issued as necessary to IMR authors by Safer Leeds. A briefing for IMR authors will be held on Tuesday 2 September.

The table below sets out what is expected from each agency:

Who	What	By when
Leeds City Council Adult Social Care	Chronology IMR	30 September 2014 28 October 2014
Leeds City Council Children's Social Work Services	Chronology IMR	30 September 2014 28 October 2014
Leeds City Council Education – Secondary School	Chronology IMR	30 September 2014 28 October 2014
Leeds Clinical Commissioning Group – GPs for all family members	Chronology IMR	30 September 2014 28 October 2014
Leeds and York Partnership NHS Foundation Trust	Chronology IMR	30 September 2014 28 October 2014
Leeds Community Healthcare NHS Trust – Child & Adolescent Mental Health Services and School Nursing Service	Chronology IMR	30 September 2014 28 October 2014
Leeds Teaching Hospitals Trust	Chronology IMR	30 September 2014 28 October 2014
West Yorkshire Police	Chronology IMR	30 September 2014 28 October 2014
Leeds Domestic Violence Service	Chronology IMR	30 September 2014 28 October 2014
Yorkshire Ambulance Service	Chronology IMR	30 September 2014 28 October 2014

Timescales

The period under review is 1 January 2010 to 29 April 2014. In addition, each agency should include any relevant events prior to 1 January 2010 and a summary of any contacts prior to 2010 that gave rise to concern.

The review began on 4 August 2014. The aim is to conclude the review within six months.

Parallel Investigations

An inquest will be conducted.

In line with Department of Health guidance, a mental health investigation will take place as the perpetrator had been seen by a mental health service within the six months prior to the homicide.

Any misconduct issues arising during this review will be addressed by the individual agency to ascertain what action, if any, is required. If an IMR author finds information which indicates malpractice or significant errors of judgment or practice there is a duty to share this through the appropriate channels.

Media strategy

Any media enquiries should be referred to neil.obyrne@leeds.gov.uk at Safer Leeds.

Appendix 2 - Action Plans

Strategic recommendations

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
• All statutory agencies will ensure that they have policies and procedures in place for responding to domestic abuse including explicitly addressing coercive control.		Safer Leeds			
• The Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership will ensure that all member agencies develop plans for skilling up workers to understand coercive control.		Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership			
• All statutory agencies will ensure that they provide information about coercive control on their websites and other material about domestic abuse aimed at the public.		Safer Leeds			

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
• Safer Leeds will request that the West Yorkshire Domestic Violence Sub group consider conducting a public awareness campaign about domestic abuse, including coercive control.		Safer Leeds			
• Safer Leeds will map current services managing domestic abuse perpetrators across all statutory agencies involved in the Safer Leeds partnership including ensuring that: ▪ agencies outside the criminal justice system recognise that they have a responsibility to manage perpetrators; ▪ the needs of victims are considered by agencies working with perpetrators.		Safer Leeds			
• Safer Leeds will consider raising the impact on domestic		Safer Leeds			

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
abuse victim of legal aid changes through the Leeds Domestic Violence & Abuse Board.					
• All statutory health agencies in Leeds will develop a plan for implementing the NICE guidance on domestic abuse, including responding to perpetrators.		Health agencies			
• Leeds & York Partnership Foundation Trust, Leeds Adult Social Care, Leeds Women's Aid and West Yorkshire Police will ensure that all staff understand when a DASH risk assessment should be conducted and will ensure that staff are either trained to do a DASH assessment or are aware of the referral pathways to follow to ensure a DASH assessment is done.		Leeds & York Partnership Foundation Trust, Leeds Adult Social Care, Leeds Women's Aid and West Yorkshire Police			
• Leeds & York Partnership		Leeds & York			

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
Foundation Trust and Leeds Adult Social Care will ensure that where domestic abuse is a known issue, the victim will be offered a DASH risk assessment, where possible, either directly or through referral to another agency.		Partnership Foundation Trust and Leeds Adult Social Care			
• LYPFT will increase the number of front-line practitioners able to conduct such an assessment.					
• Leeds Adult Social Care will ensure that domestic abuse is explicitly addressed within the recommendations section where it is a known issue within a Mental Health Act Assessment.		Leeds Adult Social Care			
• West Yorkshire Police will ensure that DASH risk assessments are carried out for all confirmed reported domestic incidents.		West Yorkshire Police			
• Leeds Adult Social Care will ensure that the safety of the victim and any children or		Leeds Adult Social Care			

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
adults at risk within the household is explicitly considered within the Mental Health Act Assessment where domestic abuse is a known issue.					
• Leeds & York Partnership Foundation Trust will ensure that the safety of the victim and any children or adults at risk within the household is explicitly considered as part of discharge planning where domestic abuse is a known issue.		Leeds & York Partnership Foundation Trust			
• The Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership will review the support available to help victims assess their own risk and plan for their safety.		Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership			
• The Chair of the Community Safety Partnership shall write to Resolution, the Solicitors Regulation Authority and the					

Strategic recommendation	Actions	Lead	Milestone	Target date	Date of completion & outcome
Law Society in order to invite the relevant organisations to raise awareness amongst their members as to the definition of domestic abuse and the potential consequences of controlling and coercive behaviour in domestic abuse situations, particularly in the light of the recent changes to the criminal, legislative definition					
• Leeds Adult Social Care will ensure that actions to address domestic abuse are included within the recommendations section of a Mental Health Act Assessment where domestic abuse is a known issue.		Leeds Adult Social Care			
• Leeds & York Partnership Foundation Trust will ensure that all relevant key issues from the Mental Health Act Assessment are highlighted on the electronic records of patients and addressed within the period of detention.		Leeds & York Partnership Foundation Trust			

Leeds Adult Social Care

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
To consider how immediate recommendations agreed by the Approved Mental Health Professional and the section 12 Doctor are shared and recorded with the ward staff to ensure there is appropriate follow up.	Discussion between Adult Social Care and health colleagues to discuss further, set up a protocol and ensure this is implemented in training.	Named individuals		August 2015	
For the Approved Mental Health Professional Assessment template to be reviewed; (1) in the 'Assessment Conclusion' section to have mandatory boxes to confirm if referrals are needed for Children's Social Services, Adult Social Care, Adult Safeguarding and MARAC for the service user and anyone impacted/at risk from the service user. To record if any further follow up is needed and who will complete the follow up. Leeds Adult Social Care will ensure that domestic abuse is explicitly addressed within the recommendations section where it is a	Review of the AMPH report template	Named individuals	Return the revised assessment to the Mental Health Act Forum for implementation	August 2015	

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
known issue within a Mental Health Act Assessment. Leeds Adult Social Care will ensure that the safety of the victim and any children or adults at risk within the household is explicitly considered within the Mental Health Act Assessment where domestic abuse is a known issue (2) To have a section which has to be signed by the Mental health Duty Team Manager to confirm they have read the assessment and to record any additional risk factors and recommendations which they think need addressing. (3) For the AMPH to alert the duty manager if any specific recommendations would need signing off by the duty manager.					
The new recording system which will be used by Adult Social Care (CIS) to link recommendations identified within the AMHP assessment with evidence that actions have been completed.	Add to the statement of requirements for CIS	Named individuals	Go live date for CIS July 2015	July 2015	
For the AMHP training programme and continual professional development training to include specific reference to	Named individuals to work with Named individual and the Mental	Named individuals		August 2015	

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
risks for others who may be affected by the mental health service user. To include reference to children's services and safeguarding, adults safeguarding and domestic violence, including the MARAC process	Health Team Managers regarding continual professional development regarding MARAC and emotional abuse	Named individ			
For the Leeds Safeguarding Partnership Website to have more explicit information for members of the public about alternative sources of help regarding Domestic Violence.	Named individuals to discuss with the Safeguarding Adults Board and the Safeguarding Unit	Named individuals		September 2015	
For the mandatory safeguarding training for Leeds Adult Social Care staff to include: written information about MARAC and links about organisations that could help victims of domestic violence who may be experiencing lower level risks of domestic violence and may not meet the criteria for MARAC. Clarity for all staff to understand when a DASH risk assessment should be conducted, to include training about how it should be completed, including referral pathways to follow to ensure a DASH assessment is done.	Named individuals to discuss with Named individ (Head of Safeguarding) and Named individuals (Lead for Training in Adult Social Care) Formulation of a strategic and operational development plan to be drafted for implementation.	Named individuals Named individuals		September 2015 October 2015	

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
Knowledge that the risk of committing homicide is explicitly considered for all patients that are alleged to be perpetrators of domestic abuse.					
For Adult Social Care to have a policy in place for responding to domestic abuse including: Explicitly addressing coercive control. Ensuring that information about coercive control is on the LCC websites and other material about domestic abuse aimed at the public. Consideration of the needs of victims when ASC staff are working with perpetrators. A reference to NICE guidance on domestic abuse, including responding to perpetrators.	Further discussion between Adult Social Care and Domestic Violence Board partners to ensure corporate uniformity	Named individuals		December 2015	
For Adult Social Care and the Adult Safeguarding Board to be explicitly referred to within Leeds City Council's Domestic Violence and Abuse Scrutiny Board's recommendations. For Senior Adult Social Care Staff to discuss the recommendations for Adult Social Care from this review to consider a Domestic Violence	Named individuals to discuss with Leeds City Council's Domestic Violence and Abuse Scrutiny Board	Named individuals, Leeds City Council's Domestic Violence and Abuse Scrutiny Board		September 2015	

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
policy/guidelines in relation to service users and their families.					

Leeds Clinical Commissioning Group

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
1) Feedback to GP Practice	By letter and meeting	NHS England Safeguarding Lead/IMR author	Meeting arranged for 16th July	July 2015	Amber
2) Clinicians in Primary Care assessing mental health presentations are advised to routinely assess and record 1.Risk to self 2.risk to others 3.percieved risk from others	Included in domestic abuse training and newsletter	NHSE/CCG	Included in safeguarding newsletter sent to all Leeds GP practices	March 2015	Green
3) GP practices are advised to ensure that, where staff recognise risks to self/others or risk from others information is recorded, shared and accessible to clinical colleagues and other practice staff who need to be aware of these issues.	Newsletter and domestic abuse training	NHS England/CCG	Included in safeguarding newsletter sent to all Leeds GP practices In addition to this a safeguarding / DA	March 2015	Green

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
			template is in draft form for recording DA concerns in GP records		

Leeds Community Healthcare – CAMHS

Recommendation	Action	Lead	Milestones	Target date	Date of completion & outcome
To implement core questions of routine and selective enquiry into domestic violence into the assessment undertaken by CAMHS practitioners	IMR Author to raise issue with CAMHS Senior Management Team	CAMHS Manager (CAMHS1) to allocate lead practitioner. Lead to organise task and finish group.	1) Organise task and finish group. 2) Review systematic approaches to core questions within the CAMHS assessment. 3) To re-introduce domestic violence enquiry as a matter of routine into CAMHS assessment.	01/05/15 01/05/15 30/09/15	Completed Completed

Recommendation	Action	Lead	Milestones	Target date	Date of completion & outcome
			4) Raise awareness of changes (and rationale) with CAMHS practitioners. To include domestic violence awareness. 5) Undertake “spot check” review of CAMHS Care Notes for evidence of routine and selective enquiry into domestic violence. 6) Include No 5 into annual record keeping audit.	30/09/15 31/03/16 10/06/15	Completed and has been added to the annual service specific records audit.

Leeds Community Healthcare – School Nursing

Recommendation	Action	Lead	Milestones	Target date	Date of completion & outcome

Recommendation	Action	Lead	Milestones	Target date	Date of completion & outcome
To implement a SNS review of acting on information shared with the service from A&E departments.	IMR Author to raise issue with SNS Senior Management Team	SNS Manager (SNS2) to Lead or allocate lead practitioners Lead to organise task and finish group.	1) Organise task and finish group. 2) Undertake review of current pathway. 3) To develop and utilise SOP for SNS in relation to acting on information received from A&E departments. 4) Raise awareness of changes (and rationale) with SNS practitioners. 5) Undertake “spot check” review of SNS Notes for evidence of SOP being in operation. 6) Include No 5 into annual record keeping audit.	08/05/14 08/05/15 31/08/15 30/09/15 31/03/16 10/06/15	Completed Completed Completed and has been added to the annual service specific records audit.

Recommendation	Action	Lead	Milestones	Target date	Date of completion & outcome

Leeds Teaching Hospital Trust

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
Leeds Teaching Hospitals NHS Trust will develop a plan for implementing the NICE guidance (LGB20), Domestic Violence and Abuse, how services can respond effectively	LTHT will review current processes and Trust pathways in respect of Domestic Violence and abuse in the organisation, by considering and posing key questions and challenge against the key areas within the NICE guidance.	Head of Safeguarding	A comprehensive action plan to help identify and respond to domestic violence and abuse in LTHT will be developed.	September 2015	Amber
LTHT to consider developing training needs analysis on domestic violence issues, prioritising this review of current arrangements and pathways in high volume patient areas.	Training Needs Analysis to be progressed and completed by the new Head of	Head of Safeguarding		September 2015	Amber

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
	Safeguarding				
LTHT to explore how relevant clinical information held by mental health services such a mental health assessments and risk assessments can be communicated to and recorded by LTHT	The new Head of Safeguarding to agree a process for recording relevant information on LTHT clinical records that relate to risk of domestic violence, harm to self and others.	Head of Safeguarding	This was completed by previous head of safeguarding in 2013	September 2015	Green

Leeds Women's Aid and Leeds Domestic Violence Service

Recommendation	Action	Lead	Milestones	Target Date	Date of Completion & Outcome
LWA to prepare a more detailed Protocol for the Drop-In service which codifies and explicitly states appropriate processes and actions to be implemented depending on a range of presenting client circumstances, including notes and record keeping.	LWA Management, Workers and Volunteers to review, trial, revise and implement New Protocol to be incorporated in LWA system Staff and Volunteer training Documents and	JF	LWA Drop-In Staff, Volunteers and LWA Management meeting to review existing Guidelines New Protocol to be written. New protocol to be trialed and evaluated. Approval by LWA	5.1.15	14.1.15

Recommendation	Action	Lead	Milestones	Target Date	Date of Completion & Outcome
	information to be stored correctly on files		Management. Implement revised Drop-In Protocol.		
LWA Risk Assessment protocol for drop-in and telephone services to be revised which codifies and explicitly states appropriate processes and actions to be implemented relating to risk assessment.	LWA Manager and Keyworkers to discuss and agree Produce protocol and checklist Staff training Implementation Documents to be implemented and stored on files	JF	LWA Manager and Keyworkers meet to discuss and revise existing protocol. New Protocol to be written. New Protocol to be trialed and evaluated. Final revision of Protocol. Training plan devised. Managers to facilitate a time to train Workers and Volunteers. New Protocol embedded in LWA documents.	5.1.15	Consulted, trained and the approved at team meeting on 14.1.15
Review of the Referral Form for LDVS support services used by all referring sources. Specific focus on enhancing the information obtained from the	LDVS Managers meet to review current LDVS Referral Form and	JF/LT/NP	LDVS Managers Meeting arranged to discuss. LDVS teams	5.1.15	12.12.14 15.12.14

Recommendation	Action	Lead	Milestones	Target Date	Date of Completion & Outcome
client and/or referring agent with specific questions relating to actual and perception of risk and the welfare of children & young people in the home.	agree areas for improvement LDVS teams invited to comment LDVS Managers write revised Referral Form Implement revised LDVS Referral Form Send revised LDVS Referral Form to all referring agencies – including non-contracted associated services (LWA Drop-In & BCD PARS) Add LDVS Referral Form to LDVS partner websites	All Key Workers	provide feedback on revised Referral Form. LDVS Managers or Keyworkers to meet to re-design LDVS Referral Form. Discussion with MODUS database providers to enable storage of new information. New referral form shared within LDVS partners. Briefing session by LDVS Partners with their Staff and Volunteers. Implementation date for making new referral form available to all referring sources.		17.12.14 No system revision required 19.12.14 22.12.14 5.1.15
LDVS Lead and Service Managers include 'Changes to Policies, Procedures and Protocols' as a standard agenda item at all LDVS	LDVS Management to agree Develop Standard Agenda to include	JF/LT/NP	Next LDVS Management meeting to develop a Master List of	31.10.14	14.11.14

Recommendation	Action	Lead	Milestones	Target Date	Date of Completion & Outcome
Management meetings. Review and Revision actions and outcomes to be monitored in meeting minutes. This will help to ensure all LDVS partners aware of revisions and to highlight those which are due for review.	Changes to Policies, Procedures & Protocols item		Policies, Procedures and Protocols for all areas of LDVS. Review dates and person with key responsibility to be included. Agenda Item included on all future LDVS Manager meetings.		17.12.14 5.1.15 Following amendment from DHR panel; revised to 'Changes to Policies…….'
Introduction of a referral alert monitoring system within LDVS Outreach. This will ensure contact is attempted with all clients referred for support within the prescribed timescale to improve client outcomes and enable potential problems in meeting this performance measure to be identified and escalated to Senior Management in a timely manner.	Review existing referral alert and monitoring system Introduce new operating system to provide daily alert of required and outstanding activity Develop new referral process and monitoring protocol Implement robust duty system to support new referral	BCD – LT/DC/OM & KW	Implement new process for assessing, processing and monitoring referrals. Implement new Outreach Referral Process & Practice Guidelines (with a Response Protocol). Introduce weekly database	May 2014	21.05.14 June 2014 May 2014

Recommendation	Action	Lead	Milestones	Target Date	Date of Completion & Outcome
	process Training of Staff Management Overview		monitoring report. Introduction of a new duty system and effective monitoring of a duty rota.		May 2014

Leeds & York Partnership Foundation Trust

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
Where a patient is being discharged from hospital clear information should be shared with the community service.	All calls received from inpatient wards to Aire Court reception/switchboard concerning service users supported by CMHT should be transferred to the CMHT duty number/office so that a clinical conversation can be had. If Duty is unavailable the	Locality Manager Team leader administration Clinical Lead with CMHT duty guidelines	To be discussed in the community mental health team (CMHT) Business Meeting on 22nd October, CMHT Away day on the 14th	October 31st 2014	COMPLETED

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
	caller must be asked to phone back. Messages must not solely be left in clinician's trays due to uncertainly when messages can be actioned.		October & next Clinical Lead Meeting.		
	When advising of key clinical decisions for service users, Inpatient Ward clinicians must speak to the CMHT clinician involved and if unavailable ask to speak to the CMHT duty worker/Clinical Lead to plan appropriate follow up arrangements/information for the service user. If unavailable the	Matron acute inpatient services	Minutes of leadership meeting	November 2014	COMPLETED

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
	caller must phone again and not solely leave messages in order that accurate information can be given to service users.				
	There should be a review of the processes within community teams to ensure that messages left for staff are received and that all staff are aware of their responsibilities in the process	Clinical Service Manager, Community Services		January 2015	COMPLETED
In patient wards should have clear contact information for community services	Citywide CMHT service to develop service leaflet with key contact details and overview of service including out of hours contact details for service users.	Coordinating Clinical Leads across hubs	Leaflet completed	January 2015	COMPLETED
The Trust policy for 7 day follow up	Review of follow	CPA	New	December	

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
should be reviewed to include any locally agreed standards	up arrangements for people leaving acute services (Inpatient and ICS) to ensure standard shared understanding and one that fits with clinical need.	development Manager	procedure	2014	
Where carers are involved, ward staff should ensure that they are invited to key clinical meetings to ensure their involvement.	Recommendation to be discussed at the Acute Inpatient Leadership Forum in order to review current procedures in relation to notifying carers or significant family members Acute leadership Forum to determine how this standard could be audited	Matron acute inpatient services	Minutes of meeting audit as agreed by the forum	November 30th 2014	COMPLETED
Where a child is involved in a case such as this a referral should be made to the child safeguarding team in their		Matron acute inpatient services		November 30th 2014	COMPLETED

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
own right.					

West Yorkshire Police

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
All statutory agencies will ensure that they have policies and procedures in place for responding to domestic abuse including explicitly addressing coercive control.	Review Force Domestic Abuse policy to assess compliance.	Safeguarding Delivery Manager	Content of Force Policy. Current definition states: Domestic abuse is defined as: "Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between	22/07/2015	22/07/2015

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
			those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Additional guidance is provided in the policy of the definition of these terms[39]		
The Safeguarding Children Board, Safeguarding Adults Boards and Safer Leeds Partnership will ensure	Review of training provision	Safeguarding Delivery Manager	Content of training courses.	22/07/2015	22/07/2015

[39] The Force Policy definition of domestic abuse includes coercive control and the national definition of what this is. The policy itself directs how all forms of domestic abuse should be responded to and this includes the response to abuse that consists of coercive control.

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
that all member agencies develop plans for skilling up workers to understand coercive control.			The Force uses national training materials for new recruits which contain material specific to Coercion and control.[40] It is also included in all other domestic abuse training for example the new managers' course and		

[40] Coercive control is an integral part of training in respect of domestic abuse. The College of policing has developed a coercive control national training package which will be rolled out to Police Forces this year. WYP have committed to a 3 month training period at Districts to implement this additional training throughout its Front line staff and within the safeguarding units once it has been received.

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
			running the 'Safeguarding - Everyone's Business'.		
All statutory agencies will ensure that they provide information about coercive control on their websites and other material about domestic abuse aimed at the public.	Review of website	Safeguarding Delivery Manager	Current content of website. The current West Yorkshire Police website uses the Force definition of domestic abuse which includes coercion and control. Links to other sites are given which	22/07/2015	22/07/2015

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
			provide further information		
The Chair of Safer Leeds will write to the Police & Crime Commissioner for West Yorkshire requesting that they consider conducting a public awareness campaign about domestic abuse, including coercive control.	Review of public awareness campaigns held and planning of additional campaign.	Safeguarding Delivery Manager	Campaign material and planned activity[41]	10/12/2015	
Safer Leeds will put in place a strategy for managing domestic abuse perpetrators across all statutory agencies involved in the Safer Leeds partnership including ensuring that: agencies outside the criminal justice system recognise that they have a responsibility to manage perpetrators; the needs of victims are considered	Review of existing and planned offender management arrangements; further development of domestic abuse perpetrator offender	Safeguarding Delivery Manager	Offender management processes in respect of domestic abuse perpetrators[42]	01/01/2016	28/07/2015

[41] West Yorkshire Police has routinely run domestic abuse awareness raising campaigns at Christmas to coincide with the peak in incidents and have also run biennial campaigns to coincide with the Euros and World Cup competitions. A campaign is currently being planned launch to coincide with the international 16 Days of Action which run from 25 November to 10 December 2015. This campaign will feature coercion and control as themes.

[42] High risk domestic abuse offender management is currently effected through the Force's participation in MAPPA, MARAC and the Force's Serious Offences Review Team. An action in the West Yorkshire Police HMIC domestic abuse action plan has been to extend this to lower levels of perpetrator. This has been significantly progressed through the development of a domestic abuse offender risk

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
by agencies working with perpetrators.	management structures.				

scoring matrix on the Force's Corvus database which has identified 1,538 domestic abuse related offenders. Work is continuing to develop management structures in relation to these perpetrators. Domestic abuse perpetrators will be incorporated within a refreshed approach to offender management which will incorporate these offenders within a new 'Risk of harm ' cohort which will be managed within the IOM multi-agency hubs with NPS and CRC. Districts have been informed that a representative from the Offender management police team should be present at MARAC to advise on suitable and available interventions for perpetrators of domestic abuse to prevent further offences and protect the victims and children.

Update 29/7/15: Operation Haven has now commenced in Leeds which will now include further management domestic abuse offenders. The team consists of

1 police sergeant
1 x NPS probation officer
1 x (2 on job share) CRC probation officers
1 x Crime Reduction Initiative Officer – outreach interventions, case management, drug / alcohol misuse worker in police cells
1 x Developing Initiatives for Safer Communities Officer – outreach interventions, case management, substance misuse, prison / through the gate work
2 x DV victim services officers

Interventions include:

Prison - identification of prisoners being released to Leeds addresses for DV offences on a month by month basis; Lead officers identified from each of the represented agencies; Intervention plans agreed; Probation officers take lead for all statutory managed offenders; further support offered around pre-release visits and support for identified needs – substance misuse, housing, employment, training, education etc.; the police support with risk assessment work, address checks, intelligence gathering, enforcement tactics - 28 individuals processed due for release in July and Aug.

Referrals: Daily assessment of suspects under following criteria – High DASH, AND , 4 incidents in 28 day period OR 6 crimes in 12 month period; **CRI**

assessment - of suspects while in custody - Visits when staff working to all detained suspects to assess interventions.

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
West Yorkshire Police will ensure that all staff understand when a DASH risk assessment should be conducted and will ensure that staff are either trained to do a DASH assessment or are aware of the referral pathways to follow to ensure a DASH assessment is done.	Review of current levels of DASH completion; Implementation of remedial action to address developmental areas identified.	Safeguarding Delivery Manager	Audit of DASH process to examine if identified areas for development met.[43]	01/07/2015	01/07/2015
West Yorkshire Police will ensure that DASH risk assessments are carried out for all confirmed reported domestic incidents.	Review of current levels of DASH completion; Implementation of remedial action to address developmental areas identified.	Safeguarding Delivery Manager	Audit of DASH process to examine if identified areas for development met.	01/07/2015	01/07/2015

[43] West Yorkshire Police has sampled 250 DASH reports in June 2015. Completion rates were found to be good. 95% of reports which should have had a DASH report had one completed. These results are being incorporated into performance reviews with District senior management teams to increase completion rates.

Recommendation	Action	Lead	Evidence of Outcome	Target Date	Date Completed
That West Yorkshire Police review its training in respective of domestic abuse to ensure that concepts of coercion and control are fully embedded and officers recognise behaviours which meet the Force definition and follow procedures accordingly.	See review of training above	Safeguarding Delivery Manager	See review of training above	22/07/2015	**22/07/2015**
That West Yorkshire Police remind Safeguarding Unit staff of the importance of formally recording third party concerns that a victim is subject to abuse.	Briefing to Unit staff	Safeguarding Delivery Manager	Briefing delivered to SGU managers at management meeting and cascaded to local SGU staff by managers.	21/06/2015	21/06/2015

Yorkshire Ambulance Service

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
Within 3 months YAS will put a	The Named	Head of	Reminder	Jan 2015	Feb 2015

Recommendation	Action	Lead	Milestones	Target date	Date of completion and outcome
bulletin in OU to remind staff of the impact on children and young people witnessing or affected by Deliberate Self-Harm/Para-suicide or suicide. The age & relationship of the child or young person must be documented and a referral to Children's Social Care must be made	professional for safeguarding Children will email the reminder to the Corporate Communications team to publish	Safeguarding	published in YAS Operational Update		

Appendix 3 – LYPFT's Commentary on the Overview Report

COMMENTS OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATON TRUST ON 'SAFER LEEDS' DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT (DHR13) DATED JULY 2016

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1. **INTRODUCTION**

1.1 Leeds and York Partnership NHS Foundation Trust ('LYPFT') has considered the final version of the Safer Leeds Domestic Homicide Review Report ('the report') which was provided to LYPFT on 11 July 2016.

1.2 LYPFT is fully committed to ensuring that any lessons to be learned from this review are actioned appropriately. Reflecting this, LYPFT has accepted all of the recommendations made by the Safer Leeds Panel as set out in Section 9 of the report. A number of these recommendations have already been implemented and work is underway to ensure the remainder are also actioned.

1.3 However, LYPFT has concerns about the conclusion reached by the report that Karen's death could have been prevented had agencies *'done things differently'*. LYPFT does not believe that this is a fair or logical conclusion insofar as its own involvement is concerned.

1.4 LYPFT is grateful to Safer Leeds for the opportunity to provide this commentary, which focuses on the issue of preventability.

2. **PREVENTABILITY**

The report concludes at paragraph 476 that *"… there were several points where either agencies could have done things differently themselves or where they could have supported Karen to understand the risk she was facing differently so that she could have made different decisions. On this basis, it is at least possible that the overall outcome might have been different and that Karen's death could have been prevented".*

LYPFT does not accept this conclusion, for the following reasons:

2.1 Signposting: The report suggests that, had Karen been signposted to domestic abuse services earlier in the course of Steven's admission (i.e. prior to 10 April 2014 when LYPFT put her in contact with the Police Safeguarding Unit), this might somehow
have altered the outcome by giving her "…*more time to consider whether to try to obtain an Occupation Order to prevent Steven returning home in the light of specialist advice, whether to seek alternative accommodation herself or whether there were any other options open to her"* (paragraph 456 and also paragraphs 351 and 473). This analysis is not supported by the evidence, for the following reasons:

- Leeds Women's Aid specifically discussed with Karen on 11 April 2014 the viability of her obtaining a court order against Steven and she was advised that there was not sufficient up-to-date evidence to support such an order, hence the advice to inform the Police about any future incidents so there would be a log of events going forward. There is no basis for asserting that this advice would have been any different had it been given two weeks earlier.

- There is also no evidence to support the hypothesis that, had Karen been put in contact with domestic abuse services two weeks earlier, she is likely to have made any different decision about whether to seek alternative accommodation herself. It is clear from comments she made at the time that she would not consider leaving the family home at least until after her younger son had completed his exams.

- Even if Karen had spoken to specialist domestic abuse services two weeks earlier, all the evidence indicates that it would not have been possible for her to have obtained an occupation order prior to the events of 29 April 2014.

- Even if it had been possible to obtain such an order prior to that date, this would not necessarily have prevented Steven from going to the family home and attacking Karen as he did on 29 April 2014.

- None of the specialist domestic abuse agencies which became involved after 10 April 2014 assessed Karen as high risk or took steps to protect her. Again, there is no basis for asserting that the position would have been any different had Karen been speaking to them two weeks earlier.

2.2 Risk assessment - The report suggests that, had LYPFT recorded a FACE risk score of 2 instead of 1 for 'risk to others', a written risk management plan would have been drawn up which might have altered the sequence of events (paragraphs 435, 461 and 472). LYPFT does not accept this for the following reasons:

- Recording a FACE risk score of 2 rather than 1 would have made no difference to the management plan which was to refer Karen to the Police Safeguarding Unit as the appropriate specialist domestic abuse agency which, in turn, led to both Leeds Women's Aid and Leeds Domestic Violence Service becoming involved. The steps taken by the clinical team would have been exactly the same regardless of whether or not the plan to refer to specialist agencies had been committed to writing in the form of a formal risk management plan.

- The hypothesis that a written risk management plan would somehow have revealed the failure by the Police Safeguarding Unit to treat this as a referral which, in turn, might have led to the Police taking a different approach further down the line (paragraphs 435 and 461) is highly speculative and not supported by the evidence. Once the consultant psychiatrist had spoken to the Police Safeguarding Unit to make that referral on 10 April 2014, there would have been no basis for him to then make further contact with them in the absence of any indication that this has not been accepted as a referral, regardless of whether or not the plan had been committed to writing.

- ☐ It is also speculative to suggest that, had the failure to accept this as a referral somehow been revealed by there being a written risk management plan in place, the Police would have undertaken a DASH risk assessment (also paragraphs 435 and 461). This is not supported by the evidence of what in fact happened - i.e. the Police did not regard a DASH risk assessment as being indicated either having spoken directly to Karen over the telephone on 10 April 2014 or subsequently when they attended her home in response to incidents occurring following discharge. It is therefore more likely than not in LYPFT's view that a DASH risk assessment would not have been conducted even if it had somehow been possible for LYPFT to discover that the Police Safeguarding Unit had not accepted its referral.

2.3 Ward review 16 April 2014 - The report suggests that Karen should have been invited to the ward review on 16 April 2014 (paragraph 221) and that she could somehow have been given more notice of Steven leaving hospital that day (paragraphs 223 and 429). However, the report contains no analysis as to how this could have made any difference to what subsequently happened. LYPFT would make the following points in relation to this:

- ☐ Steven was free to leave hospital on 16 April 2014 because there was no legal basis to further detain him. Confirmation of Karen's agreement to him returning home had been obtained directly from her that day and it was simply not an option open to the Trust to set some future discharge date in the face of Steven wanting to go home that day. To suggest otherwise is incorrect.

- ☐ Karen had already confirmed directly to staff over the telephone that she had agreed to him coming home. There is no reason to think that there would have been anything new or different said had that discussion taken place in person that would have changed anything.

- ☐ LYPFT is also unclear as to the evidential basis for the assertion made at paragraph 429 that "*Confirmation of discharge on the same day that Steven was discharged resulted in last minute negotiations between Karen's solicitor and Steven's*". Karen and Steven were both aware well before 16 April 2014 that discharge was imminent and could have informed their respective legal teams of this. Specifically, the consultant psychiatrist had told Karen over the telephone on 10 April 2014 that Steven would be discharged either that week or the following week.

2.4 Homicide-suicide risk - The report asserts that the risk of homicide followed by suicide should have been explicitly considered by the LYPFT (paragraphs 207, 392 and 446).

- ☐ LYPFT's position on this is that Steven's risk of harm both to himself and to others was appropriately considered in the course of his hospital admission and there was no indication in this case to explicitly consider the risk of him committing homicide-suicide. It is also relevant in LYPFT's view that agencies who had specialist experience in domestic abuse did not consider the homicide-suicide risk to be anything other than low.

- In terms of preventability, the suggestion that homicide followed by suicide should have been 'explicitly considered' implies that such explicit consideration would somehow have led to the conclusion that Karen was at risk of homicide. In fact, had there been explicit consideration of homicide-suicide risk, the conclusion would certainly have been that such risk was extremely low. This would accordingly have had no impact on the outcome.

2.5 Hindsight - LYPFT would make the following comments in relation to use of hindsight:

- The report acknowledges that the review had the benefit of hindsight (paragraph 368). Whilst LYPFT accepts that hindsight can be useful in terms of learning lessons for the future, judgements about the standard of decision- making and risk assessment at the time should not be influenced by the benefit of hindsight or by the ultimate outcome.

- LYPFT could not reasonably have foreseen the tragic events which unfolded on 29 April 2014. In LYPFT's view, the report does not make sufficiently clear that its conclusions have been reached on the basis of looking back retrospectively at events with the knowledge of what happened on 29 April 2014, the nature of which could not realistically have been foreseen at the time.

3. SUMMARY

3.1 LYPFT did all that it could be expected to do - i.e. it identified that Karen was the victim of domestic abuse and put her in contact with the appropriate agencies who could advise her.

3.2 There was nothing else that LYPFT could legally or practicably have done which could have avoided the outcome. Specifically, LYPFT had no legal basis to continue to detain Steven in hospital or to determine where he or Karen chose to live.

3.3 The suggestion that the events of 29 April 2014 could have been avoided by involving specialist agencies earlier and/or committing to writing the plan to involve them simply does not stand up to analysis.

3.4 If, despite these points, the report continues to conclude that Karen's death could have been prevented, this should in LYPFT's view be balanced by reference to the following:

- The report's conclusions have been reached on the basis of looking back retrospectively at events with the knowledge of what happened on 29 April 2014, the nature of which could not realistically have been foreseen.

- Even if it is 'at least possible' that the death could have been prevented, it is more likely that it could not have been prevented.

Leeds & York Partnership NHS Foundation Trust. July 2016

Appendix 4 - Leeds Community Safety – Comments on Domestic Homicide Review 13

This paper gives an outline of the Community Safety Partnership's position on the DHR13 Overview Report and acknowledges Leeds and York Partnership Foundation Trust's report at Appendix 3.

Firstly, the Community Safety Partnership wishes to express condolences to the families of both parties involved in this review and hopes that this review goes some way in assuring families and communities that we are committed to reflecting on and learning from such sad and unfortunate circumstances to try to improve services in the future.

The Leeds Community Safety Partnership (CSP) has undertaken this review in accordance with the Home Office Multi Agency Guidance for the Conduct of Domestic Homicide Reviews (August 2013). We consider the report to be of a high standard and its content to be accurate. We do, however, hold a differing position to the view of the Chair in relation to the preventability of this death.
The CSP has considered all the available information and has given appropriate weight to the varying viewpoints presented throughout the review process. We have ensured that members of the CSP have been fully briefed on all agencies' perspectives in this review in order that they reach an informed decision about the conclusions. Having held a special meeting to discuss this, the CSP would suggest that, on balance, the wording below is a more accurate reflection of its view on the issue of preventability:

'It is evident that there were several points where a number of agencies could have done things differently or could have better supported Karen to understand the risk she was facing and there are lessons to be learnt from the review which will better inform future practice and help mitigate risk in the future. Nevertheless, an analysis of the information and actions of the agencies involved indicates that there is insufficient evidence to support a conclusion that the death was predictable or preventable. The term preventable is open to interpretation. In our view, the threshold applied by the author to reach this conclusion is not consistent with thresholds applied by other authors who have undertaken reviews on the CSP's behalf.'

The CSP will continue to roll out lessons learned from this and other Domestic Homicide Reviews with the aim of preventing future harm to victims and their families affected by domestic violence. We will listen to and consult with a diverse range of service users and members of the public to ensure our work is informed by the views of the communities we serve.

Appendix 5 – Summary of the Mental Health Act[44]

The Mental Health Act 1983 (which was substantially amended in 2007) is the law in England and Wales that allows people with a 'mental disorder' to be admitted to hospital, detained and treated without their consent – either for their own health and safety, or for the protection of other people.

People can be admitted, detained and treated under different sections of the Mental Health Act, depending on the circumstances, which is why the term 'sectioned' is used to describe a compulsory admission to hospital. Section 2 is used to admit someone for assessment, Section 3 for treatment and Section 4 in an emergency. People who are compulsorily admitted to hospital are called 'formal' or 'involuntary' patients.

The decision to detain someone in hospital is taken by doctors and other mental health professionals who are approved to carry out certain duties under the Act and must follow specific procedures.

Sections 2 and 3

The sections most commonly used to admit someone to hospital are Sections 2 and 3.

Section 2 is an 'assessment' order. It allows for someone who is unwell to be admitted to hospital so health professionals can find out what is wrong, recommend how to help and start treatment.

Two doctors must agree that someone should be detained in hospital for assessment, and one of them must be a 'Section 12 approved' doctor. They then recommend admission using statutory forms. An approved mental health professional (AMHP) or someone's nearest relative can then apply to hospital managers for an individual to be admitted under Section 2 (though applications from nearest relatives are very rare).

An AMHP should inform the nearest relative if someone is to be detained under Section 2. People admitted under Section 2 can be kept in hospital for up to 28 days. Section 2 cannot be renewed: if health professionals want to detain a patient for a longer period, they must do so under Section 3 of the Act.

Section 3 allows people to be admitted and detained for treatment for up to six months. Two doctors have to agree someone should be detained for treatment in the interests of their health or safety, or for the protection of others. One of them must be a Section 12 approved doctor. An approved mental health professional (AMHP) or nearest relative can then apply to hospital managers for an individual to be admitted under Section 3. Applications from nearest relatives are very rare.

A nearest relative must be consulted by an AMHP before someone is detained under

[44] Thank you to the Mental Health Care website for this summary. http://www.mentalhealthcare.org.uk/mental_health_act#What_the_law_allows

Section 3 unless it is not practicable to do so, or unless consultation would result in 'unreasonable delay.' If a nearest relative objects, detention under Section 3 cannot go ahead unless legal action is taken to remove the title of nearest relative (and the rights that accompany the title) from the person who is objecting.

A patient's responsible clinician may renew Section 3 to keep them in hospital for a period longer than six months. The responsible clinician may also decide to discharge a patient onto a Community Treatment Order. This means they will be treated in the community, rather than in the hospital.

In an emergency – Section 4

Section 4 applies when there is a crisis and someone needs urgent help but there is not enough time to arrange for an admission under Section 2 or Section 3.

Section 4 allows people to be admitted and detained for up to 72 hours after one doctor has said that urgent admission is needed. An application for a Section 4 admission is usually made by an approved mental health professional (AMHP). A nearest relative can also make an application, but this very rarely happens.

During the 72-hour period, a second doctor should review the patient. The outcome may be that the individual is detained under Section 2 or Section 3; that the individual agrees to stay in hospital as an informal or voluntary patient; or that he or she is allowed to leave the hospital. If this is the case, community-based mental health professionals will usually make sure an individual is getting appropriate treatment and support.

Use of Section 4 has been steadily decreasing over recent years. In 2013/14, Section 4 was used just over 300 times in England, compared with 851 times in 2007/8.

Detaining voluntary patients – Section 5

People who are admitted to hospital when they are unwell without the use of compulsory powers are called ‘informal’ or ‘voluntary’ patients.

If someone has been admitted to hospital as an informal or voluntary patient, they are not detained and are free to come and go.

However, the doctor in charge of their care (or someone delegated by this doctor) can complete a Section 5(2) to stop them leaving hospital. This would be done if mental health professionals believed there were risks to the patient or other people. Section 5(2) lasts for up to 72 hours, allowing time for a decision to be taken about whether a Section 2 or Section 3 should be applied.

In a small number of cases – if a doctor is not available – a registered nurse can use Section 5(4) to prevent someone leaving hospital. This power only lasts for up to six hours and ends when a doctor arrives on the ward.

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Michelle De Souza
Manager - Domestic Violence Team
Safer Leeds
Leeds City Council

14 09 2016

Dear Ms De Souza,

Thank you for submitting the Domestic Homicide Review report for Leeds to the Home Office Quality Assurance (QA) Panel. The report was considered at the Quality Assurance Panel meeting on 2 September 2016.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. The Panel found this to be a good report. They felt the report included examples of good practices that helped the review feel balanced and non-accusatory. The Panel would also like to commend the victim's younger son for his excellent contribution to the DHR, which provided valuable insight.

There were some aspects of the report which the Panel felt could be revised, which you will wish to consider before you publish the final report:

- The Panel felt the Executive Summary and Overview Report could be shorter. Both need to be checked for spelling and grammatical errors;
- The Panel considered the report would benefit from clarity on whether an Independent Mental Health Inquiry was conducted, and if not set out the reasons for this;

- The Panel felt the report could further consider the effects that the marital separation, whilst continuing to cohabit, could have had on the couple and if there are lessons to be learned from this;
- The report is anonymised in terms of names but there are still some very identifying dates;
- The report highlights confusion between agencies on the process to follow in order to obtain an occupation order. The Panel considered that an action within the report could help to ensure consistent advice is provided to victims in the future. The Panel also felt the review could consider whether signposting victims to guidance on injunctions (e.g. published by Rights of Women) could have helped to overcome the financial barriers faced by the victim in obtaining an occupation order;

Finally the Panel noted the disagreement on the conclusion of the report regarding preventability and felt that every effort should be made to address these disagreements ahead of publication but the Panel were equally clear that it should not delay publication.

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

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

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

Yours sincerely

Christian Papaleontiou
Chair of the Home Office DHR Quality Assurance Panel

Safer Leeds
Working in partnership to keep communities safe

Leeds CITY COUNCIL

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Contact: Michelle De Souza

Date: 12th October 2016

Dear Mr Papeleontiou,

Re: Leeds Domestic Homicide Review 13

Thank you for your letter dated 14th September detailing feedback from the Home Office Domestic Homicide Review Quality Assurance Panel. I can confirm that your letter will be included as an appendix to the published DHR13 Overview Report alongside this letter.

We have discussed the issues raised by the Home Office Domestic Homicide Review Quality Assurance Panel with the Independent Chair and Review Panel members and our responses are detailed below.

- *The Panel felt the Executive Summary and Overview Report could be shorter. Both need to be checked for spelling and grammatical errors.*

The Report Author has shortened the Executive Summary however feels that, due to the Coroner's interest in the Overview Report, the full report ought to remain the same length. Both reports have been checked for spelling and grammar.

- *The Panel considered the report would benefit from clarity on whether an Independent Mental Health Inquiry was conducted, and if not set out the reasons for this.*

NHS England has confirmed that they are still to consider conducting an Independent Mental Health Inquiry and this will be discussed at a meeting on 31st October 2016.

- *The Panel felt the report could further consider the effects that the marital separation, whilst continuing to cohabit, could have had on the couple and if there are lessons to be learned from this*.

Having invited Review Panel Members and the Chair / Report Author to consider this point, feedback reiterated issues explored in Review Panel discussions regarding the need to ensure service providers are alerted to the risks to victims when co-habiting after separation where there has been a history of controlling behavior. This is being addressed as part of the city's workforce development programme on domestic violence.

Safer Leeds
Working in partnership to keep communities safe

Leeds CITY COUNCIL

- *The report is anonymised in terms of names but there are still some very identifying dates.*

We provided the DHR Quality Assurance Panel with an anonymised but unredacted version of the report. We will of course redact the report appropriately prior to publication.

- *The report highlights confusion between agencies on the process to follow in order to obtain an Occupation Order. The Panel considered that an action within the report could help to ensure consistent advice is provided to victims in the future. The Panel also felt the review could consider whether signposting victims to guidance on injunctions (e.g. published by Rights of Women) could have helped to overcome the financial barriers faced by the victim in obtaining an Occupation Order.*

Having invited Review Panel Members and the Chair / Report Author to consider this point, feedback has highlighted that the report states the victim was signposted to Rights of Women and that the option to obtain an Occupation Order via the victim's solicitor was explored by the victim. It was felt that the recommendation from the Home Office DHR QA Panel to include an action in the report to 'ensure consistent advice is provided to victims in the future' will be a challenge however we will ensure information signposting victims to help is available on the Leeds Domestic and Abuse Website.

- *Finally the Panel noted the disagreement on the conclusion of the report regarding preventability and felt that every effort should be made to address these disagreements ahead of publication but the Panel were equally clear that it should not delay publication.*

A comprehensive process to obtain a consensus was undertaken prior to our submission of the report to the QA panel. This process was outlined in the report and a covering letter.

In relation to the panel's comments above, Safer Leeds has further requested that the Chair / Report Author and the Leeds and York Partnership Foundation Trust consider their positions on the issue of preventability. Both parties have responded stating they feel there is no room for further movement on their positions. The Safer Leeds position on this issue remains as stated in the report.

I hope this letter goes some way in responding to the issues raised in your letter.

Yours sincerely,

R.N.Evans

Neil Evans
Chair, Safer Leeds Executive