Sheffield First

SAFER AND SUSTAINABLE COMMUNITIES PARTNERSHIP

Domestic Homicide Review
Overview Report

REPORT INTO THE DEATH OF ADULT C
2012

Report produced by Brian Lawson

Date: 18th December 2012

REDACTED VERSION FOR PUBLICATION

SECTION ONE: INTRODUCTION

1.1 Background

This Domestic Homicide Review (DHR) examines agency responses and support given to Adult C, a resident of Sheffield prior to the point of her death *(redacted – sensitive information).* The review will consider agencies contact and/or involvement with Adult C, Adult CS and other relevant family members from January 2004.

The key purpose for undertaking this DHR is to enable lessons to be learned where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Incident

Adult C's body was discovered at 7.20am by a neighbour. Child CGF, who had been staying at the house overnight, was found by the neighbour on the street – the neighbour took Child CGF back to the house and discovered Adult C slumped outside the back door. Adult CS had been agitated the previous night and adult CH left early to go to work whilst adult C attempted to calm the situation. Adult C rang NHS Direct for advice at 0430 that morning in relation to adult CS's mental state. Adult CS was charged with her murder and subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility. A post mortem concluded that Adult C died of multiple stab wounds.

1.2 Reason for conducting the review

1.2.1 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.2.2 The guiding principles which underpin this review are:

- **Urgency** – agencies should take immediate action and follow this through as quickly as possible.
- **Impartiality** – those conducting the review should not have been directly involved with the victim or family.
- **Thoroughness** – all important factors should be considered.
- **Openness** – there should be no suspicion of concealment

- **Confidentiality** – due regard should be paid to the balance of individual rights and the public interest.
- **Cooperation** – the agreed procedure and statutory guidance contained within Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011 should be followed.
- **Resolution** – action should be taken to implement any recommendations that arise.

1.3 Process of the review

1.3.1 The Home Office was notified on the 18th June of the intention to conduct a DHR. The Review Panel was established and met for the first time on the 17th July 2012. The overview report will therefore be finalised by the 18th December 2012.

1.3.2 The DHR was commissioned by the Safer and Sustainable Communities Partnership in line with the expectations of Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011.

1.3.3 The Review Panel comprised the following agency representatives (see table below) and met on the 17th July, the 25th October, the 13th November and the 11th December 2012.

REP FOR:	NAME	POST
Safer and Sustainable Communities Partnership	Jo Daykin-Goodall	Director Substance Misuse Strategy for Sheffield
Sheffield City Council	Steve Eccleston	Assistant Director Legal Services
Sheffield Safeguarding Children's Board	Victoria Horsefield	Practice Review and Standards Manager
Sheffield City Council	Simon Richards	Head of Adult Safeguarding
South Yorkshire Police	Peter Horner	Head of PPU
South Yorkshire Probation Service	John Connelly	Senior Probation Officer
NHS Sheffield	Kevin Clifford	Chief Nurse
Sheffield Teaching Hospitals NHS Foundation Trust	Christopher Morley	Deputy Chief Nurse
Victim Support	Christine Empson	Divisional Manager
Sheffield Health and Social Care NHS Foundation Trust	Michelle Fearon	Head of Service - Fitzwilliam Centre
NHS Sheffield	Magda Boo	Public Health
Sheffield City Council – in attendance	Alison Higgins	DAP Manager
	Alison Howard	PA / Team Support Officer

1.3.4 Brian Lawson was appointed as the Chair of the review and a formal commissioning meeting was held on the 23rd July 2012. The circumstances did not meet the criteria for a Mental Health Investigation given the length of time since Adult CS had had contact with Mental Health Services.

1.4 Terms of reference

The following terms of reference were agreed:

1.4.1 The victim had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which Adult C died was a 'one off' or whether there were any warning signs and whether more could be done in Sheffield to raise awareness of services available to victims of domestic violence including where the abuser is a family member other than an intimate partner.

1.4.2 Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim.

1.4.3 Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Sheffield or elsewhere.

1.4.4 Whether the victim had experienced abuse in other relationships and whether this experience impacted on her likelihood of seeking support in the months before she died.

1.4.5 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

1.4.6 Whether the alleged perpetrator had any previous history of abusive behaviour to an intimate partner or family member and whether this was known to any agencies.

1.4.7 Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim, or the alleged perpetrator.

1.4.8 Consideration will be given to the alleged perpetrator's history of mental health issues and substance misuse in order to establish whether opportunities for agency intervention were missed especially around possible aggressive behaviour to others.

1.5 Individual Management Review Authors

The following Independent Authors completed Independent Management Reviews on behalf of their organisations as indicated.

Agency	Author Name	Author Title
Victim Support	Elisa Pack	Senior Service Delivery Manager Sheffield and Rotherham
South Yorkshire Police	Helen Smith	Police Sergeant Public Protection Unit
Sheffield Teaching Hospitals NHS Foundation Trust	Christina Herbert	Lead Nurse Older People/Vulnerable Adults, Central Nursing
General Practice	Dr. Amy Lampard	General Practitioner
CAFCASS	Pat Armitage	Enhanced Service Manager for South Yorkshire, Hull and Humberside
Sheffield Health	Vin Lewin	Acting Safeguarding and Children Lead

and Social Care NHS Foundation Trust		Nurse
Territorial Army	Captain Alexander Whitaker	Adjutant
NHS Direct Northern Division	Mark Barker	Regional Mental Health Lead
Health Overview Report	Magda Boo	Joint Commissioning Manager Public Health
Sheffield Children Young People and Families Service	Matthew Reid	Assistant Service Manager

The IMR Authors met together on the 7th August and the 4th October 2012 as well as jointly with the Panel Members on the 25th October and the 13th November 2012.

1.6 Development of the IMRs

1.6.1 The first meeting of the IMR group shared the learning in relation to report writing from the first Sheffield DHR- Adult A. Issues in relation to consent and information sharing were carefully considered in this context using the framework developed previously.

1.6.2 Careful thought was given to ensure that the focus of the review remained on the terms of reference and on Adult C whilst acknowledging and discussing some of the other important issues which were raised in various IMRs which related to other members of the family and another address. This is discussed later in the report in more detail.

1.6.3 In addition a comprehensive integrated chronology of agency involvement and significant events from January 2004 to the 18th May 2012 has been compiled and analysed by the DHR Panel. This document appears at Appendix One.

1.6.4 IMRs were commissioned and submitted within timescales and were quality assured by the Domestic Abuse Partnership Manager Alison Higgins in the first instance in conjunction with the Chair.

1.6.5 As a result of detailed work by IMR Authors we were also able to identify additional organisations who had contact with the subjects, particularly with Adult CS, and who were able to contribute to the DHR. These organisations included Sheffield Mind, Turning Point and the Cavendish Centre for Cancer Care. None of these organisations involvement was significant enough to require an IMR.

1.6.6 South Yorkshire Ambulance Service also contributed information to the DHR and were not required to provide an IMR as their involvement was solely to attend the fatal incident on the 18th May 2012

1.7 Subjects of the Review

1.7.1 Following clarification of consents and scope in relation to the terms of reference for the DHR the following individuals were identified as subjects of the review. Adult CS's consent was dispensed with as being in the Public Interest to do so.

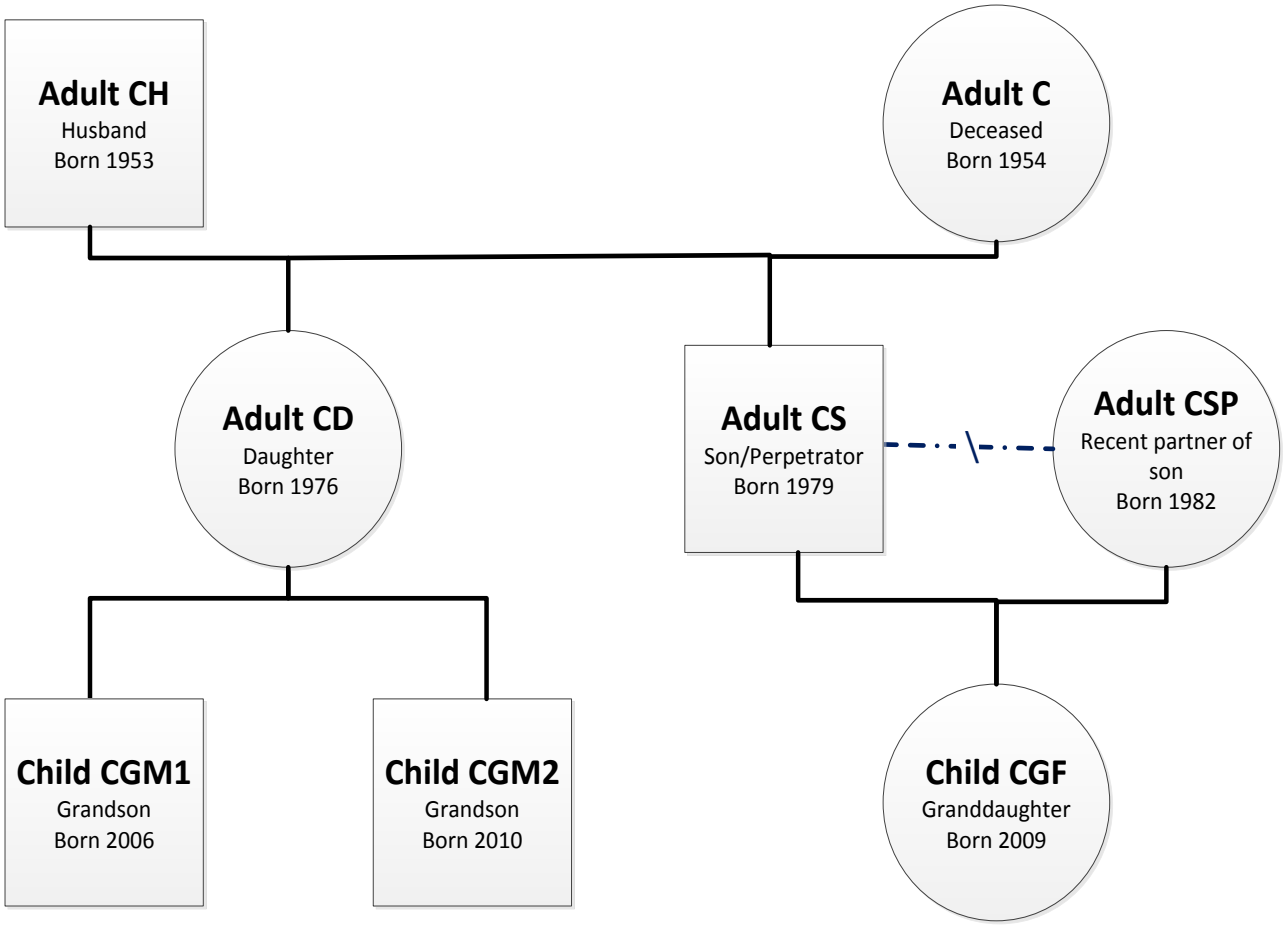
1.7.2 Although adult CD was a subject of the review we decided, in consultation with the appropriate services and with Adult CD, that it would be in her interests not to ask for consent to access her health and mental health records, given the state of her mental health following her mother's death.

We agreed that information regarding adult CD would be used in the DHR where it was relevant to the address which Adult C lived at and where consent issues were resolved independent of CD. These records related to information used in Family Court Proceedings in relation to child CGM1 and Police incidents at the address which adult CD was involved in.

Adult C also has an additional child CGM2. Given that child CGM2 is in the care of his father, and was not a regular attendee at Adult Cs home address, it would not be relevant to include CGM2 in the \review and to seek consent to access records relevant to him.

Adult C	Year of birth 1954
Adult CH Husband of C	Year of birth 1953
Adult CS Son of Adult C and convicted perpetrator	Year of birth 1979
Adult CD Daughter of Adult C	Year of birth 1976
Children	
Child CGF Granddaughter of Adult C (daughter of Adult CS)	Year of birth 2009
Child CGM1 Grandson of Adult C (son of Adult CG)	Year of birth 2006
Adult CSP Recent Partner of Adult CS and mother of Child CGF	Year of birth 1982

1.8 Family Genogram



1.9 Involvement of the Family

1.9.1 Adult CH, husband of Adult C and father to Adult CS was interviewed by the Chair and the Domestic Abuse Partnership Manager Alison Higgins on the 24th and the 28th August and on the 19th November 2012. Regular contact was maintained during the process and a visit in October was cancelled *(redacted – sensitive information)*. Adult CH was invited to view the report on the 3rd December 2012 and again on the 11th December but felt unable to do so at the time. Adult CH finally read the report with the support worker from the Victim Support Homicide Team in February 2013.

1.9.2 The partner of Adult CS Adult CSP was interviewed by the Chair and the Domestic Abuse Partnership Manager Alison Higgins on the 28th August 2012.

1.9.3 The aunt and niece of Adult CH were interviewed by the Chair and the Domestic Abuse Partnership Manager Alison Higgins on the 12th November 2012.

1.9.4 Attempts were made to contact and interview a friend of Adult C. These were not progressed once we had had contact with the aunt of Adult CH who had known Adult C for 30 years and was able to provide us with a pen picture of her. We felt that interviewing the friend would not add anything significant to the clear picture we already had by that point.

1.9.5 On this basis we also decided not to contact the victim's employer.

SECTION TWO: DOMESTIC HOMICIDE REVIEW PANEL REPORT

2.1. Summary of key subjects and agency involvement

Adult C

Adult C was living with her husband and son in a house which is owner occupied. Adult C was employed *(redacted – sensitive information)* in Sheffield. She did not allege domestic abuse or contact domestic abuse support services in Sheffield.

Adult C had several health problems, including heart disease, and numerous recorded contacts with specialist services in Sheffield Teaching Hospitals NHS Foundation Trust *(redacted – sensitive information)*.

Adult CH

Victim Support's Victim Care Unit had contact with Adult CH on 16/11/2011 in relation to an incident recorded on the 12/11/2011 due to *(redacted – sensitive information)*. Records show that Adult CH declined their support *(redacted – sensitive information)*

Adult CH has had little or no contact with other agencies.

Child CGM 1

CAFCASS were involved with Adult C and Adult CH and their application for a Residence Order on their grandson ChildGM1, son of Adult CD.

This order was made on 7/11/11. In 2010 a younger child of Adult CD's was the subject of an application for residence by his father following safeguarding concerns *(redacted – sensitive information).*

The Council undertook a section 7 welfare report. Adults C and CH were involved in supervising the contact.

Both Police and Children's Social Care were involved in incidents relating to Child CGM1 which resulted in him being placed with Adult C and CH.

Adult CS

In 2004 Adult CS was placed on the severe mental illness register and referred to Community Mental Health services following a severe psychotic episode – recent cannabis use was noted by the GP. Attendances at the GP related to problems sleeping.

Adult CS was discharged from Sheffield Health and Social Care Trust's Continuing Needs Team in 2005. Adult CS has had several outpatient and A&E attendances at Sheffield Teaching Hospital's Trust.

Adult CS was in the Territorial Army and served in *(redacted – sensitive information)* in 2007. He reported to his GP that he was drinking heavily on his return.

People connected with Adult CS state that his mental health had significantly deteriorated over recent days.

Adult CS pleaded guilty to manslaughter on the ground of diminished responsibility at the beginning of October 2012 and is now detained in secure mental health accommodation.

Adult CD

There are five police incidents logged in relation to the address between September 2010 and November 2011 which involved Adult CD. The incidents involved both Adult CH and Adult CS but not Adult C herself. One also involved conflict regarding Adult CD's children who were staying with her parents at the time.

Adult CSP and Child CGF

Child CGF was born in January 2009 at the Jessop Wing of Sheffield Teaching Hospitals NHS Foundation Trust. Child CGF's parents separated early 2010 and her main home is with her mother Adult CSP. There was regular contact with Adult CS at the home of Adult C and Child CGF was present in the house when the fatal incident took place in 2012.

There is no documented evidence of domestic abuse in the relationship between Adult CS Adult CSP. Children's Social Care did visit CSP and CGF following allegations of neglect which were not progressed.

Adult CSP was not known to the services of the Sheffield Domestic Abuse Partnership and does not appear to be known to other domestic and sexual abuse support services in the city.

2.2. Four key timeframes

2.2.1 Initial psychotic episode and recovery Adult CS:

This covers the period from May 2004 to September 2005 when Adult CS was discharged from mental health services in September 2005. This period chronicles his engagement with services over this time and captures his expressed interest in joining the TA.

2.2.2 Time spent in the TA by Adult CS and departure from the TA

This covers the time spent in the TA between his volunteering in September 2005, his deployment and return from *(redacted – sensitive information)* between January and September 2007 and his lapse in attendance form October 2007 to October 2008. Adult CS was not deployed to the front line and was not exposed to trauma during his active service with the TA. It was at this time that Adult CS was forming a relationship with Adult CSP and his daughter Child CGF was conceived.

2.2.3 Engagement at the family address prompted by behaviour Adult CD and care of Child CGM 1

This covers the period from September 2010 up until the end of 2011 and covers the application for a Residence Order made by Adults C and CH in respect of their grandchild CGM1 son of Adult CD. This period covers the involvement of CAFCASS, South Yorkshire Police and Children's Social Care in relation to the care of child CGM1 and incidents at Adult C's home address.

2.2.4 The four days leading up to the fatal incident and its immediate aftermath

This covers the period immediately preceding the fatal incident in 2012.

2.3 Summary of key themes arising from the IMRs and interviews with friends and family

2.3.1 Adult C and professional privacy

It is clear, both from the IMRs and from family interviews, that Adult C was a private person who would not discuss immediate family issues with wider family, friends or those providing other services to her.

Her strong belief, and that of her immediate family, was that they would sort out difficulties and challenges in the family with the minimum support of services. This is evidenced in the care of CS during his psychotic episode in 2004 and again over the care and support of Adult CD and Child CGM1.

2.3.2 Stressful environment in the family home

From September 2010 there was an additionally stressful environment in the family home as Adult C's own health deteriorated. This additional stress derived from the Residence Order on child CGM1 and the relationship with Adult CD. This also had an impact on adult CS who was also causing concern in his own right in relation to his employment and substance use.

2.3.3 Secondary themes of relevance to this DHR

A number of areas of good practice have been identified by the review process which include: co-ordinated mental health support; safeguarding investigation and post trauma support for the family

It has been important for the review to reflect on the importance of the related mental health and alcohol and substance misuse issues in this review and to identify how these relate to risk factors associated with domestic abuse in this case and more widely. It has been particularly important to look at this in the wider family context of a number of violent incidents between family members not directly involving Adult C but occurring at her home address.

Children's Safeguarding has also been an important feature of this Review in particular in relation to concerns about adult CD's children and the additional stress and responsibility this placed on Adult C.

Adult C was willingly involved in providing significant care and support to both her children and her grandchildren at a time when her own health was failing. Whilst Adult C may well not have accepted additional care or support in her own right, and may not have requested such support her role as a significant carer with significant health issues could have been identified and a carer's assessment offered.

2.4 Summary of the contribution of family

2.4.1 Background

The following members of the family who were subjects of the DHR were involved in and interviewed as part of the DHR of Adult C:

- Adult CH – Husband of Adult C
- Adult CSP – ex-partner of Adult CS, Mother of child CGF

In addition, we spoke to the aunt of Adult CH who had known Adult C for over 30 years. We also spoke to Adult CH's cousin who lives with the aunt. They also have regular current contact with Adult CD.

In the course of the DHR we also attempted to speak to a close friend of Adult C and to Adult C's daughter, Adult CD. We were unable to make contact with the friend and decided not to progress this once we had spoken to the aunt. Adult CD withdrew from being interviewed because of the uncertainty of the impact it might have on her mental health and current functioning, which we felt it important to respect.

The family were able to provide important additional information about:

- A profile of the kind of person Adult C was in life
- The events leading up to the fatal incident
- Background information in relation to Adult CS
- Details of the impact of the trauma of the event and the support provided around it
- What they would have liked to have happened differently and the learning they wanted to see arising out of the events which led up to the fatal incident

2.4.2 A Profile of Adult C

A picture emerges of a private, generous and family focused person with a strong loyalty to family, a good sense of humour and someone well respected and liked at work and by friends and family. Her funeral was very well attended and her managers made a particular point of acknowledging her loss. She had no close family locally apart from a surviving sister in Scotland.

Adult C comes across as a very loving, loyal and generally supportive mother and grandmother. She provided continuing support to and acceptance of both CS and CD with their respective mental health issues, despite their often self centred behaviour. It was often left to Adult CH to provide boundary and challenge to some of the behaviours and attitudes of Adults CS and CD. Adult C enjoyed caring for her grandchildren. She appears to have been stoical and accepting of the health challenges she faced, taking on additional responsibilities for her grandchildren in the same way.

She also appears to have been a very private and confidential person, not discussing or sharing personal concerns about her health or her family either with close friends, wider family or those involved in providing care and support in relation to her health condition. Adult C's values and approach to life appear to have been to sort out personal and family issues inside the family without wishing to take up offers of external support. She appears to have kept up this approach to life and her family even as her own health was failing and she was becoming frailer.

2.4.3 Events leading up to the fatal incident

It is clear from agency reports that Adult CS was unwell for some days prior to the fatal incident and that this episode followed a previous pattern in relation to:

- A similar time of year
- Sleeplessness
- Paranoid thoughts and hallucinations
- A perception of threat from Adult CH
- Tearfulness

Adult CH and Adult CSP were able to provide a more detailed account of the days prior to the fatal incident and a more detailed background in relation to how CS was in relation to some of the challenges in his life.

2.4.4 Background

Adult CS could be selfish and self-centred and this could lead to problems. He could be lazy and found it difficult to motivate himself – this was particularly an issue around work, where he found it difficult to hold down a job. He is also described as 'the quiet gentle one', often in the shadow of Adult CD. There were issues about his cannabis use and his drinking. Issues around work and cannabis use would cause tension in the home.

Adult CSP described two incidents of domestic abuse, one serious, to the Chair and the Domestic Abuse Manager during interview. They were not reported to anyone at the time and led directly to the end of their relationship. Adult CSP also describes Adult CS's difficulties in accepting the end of their relationship and receiving lots of text and phone calls. She describes an incident of him watching her house for several hours and turning up late at night. Adult CSP felt that Adult CS was not very involved in the care of Child CGF when their relationship ended, feeling that the grandparents provided most of the care

Both Adult CH and Adult CSP described Adult CS's time in the TA as positive and that he responded well to the structure that it gave him.

2.4.5 Events leading up to the fatal incident

Both Adults CH and CSP describe the discovery of a benefit fraud in the months before as being a trigger to a deteriorating relationship between Adult CS and his parents. This was happening at a time when there was also a lot of stress in the household around Adult CD and the care of her Child CGM1. Both Adults CH and CSP describe Adult CS's use of cannabis again and Adult CH also describes the tension this caused with Adult C. He reports that Adult C had told Adult CS to leave the family home if he was going to smoke cannabis.

Adult CSP describes an incident of seeing Adult CS at the house on the week before the incident when she was dropping off Child CGF for her regular contact visit. He was very tearful but eventually calmed down. Adult CH describes Adult CS as not sleeping in the last four days prior to the fatal incident. He also attempted to get Adult CS to go to an NHS walk in clinic just before the incident, but Adult CS changed his mind at the last minute having initially agreed to go.

All the parties interviewed expressed surprise that Adult C was the subject of the fatal incident, rather than Adult CH. There was a previous pattern of threat to Adult CH and Adult CH also reports being threatened in the run up to, and on the actual morning of, the fatal incident. Adult CH left the house for work early on the morning of the fatal incident to try and diffuse the situation.

2.4.6 The impact of the trauma

Adult CH described having been diagnosed with post traumatic stress following the incident and he values the support organised through South Yorkshire Police, Victim Support and his GP to help him with this.

Adult CH has maintained contact with Adult CS whilst in a secure mental health setting and he has coped reasonably well with the trial and with the press and media coverage. Adult CD's mental health has been stable recently and she continues to receive support from mental health services. In the short term, Adult CSP has moved in with Adult CH. The support Adult CH has received following the fatal incident from Victim Support and Trauma Assist is an example of good practice. Adult CSP has identified the likely need for ongoing support for herself and the children in coping with the later implications of the incident.

2.4.7 How things could have been different and what learning the family would like to see

Both Adults CH and CSP would have wanted a different response from NHS Direct on the morning of the fatal incident and both accept that this may not have changed anything. Neither felt that any agencies were to blame for what happened and Adult CH regretted, with hindsight, not being able to get Adult CS to agree to go to the walk in centre for treatment. He has also expressed a wish to have taken a stronger stand on CS's cannabis use

2.5. Analysis of Individual Management Reviews

2.5.1. Sheffield Health & Social care NHS Foundation Trust

Summary

Adult CS was treated from May 2004 until his formal discharge in September 2005. There were three kinds of involvement:

- Immediate treatment and support in relation to the acute psychotic episode which was intensive in the first 10 days and had improved significantly by the time of a home visit on the 8th of June.
- A longer period of support from June to December which was largely symptom free and progressively stable on medication.
- The provision of support around a deterioration in mood with associated reporting of heavy drinking and cannabis use. Referrals to both Mind and Rockingham Drug project were made and support was provided to assist Adult CS to re-engage in social activities.

The parents, Adult C and Adult CH, are described as being very supportive of Adult CS at this time. They attend appointments and are present during home visits. They are clear that they wish to support him at home during the acute phase of the episode, in the context of being offered inpatient support. Conflict is also noted in relation to Adult CD.

At the time of discharge in September 2005 Adult CS reports an intention to join the Territorial Army.

Analysis.

There are clear similarities with the descriptions of the features of the acute psychotic episode in May 2004 and the episode in May 2012:

- Sleeplessness.
- Cannabis use.
- Voices talking about conspiracies and people being out to get him.
- Threat to and attack on Adult CH.
- Uncontrollable tearfulness.

The interview with the CPN involved describes Adult C and CS as having a ‘strong emotional bond’ and that the continued support and encouragement provided from Adult C was a key factor in CS’s recovery. Adult CS is also assessed as seeming to have a strong relationship with Adult CH who describes the behaviour as out of character.

The treatment of the psychotic episode and the depressive episode are focused, planned and co-ordinated. In the acute episode there is intensive home and out patient support to CS and the GP is involved. The administration of antipsychotic medication is managed appropriately. The range and level of support provided, particularly by the crisis team constitute an example of good practice in handling the acute crisis. During the depressive

episode Adult CS is provided with an appropriate range of support including referral to external agencies.

However no records were found in relation to support and referral around the pattern of excess drinking which was identified. The frame of understanding of the threats of violence to Adult CH used in the assessment sees this as part of the symptomatic manifestation of the illness rather than an issue of domestic abuse as the situation was described as 'out of character' and then seemed to disappear following treatment.

No risk was identified in relation to Adult C at this time and their relationship was described as supportive and strong.

Conclusion.

Services provided to Adult CS during this period were timely and appropriate. They respected the families' wishes and provided a range of well co-ordinated services. Subsequent events leading to the review were unforeseeable and unpredictable.

Issues around CS's drinking and his stated intention to join the Territorial Army could have been followed up more proactively but did not materially impact on the events leading to the review. Similarly consideration could have been given to placing Adult CS on the Care Programme Approach (CPA) which would have provided extended contact. This does not appear warranted by the extended symptom free time in the years following.

The service was aware of a number of additional pressures in the household in relation to Adult CD and the service was aware of issues in relation to Adult C's health. A formal carer's assessment may have provided an opportunity to explore the pressure on the family.

2.5.2. NHS Sheffield: General Practice

Summary.

General health of Adult C.

Adult C's general health was impacted by three ongoing medical conditions at the time of her death:
(redacted – sensitive information)

Adult C was also prescribed anti-depressants in April 2012 following discussion of low mood. However Adult C did not mention any stress or concerns about Adult CS, even during his psychotic period. She did not discuss stress at home in relation to Adult CD.

Adult CH.

Rarely saw his GP and did not mention any concerns in relation to Adult CS even when he was psychotic.

Adult CS.

A GP experienced in mental health saw Adult CS the day before the disclosure of his mental health problems where CS was able to behave coherently and is recorded as discussing stopping smoking. He presented the following day with his father and was immediately referred to psychiatric services who responded and provided support.

From 2004- 2007 it is noted that several occasions that Adult CS talks to the GP about excessive alcohol consumption. He is also described as 'having drunk a lot' prior to a fasting blood test in October 2010.

Adult CS did attend in relation to perceived sleep problems in October 2008. He was referred to ENT in 2008 but did not attend and he was re-referred in October 2011.

In March 2006 Adult CS informed the GP that he was joining the TA and needed blood group testing.

Analysis.

Adult C's physical health issues were well managed by General Practice and well co-ordinated with other services. Adult C disclosed having 'lots of problems' and her daughters health being causes of stress on the 9th April 2010 and on the 7th January 2011. These issues where not expanded upon and opportunity to further explore the stress in the family and routine inquiry into potential violence in the home was missed. Adult C did not present at the GP's in a frequent pattern which can be associated with prior disclosure of domestic abuse.

Adult CH attended in January 2012 and was offered smoking cessation advice. There was no mention of issues relating to the health of Adult C, issues with CD or their taking over care of their grandchild CGM1.

Adult CS did disclose an attack on his father at the initial consultation in relation to the psychotic episode in May 2004. This is the only point where the GP is made aware that physical abuse has occurred at the address. There is no evidence of an assessment on Adult C or CH as to whether or not they felt safe in their choice to care for CS at home. The potential for domestic abuse and a possible referral to domestic abuse services could have been considered at this point.

Adult CS frequently mentions excess alcohol consumption, which is documented but the level of dependence was not assessed and the impact was not documented. He was not referred to any specialist services although this would have been appropriate. This is also the case in relation to disclosure of cannabis use. It would have been appropriate to enquire about alcohol and cannabis use and any deterioration in mental health at each appointment.

The policy framework, general awareness of and training to recognise domestic abuse has been developing in General Practice over recent years and there would have been low levels of awareness at the point of the disclosure of violence to CH during the psychotic episode in 2004. The GP interviewed agreed that the awareness of domestic abuse at the practice needed to be increased and some work towards this has taken place.

Conclusion.

The provision of physical medical care for Adults C, CH and CS was all in line with contemporary guidance. Communication between the practice and secondary care is generally of a high standard. Increased stress was hinted at during appointments with Adult C and Adult CH which were not explored any further. Adult C did not disclose any domestic abuse within the household.

It would have been appropriate to refer Adult CS to specialist services in relation to cannabis and alcohol use. There could have been clearer communication with mental health services in relation to this issue.

The mention of Adult CS joining the TA does not appear to have been followed up as a matter of concern following an acute psychotic episode.

2.5.3. The Territorial Army

Summary.

Adult CS's earliest known contact with the TA is through a recruiter on the 2nd September 2005. He was formally discharged from the TA on the 21st February 2011. His time in the service can be split into four phases.

Recruitment and Training September 2005 to December 2006.

CS states, on his application form, that he has no medical issues that go against eligibility requirements, including no previous or current psychiatric problems. At a medical examination on 4th October 2005 Adult CS again states that he does not suffer from and has never suffered from nervous breakdown or mental illness. Further medical examination was not requested.

Adult CS undertakes basic training between October 2005 and February 2006. He does not undertake any specific knife training. Recruit training can be a particularly stressful and pressurised environment for those unfamiliar with the military. There is no record that Adult CS struggled with any part of his training. He performs in the middle third of his training platoon and is described as a 'team player with a positive attitude to learning'.

Op Oculus: Deployment to *(redacted – sensitive information)* January to September 2007.

CS passed a static covert surveillance course which ran from 14th January to 23rd February 2007 and qualified him to go to *(redacted – sensitive information*, which he had volunteered to do.

He performed well on this tour, employed as a driver to drop off, pick up and resupply surveillance teams. The direct threat to him was low. No concerns were raised about him as an individual. Prior to deployment he completed a mental health team pre-deployment questionnaire and answered no to the question 'Have you previously received any mental health treatment or assessment including anxiety or depression?' He completed a post deployment stress level questionnaire on the 24th September 2007 where he said he hadn't been exposed to a traumatic event during deployment and that he didn't wish to see a mental health worker.

Routine Training October 2007 to July 2008.

Adult CS's attendance at regular training declined over this time. Although he did attend the *(redacted – sensitive information)* in July 2008, he did not qualify for his annual bounty and he did not volunteer for service in *(redacted – sensitive information)*.

Non Attendance Discharge July 2008 to February 2011.

In interview Adult CS disclosed that he had lost interest in the TA due to changing domestic circumstances, including a new girlfriend and the birth of his child. Adult CS had also received an operational bonus of £1999.99 in error which he was required to pay back. This money would have been recovered from TA wages. Adult CS was discharged as he stopped attending training and this was done in accordance with procedures.

Analysis.

Adult CS stated on two separate occasions that he had no previous or current mental health issues which would affect his eligibility to join the TA. Had he highlighted the mental disorder he suffered from in 2004 it is likely that this would have precluded enlistment in the TA. Current policy requires that the recruitment forms be taken to their GP. This means that the GP would have considered Adult CS's mental health history and declared it on the form.

There was no indication of any domestic violence in the life of Adult CS through criminal record checks, references or family notification processes.

Adult CS does not appear to have been exposed to any traumatic event during his deployment to *(redacted – sensitive information)* nor does he report any adverse reaction to it.

Adult CS's failure to attend and subsequent discharge appears to be linked to the change in domestic circumstances and the requirement to repay the operational bonus money. There was no compulsion or pressure to volunteer for deployment to *(redacted – sensitive information)*.

His military training cannot be linked directly to the nature of this domestic homicide as he was given no specific knife training throughout his TA career.

Conclusion.

Adult CS's time in the TA was generally positive. There were no recorded instances of domestic violence, nor any indication that he would be involved as a perpetrator of domestic violence.

Current policy is now very clear about checking mental health and other issues with a GP as part of the application process. There is also no evidence that Adult CS's time with the TA had any adverse impact on his mental health nor contributed to an increased likelihood of him committing or perpetrating domestic abuse.

2.5.4. Sheffield Teaching Hospitals NHS Foundation Trust

Summary.

STH Contact with the Family.

Adult C.
Had a prolonged period of contact with STHFT both preceding and during the timeframe established for the DHR. *(redacted – sensitive information)*

The Lymphoma Nurse Specialist who provided care for Adult C and was interviewed as part of the IMR process. She was made aware that Adult C and CH had a grandchild living with them but was not aware that Adult CS was living in the house. The nurse formed the impression that Adult C was the strong member of the family, whom others turned to in order to sort things out. There was no mention or indication of Domestic Abuse. Adult C's final contact was *(redacted – sensitive information)* 2012 when she attended as a day patient for planned chemotherapy.

Adult CH.
Has a record of one outpatient attendance in 2005.

Adult CS.
Had one attendance in September 2005 for a sports injury and was also seen in the Ear, Nose and Throat Clinic in April 2009 following a GP referral for sleep apnoea. He did not attend subsequent appointments and was discharged back to the GP in September 2009. Mention is made in the notes of a partner and a new baby. *(redacted – sensitive information)*

Adult CSP.
Adult CSP accessed maternity services during 2008 and 2009 resulting in the birth of Child CGF *(redacted – sensitive information)*. Adult C is noted as an emergency contact. There is no reference to domestic abuse concerns between CSP and CS and it is not clear from the records if a routine enquiry was made.

Adult CSP presented late with a second pregnancy in 2011 and was referred to safeguarding midwives for further assessment. On the 11th June midwifery records state that Adult CSP was upset following a telephone conversation with Adult CS. On the 16th June 2011 a conversation between Adult CSP and one of the safeguarding midwives is documented. During this discussion Adult CSP discloses treatment for depression following the break up of the relationship with Adult CS. CSP reports that the relationship is good and that they currently speak daily. No concerns were reported following home visits and follow up care and CSP was discharged from maternity services in July 2011.

Analysis.

Adult C.
Throughout a long period of investigation, treatment and monitoring there was no indication that Adult C was having any difficulties within her personal or family relationships. Adult CH accompanied Adult C to some appointments. During this intense

period of contact there is no indication that Adult C was subject to any form of violence or abuse from close family members.

There is limited information documented in relation to Adult C's personal family relationships and social circumstances. *(redacted – sensitive information)*

Adult CS.
During the minimal contact with Adult CS there is no record of him being asked about a history of violence or aggression within a close personal relationship. There is no reference to a history of mental illness or to the use of any additional substances within the records available.

Adult CSP.
Routine inquiry was introduced into the Jessop Wing Maternity Services in 2009 therefore it should have been included in the assessment for the pregnancy in 2010-11. There is nothing within the patient record to suggest that this was completed. This may have been influenced by CSP's late presentation.

Depression following the break up of the relationship with Adult CS is documented on the maternity records. It does not appear that the circumstances which influenced Adult CSP to end the relationship were explored. This was a missed opportunity to selectively enquire as to whether domestic abuse was a factor of this decision.

Conclusion.

Adult C.
Whilst accessing services Adult C was not asked about domestic abuse as part of her clinical assessment as far as we can ascertain. However, neither was there anything articulated by Adult C or any apparent warning signs which suggested that Adult C was currently or had ever previously, been in a violent relationship and was seeking help.

STHFT currently has a system of selective enquiry in relation to domestic abuse rather than a system to routinely enquire about abuse and violence in all its services. It would appear unlikely that routine enquiry would have contributed to preventing the incident under review.

Adult CSP.
Opportunities to enquire whether Adult CSP had been subjected to domestic abuse in her relationship with Adult CS were missed despite the presence of routine enquiry in maternity services. It is unlikely that this would have prevented the incident under review.

Adult CH&CS.
There is insufficient evidence available to form any conclusions which would support findings in relation to the terms of reference for the DHR.

In view of this it is difficult to conclude that the circumstances surrounding Adult C's tragic death could have been anticipated.

2.5.5. South Yorkshire Police

Summary.

There were six significant contacts by the Police at Adult C's home address from the 18th May 2004 to *(redacted – sensitive information)* May 2012.

18th May 2004.

A call was received from Adult CS stating that he and his father had argued and that when he had 'run off', he had heard a 'banging noise' which led him to believe that his dad had a gun. When officers arrived at the family home CS told the officers that he had stopped using cannabis some four weeks ago and had been given medication from his doctor, which he had not taken. As a consequence, he had not slept for two days. He had however re-visited his doctor that day and had now taken his medication. There was no suggestion of a firearm having been discharged and officers left Adult CS in the care of his father, Adult CH. There were no children present at the address.

3rd September 2010.

A call was received from Adult CH who stated that his daughter, Adult CD, was at his house and was being abusive towards him and quite aggressive towards his wife. The call-handler commented that the caller 'seemed very calm' but that a female could be heard 'in the background talking loudly'.

(redacted – sensitive information)

12th September 2010.

The Police received a call from Adult CD to the effect that her brother, Adult CS, was being aggressive towards her, had 'towered over her' and she 'wasn't having it anymore'. This incident had occurred earlier on that night at her parents' house, with whom her brother was living.

(redacted – sensitive information)

Officers visited the home of her parents where it was confirmed that the two siblings had rowed. Adult CD had left the house screaming at all the parties that were present. Adult CH told officers that his daughter already had a crisis worker *(redacted – sensitive information)* and that he would be updating the crisis team of this latest episode.

The officers who attended ensured that the necessary domestic violence forms were submitted.

10th December 2010.

A call was received from CD who stated that her brother, Adult CS, had 'battered her' and that they were arguing.

Officers were sent to the address and upon arrival, spoke to Adult C about her daughter who stated Adult CD was bipolar and had been arguing with her son, Adult CS.

Officers could see that Adult CD was quite intoxicated when they spoke to her and it was confirmed that no assaults had taken place. She was removed from the house by officers to prevent a breach of the peace and she was taken to a location of her choice. She was advised that should she return and continue with her behaviour, then she would be arrested.

The officers who attended ensured that the necessary domestic violence paperwork was submitted.

19th January 2011.

A call was received from Adult CD *(redacted – sensitive information)*

The officers liaised with Social Care and made the decision jointly with Out of Hours that they would take the child to the home of Adult C. It was also agreed that Social Care would contact Adult C the following morning to discuss more long term plans for the child. Adult CD was informed where her son was being taken and gave her permission for this to happen. The use of Police Protection Powers were not required.

After taking the child to grandparents, the officers completed the procedure by completing the necessary Gen 118A Concern for Child Form.

31st March 2011.

A call was received from Adult CH, stating his daughter (Adult CD) had turned up at his house in the early hours drunk and shouting and had hit his son, Adult CS. He added that her child was staying at his house and was asleep.

Officers attended at this incident to speak to all parties involved. Adult CS told the officers that his sister had not assaulted him and signed the officer's notebook to this effect. Adult CD refused to talk to officers and left the address to return home. Adult CH stated that he had not witnessed the initial altercation as he had been asleep. Child CGM1 was asleep and was safe and well.

Police completed the required domestic violence forms (CMS11) for this incident and took no further action due to a lack of co-operation from all parties.

12th November 2011.

A silent 999 call was received by the police during which the operator could hear a discussion surrounding an assault having taken place. The number was re-contacted and the call-handler spoke to a woman (Adult C) who advised that her husband and daughter had been arguing and hitting each other.

Officers were sent to the address and arrested both Adult CH and Adult CD as both were complaining of assault of each other.

Following the interview, both were released without charge. Adult CH did have scratches but refused to make any complaint and Adult CD had no injuries. There was no further police action. Officers ensured that the necessary domestic violence forms were completed. They also made referrals to Victim Support for both CH and CD and a referral for CD to the Sheffield Domestic Abuse Helpline.

(redacted – sensitive information) May 2012.

Officers attended the home address of Adult C following a call to advise them that her body had been found.

From that point forward, the incident was treated as a murder investigation which dictated that CID were immediately involved, Scenes of Crime were called, scenes were cordoned off, and searches were carried out. This culminated with the arrest of Adult CS and subsequent murder charge.

Analysis.

18th May 2004.

Officers ascertained that Adult CS was receiving treatment for a mental health condition and that no firearms were present. They were content to leave Adult CS in the care of his father Adult CH.

3rd September 2010.

Adult CD was viewed as the perpetrator in this situation, being abusive to Adult CH and aggressive to Adult C. The situation was appropriately resolved be removing Adult CD from the premises and ensuring the safety of the child present in the house.

Completion of the domestic violence forms ensured that information was shared with partner agencies and supplied to the Public Prevention Unit. They carried out a risk assessment on Adult CD which was set at medium. Adult CD had also recently been the subject of other incidents of domestic abuse not associated with this review and therefore the risk level was heightened.

12th September 2010.

This was the first time that Adult CS had been identified as a perpetrator with Adult CD the victim. Domestic violence forms were unable to be fully completed due to the lack of co-operation from CD and CS. This resulted in a risk assessment level at standard.

10th December 2010.

This is the second occasion on which Adult CS is identified as a perpetrator by CD as the victim. The officers spoke to Adult C on arrival who confirmed that CS and CD had been

arguing. CD was visibly intoxicated and removed from the premises. Confirmation was received that no assaults had taken place. Risk assessment was assessed as standard.

19th January 2011.

The thorough assessment by the officers and liaison with Social Care's Emergency Duty Team ensured the safety of the child overnight through voluntary placement with Adult C and CH, grandparents of Child CGM1. Gen 118A Concern for a Child Form's were completed and shared with the Public Protection Unit and Children's Social Care. The manner in which this incident was dealt with is an example of good practice and effective partnership working in safeguarding a child.

31st March 2011.

The officer ensured that Child CGM1 was safe. This incident identified Adult CS as the victim and CD as the perpetrator. Domestic violence forms were not able to be completed due to all parties refusal to engage. The risk assessment level was assessed as standard and information shared with the Public Protection Unit and Children's Social Care.

12th November 2011.

This incident involved CH and CD. Both were referred to victim support and referral was made to Adult CD to the Domestic Abuse Helpline. Both were released without charge and the Domestic Violence risk assessment was set at standard.

Conclusion.

In all instances the expected level of service was provided to each customer and the correct procedure was followed. The decisions that were made were done so at the correct level and all appropriate action was taken in the circumstances.

2.5.6. Victim Support

Summary.

An ABH referral for Adult CH was received by Victim Support on the 14th November 2011. The referral was accepted and passed to a Victim Care Officer (VCO) to contact CH and offer support. Direct telephone contact was made by the VCO with CH on the 16th November 2011. During the contact CH said that ‘’All was okay, just annoyed that he was locked up for the night as he felt he was just defending himself and it was a shock to the system and that he would never let it get that far again’’.

As no further contact was required the VCO followed Victim Support’s contact methodology and set the referral to ‘no further action’.

Analysis of Involvement.

Victim Support’s involvement was in line with the organisations national contact methodology.

Team leaders are on duty to deal with any difficulties as they arise offering support and supervision as and when required in addition to quarterly one to one reviews with each Victim Care Officer in their team. As CH declined support, supervision from a team leader was not necessary and contact methodology was followed.

Due to the minimal contact and support declined, involvement of senior management was not necessary.

Direct contact was not made with either the victim or the perpetrator who are the subjects of this DHR. Contact was only made with CH who declined the offer of support from Victim Support. All policies and procedures were followed.

Conclusions.

CH was contacted within the limits of Victim Supports contact methodology. CH was offered support but declined. In view of this, the case was closed, by the VCO who followed correct procedure.

2.5.7. Children and Family Court Advisory and Support Services

Summary.

CAFCASS involvement with this family was in respect of Adult C's two grandsons by her daughter Adult CD. Adult CD's mental health issues resulted in two applications for Residence Orders one made in respect of Child CGM1 by Adult C and CH as maternal grandparents and on application by the maternal father of a child which is not the focus of this review.

Application in relation to Child CGM1.

On the 27th July 2011, an application was made by Adult C and Adult CH (maternal grandparents) for leave to apply for a Residence Order in respect of Child CGM1. Information regarding previous involvement with the family was provided by the Local Authority. A Core Assessment recommendation had been made to secure Child CGM1's residence with his grandparents (Adults C and CH) by way of a Residence Order. Adults C, CH and CD had all signed a contract of expectations agreeing to this and the case was closed by the Local Authority leaving the extended family to take responsibility for monitoring and managing Child CGM1's welfare.

(redacted – sensitive information)

On the 15th September 2011 the Local Authority advised Cafcass that an Initial Assessment would be conducted. On the 23rd September 2011 the Cafcass file was closed as no further work for Cafcass had been ordered by the Court. Future work would be conducted by the Local Authority in line with the [1]ADCS protocol.

Analysis of Involvement.

Cafcass' involvement with this family centres not around the victim, Adult C, but on her grandsons' care and protection.

The remit for Cafcass was to provide advice to the Court, based on information gathered through safeguarding checks with other agencies and discussions with the parties, as to the making of an order that is in the child's best interests.

From examination of the case files, Cafcass procedures were followed throughout and appropriate safeguarding referrals made and followed up as laid down in the Safeguarding Framework which was in Operation at the time.

The areas of concern which resulted in Section 47 referrals centre on the arrangements for the care of Child CGM1 and the fact that this appeared to be shared between Adult CD and Adults C and CH despite Adult CD's problems.

[1] Protocol For Allocating Responsibilities For Court Reporting In Private Law Children Act 1989 Proceedings Between Cafcass And Local Authority Children's Services.

Conclusions.

Cafcass involvement with this case ended at the Early Intervention stage and did not progress to locality FCA's conducting a full Section 7 assessment. This was because the Local Authority Children's Services were already involved with this family and, as set out in the ADCS protocol, the court ordered that this assessment be conducted by the Local Authority.

Adult CS is referred to briefly in one case file. A sentence states only that Adult CS lived with his parents and saw his child there sometimes. As Adult CS was not a party to the proceedings in respect of this application therefore Cafcass would have needed Adult CS's permission (or the Courts direction) to request Local Authorities or Police information held about him.

2.5.8. Sheffield City Council: Children, Young People and Family Services (CYPF).

Summary.

CYPF have predominantly had involvement with Adult C; Adult CH and Adult CD in relations to the latter's child, Child CGM1. There was brief involvement with Adult CSP in relation to Child CGF. Adult CS was on the periphery with no direct contact other than when he opened the door on an unannounced visit.

Child CGM1.

August 2007.
Children's Services have had involvement with all children highlighted within the terms of reference.
(redacted – sensitive information)

October 2008.
(redacted – sensitive information)

July to September 2010.
(redacted – sensitive information)

January 2011.
(redacted – sensitive information)
On the 29th January 2011 a Core Assessment began and Child CGM1 was seen as was Adult C; Adult CH and Adult CD. Adult CS was not included within this assessment, although a frequent visitor to his parents home he was not considered to be living there and was not considered to be a part of the household by Adult C and CH. Throughout the whole assessment Adult CS was only seen on one occasion when he answered the door whilst his parents were out. No concerns were noted about his presentation.

The outcome of the assessment concluded that Child CGM1 should remain with Adult C and CH as his primary residence. All adult parties were in agreement with this and advice was provided that should there be any further difficulties, grandparents were to seek a Residence Order. At this time the case file was closed to Children's Services as there were no further support needs identified and the family were not requesting any further support.

March 2011.
In March 2011 there was a further Domestic Violence Report received from South Yorkshire Police who had to attend at the address of Adult C and Adult CH. This was in response to a call from Adult CH who had heard an argument between Adult CS and CD after Adult CD had attended the address under the influence of alcohol. Neither Adult wanted to make a complaint. Adult CH described the incident as being '6 of one and half a dozen of the other', no further action was taken by Children's Services at this time.

September 2011.
There was no further contact or information received about Child CGM1 until September 2011 when Cafcass contacted Children's Services after Adult C and CH had made an

application for a Residence Order in respect of Child CGM1. There was a concern that Adult C and CH had not fully understood what was being asked of them in respect of being primary carer for Child CGM1 and previous documentation was requested. This was subsequently provided and there was a further visit made to ensure that they fully understood what was being said. There was no further involvement until the incident which is now under review.

Child CGF and Adult CSP.

(redacted – sensitive information) It is also noted *(redacted – sensitive information)* that Adult CSP reported no concerns 'in respect of Domestic Violence, alcohol misuse or mental health issues affecting her or Adult CS's ability to meet Child CGF's needs'. Adult CS was not seen as part of this assessment and no further actions were taken by Children's Services. This was the only involvement which Children's Services had with Adult CSP or Child CGF.

Analysis of Involvement.

The majority of Children's Services involvement centred on Child CGM1, the son of Adult CD. This is inevitably led to contact and involvement with Adult C and CH as they played an active role in the care of Child CGM1 and the support of their daughter. *(redacted – sensitive information)* Adult C and CH as parents and grandparents were considered as a protective factor for their grandson and a couple who could promote his welfare. As the Local Authority has a duty to kept children within their family wherever possible it is entirely appropriate that this should occur.

Adult CS was very much on the periphery of all involvement with Children's Services. Although Adult C and CH stated he was a frequent visitor to the household they did not state that he was living there and therefore no further checks were completed. At no stage did his parents raise any concern about his presence, nor that there were any issues with regards to his mental health or substance misuse. On the occasions when he was seen there were no notable concerns about his presentation and nothing that would give an indication of any issues. There are no reported incidents of violence perpetrated by Adult CS either towards his parents or towards his former partner, Adult CSP.

Adult CSP did not raise any current problems in her relationship with Adult CS and they appear to have maintained a civil relationship following their separation.

In terms of policies and procedure these were followed appropriately and there is no concern about the practice of any of the workers who were involved in completing the assessments. With hindsight there could have been some further exploration of the role of extended family members when completing the assessment of Child CGM1 however it is not clear that this would have elicited any further information than was already known. It would be expected that if there was any Domestic Violence between Adult C and Adult CS that these would be reported to Children's Services as Child CGM1 was present in the household.

Conclusion.

It would appear that Adult CS was not present or highlighted to Children's Services as a person of concern and for this reason he was not a central figure in the work which was being completed with the extended family. With the benefit of the hindsight and reflection it would appear there were some brief opportunities to enquire further about him but this would not have formed a part of the routine enquiries made. There was nothing within the information received by Children's Services which would give an indication of what was to occur.

The main focus of Children's Service involvement was with the children of Adult CD. The response to the concerns was appropriate and the plans for the children were in their interests and maintained them within their extended birth family. Departmental policies and procedures were followed and there were no issues with the practice of the workers involved.

2.5.9. NHS Direct

Summary.

Prior to the incident in May 2012 there were 3 calls to the NHS direct by Adult CD which have no bearing on the terms of reference of this review.

Calls taken on the *(redacted – sensitive information)* May 2012.

04:30am *(redacted – sensitive information)* May 2012: call to core 0845 46 47 service.
At 04:30 am on *(redacted – sensitive information)* May 2012, HA1 answered a call to 0845 46 47 by Adult C regarding Adult CS. Adult C described changes to Adult CS's behaviour and increased confusion.

HA1 performed an assessment of Adult CS's symptoms speaking with Adult C using the change in behaviour/confusion protocol from within the CSPT system. HA1 reached a priority 1 end point and a patient record was created for Adult CS. Adult C's telephone call and Adult CS's patient record was transferred to NA1 at 04:34 am.

04:34 am *(redacted – sensitive information)* May 2012: call to core 0845 46 47 service transferred directly to NA1.
NA1 spoke to Adult C and performed an assessment of Adult CS's symptoms speaking with Adult C using the depression algorithm. NA1 provided details of the local walk in centre and advised Adult C to contact Adult CS's general practitioner when the surgery opened or to consider attending Accident and Emergency. The call was closed at 04:42 am.

Analysis.

1st Call 4:30am.

On this occasion it is reasonable to accept that NHS Direct's involvement in the incident did not meet organisational expectations. A review of the call taken by HA1 suggested that had he utilised critical thinking around the level of Adult CS's confusion, and listened more actively when Adult C told him that Adult CS had experienced a similar breakdown previously then a disposition advising Adult C to attend A&E may have been reached. At one stage Adult C started to describe the kind of thoughts he was having. However HA1 interrupted Adult C at this time and effectively stopped her describing this in more detail. HA1 ended his part of the call by transferring the telephone call and patient record to NA1 for a nurse assessment.

2nd Call 4:34am.

It is also reasonable to accept that NHS Direct's involvement in this incident did not meet organisational expectations. NA1 failed to adhere to NHS Direct best practice guidelines for managing 3rd party phone calls by not asking to speak directly with Adult CS who was present during the phone call and could be heard in the background. NA1 missed an opportunity to explore CS's history of mental health problems, for example the type,

frequency and duration of his drug misuse problem wasn't explored or clarified. The content of his hallucinations was not explored. Had NA1 spoken with CS she may have been in a better position to evaluate his mental state at the time of the call.

NA1 assessed CS's presenting symptoms using her nursing skills and clinical knowledge, supported by one of the algorithms contained within the clinical knowledge assessment system (NHS CAS), namely the 'Depression' algorithm. NA1's risk assessment would have been supported more effectively by using a more appropriate, symptom specific algorithm e.g. 'Hallucination' or 'Behaviour Change'. Had she done so then using either of these algorithms would have prompted NA1 to explore the nature of the content of CS hallucinations.

In her reflective statement NA1 acknowledges that she should have 'asked to speak to the patient directly'. She also acknowledges that an 'alternative algorithm may have been more appropriate regarding the son hearing voices.' NA1 assessed and eliminated the risk of CS doing harm to himself; however she missed an opportunity to enquire about Adult C's own well being and sense of personal safety.

NA1's decision making may have been better informed and supported had she used an alternative, more symptom specific algorithm (Hallucination) or if she had thoroughly addressed all the questions in the depression algorithm. Her decision was to advise Adult C to contact Adult CS's General Practitioner when the surgery opened. However a more structured risk assessment exploring CS's previous mental health problems, the type, frequency and duration of his drug use and asking specific questions about the voices he was hearing may have resulted in advice to seek assessment for CS more urgently.

Both HA1 and NA1 demonstrated willingness to help and genuine concern. However the call prioritisation by HA1 and the symptomatic assessment by NA1 could have been better in terms of structure and focus as detailed above. There were also missed opportunities to directly assess Adult CS's mental health and a lack of professional curiosity to enquire about Adult C's own well being and personal safety. Whilst there was no apparent evidence during the call that Adult C felt threatened or at risk of Domestic Violence, in fact Adult C can be heard talking to CS during the call, Adult C was not directly asked about her personal safety which we consider to be a missed opportunity.

Child CGF was in the house at the time of the call. However NA1 was not heard to enquire if there were any children present. Whether or not knowledge of the presence of Child CGF would have influenced NA1's decision making is speculative. However, Best Practice Guidelines specifically addresses actions to be taken when vulnerable adults or children are present and the carer requires urgent care.

The IMR author believes it is safe to assume that both HA1 and NA1 have the necessary awareness and knowledge to recognise potential indicators of Domestic Violence. They have both undertaken the organisations competency based training which equips participants with the knowledge and understanding to recognise when adults are potentially vulnerable. The learning resource invites the participant to consider a specific scenario on Domestic Violence. It goes on to describe the challenges generated by the issue of Domestic Violence and stresses the importance of ensuring the callers immediate safety and protection from harm. However the call from Adult C was solely focused towards assessing Adult CS's mental state and there were no obvious indicators of concern for her personal safety that were verbalised by Adult C during the call.

Conclusion.

The NHS Direct review has concluded that the learning identified is individual rather than organisational learning, and improving work performance plans have been developed and worked through with both HA1 and NA1.

Having said all this, the service provided for Adult C *(redacted – sensitive information)* May 2012 fell below that which we would normally expect. HA1 and NA1 missed opportunities and demonstrated poor decision making during their assessment. More professional curiosity and appropriate use of a symptom specific algorithm may have resulted in a different outcome such as advising to attend accident and emergency department. Adherence to best practice guidelines for managing 3rd party calls should have prompted NA1 to speak directly with Adult CS and assess his symptoms first hand and this too may have changed the advice offered to Adult C.

There isn't any guidance or instruction in place advising staff to minimise Accident and Emergency Department attendance. What they have is CAS Best Practice Guidance which aims to provide a consistent approach for CAS system usage. The emphasis is getting the patient to the right place, first time, every time.

They do have a target of managing 45% of all calls within NHS Direct with no onward referral. However assessing clinical risk and maintaining patient safety is our primary concern.

NHS Direct is due to be decommissioned in 2013 and replaced by NHS 111. Would a call like the one made by Adult C to NHS 111 resulted in a different outcome? They can only speculate. What they can say is:

NHS 111 will be available to the public in England around the clock and will become operational between now and April 2013.

Adult safeguarding training will remain mandatory for staff providing the NHS 111 service.

All front-line advisors will have access to clinical advice and support around the clock.

NHS 111 will use clinical decision support system to assist front-line staff when assessing and advising patients. This system is currently called NHS Pathways.
Further information on NHS 111 can be found on:
http://www.dh.gov.yk/health/tag/nhs-111/
Further information on NHS Pathways can be found on:
http://www.connectingforhealth.nhs.uk/systemsandservices/pathways

2.5.10. NHS Overview Report.

Relevant summaries of the involvement of NHS organisations can be found in the summaries in relation to the involvement of the Health and Social Care Trust General Practice, Sheffield Teaching Hospitals NHS Foundation Trust and NHS Direct earlier in this section of the report.

Common themes from NHS provider analysis (STH, SHSC, GP):

There was no indication of any violence towards Adult C from any personal or family relationship in any of Adult C's contacts with NHS Services; this contact was frequent with STH in the last months of her life and would have provided an opportunity for disclosure.

NHS providers have records of Adult C's attendance at CS appointments and Adult CH's attendance at CS's appointments. The impression given to staff was of a 'strong relationship/strong emotional bond' and no indication of violence or abuse towards Adult C from any close family members, although violent incidents between other family members were known.

There are no documented incidents (SHSC) of violent behaviour towards Adult C on the part of Adult CS and their relationship is reported as supportive and positive. Known episodes of violence between other close family members (but not Adult C) were not fully explored from a potential domestic abuse viewpoint. Known violent episodes from Adult CS towards other family members were stated to have been 'out of character' and 'unusual' (Adult CH).

It has been recognised that many people in abusive situations attend their GP frequently before disclosing domestic abuse. Often this can be seen as multiple consultations for minor ailments or for their children. This pattern was not demonstrated in Adult C or Adult CH's notes.

During his initial consultations in 2004, both with his GP and CMHT, Adult CS revealed that he had been physically violent towards his father (Adult CH) and this was directed by his audio-hallucinations. The risk assessment of neither service recognized the potential for domestic abuse. There is no evidence or documentation within their notes, that Adults C or CH were asked if they felt at risk of violence from Adult CS and there is no evidence in the notes that they were asked if they felt unsafe caring for Adult CS at home.

Adult CS frequently mentioned his excess alcohol intake, the quantity was documented both by his GP and CMHT but his level of dependence was not assessed and the impact on his life not documented. Although he was encouraged to reduce his intake he was not referred to any specialist services.

NHS Direct

NHS Direct's involvement in the incident did not meet organisational expectations.

The 'Depression' algorithm was used to assess Adult CS' symptoms whereas communication with Adult CS directly (rather than with Adult C as a 'third party' caller)

would have enabled CS to be assessed more effectively by using a more appropriate, symptom specific algorithm e.g. ‘Hallucination’ or ‘Behaviour Change’.

A more structured risk assessment exploring CS’s previous mental health problems, the type, frequency and duration of his drug use and asking specific questions about the voices he was hearing may have resulted in advice to seek assessment for CS more urgently.

Whilst there was no apparent evidence during the call that Adult C felt threatened or at risk of domestic violence, in fact Adult C can be heard talking to CS during the call, Adult C was not directly asked about her personal safety which NHS Direct consider to be a missed opportunity.

The call from Adult C was solely focused towards assessing Adult CS’s mental state and no obvious indicators of concern for her personal safety were verbalised by Adult C during the call.

The NHS Direct review has concluded that the learning identified is individual rather than organisational learning.

Overview report author analysis:

Historical context and recent developments:

The context in which NHS providers were operating from 2004 during CS’ first experience of psychosis and by the time of Adult C’s death in 2012 were very different. There have been both legislative, clinical guidance and commissioning changes over this period which need to be acknowledged.

Alcohol services in the city were under resourced and under developed before 2007 and there were 6 month waits for services; in this context it was unlikely during this period for GPs to refer individuals for alcohol treatment who were not experiencing significant physical health problems alongside alcohol misuse. This is significant in the context of this case as it offers some explanation of why no referral to alcohol treatment was made for Adult CS in 2004 despite high levels of consumption having been noted. Since 2007 there has been significant investment in alcohol services and there is now no waiting list for treatment. The possible interventions in 2004 and since 2007 were therefore different and there were missed opportunities post 2007 to refer Adult CS to alcohol treatment services in the city.

The World Health Organisation clinical tool ‘Alcohol Use Disorders Identification Test’ (AUDIT) published in 2001 is now considered the gold standard of identification test for alcohol misuse and is now (2012) the agreed tool in Sheffield for the initial screening of alcohol misuse. There were missed opportunities to use validated clinical tools (AUDIT) to assess alcohol misuse in Adult CS by NHS providers.

There is not an agreed clinical tool nationally or locally for assessing the severity of cannabis use and this means that there is no standard collection of information from individuals about their cannabis consumption.

There is not an agreed 'city wide' dual diagnosis protocol. SHSC developed a 'Dual Diagnosis Protocol' in 2004, but with this protocol in its infancy it is unlikely that responsibility for overseeing third sector involvement with a patient would have been taken either organisationally or at an individual level.

Involvement of Turning Point and Co-ordinated Care

It is noted by the Community Mental Health Team (SHSC) in June 2004 that CS was being seen at Turning Point Adult Treatment Services to address cannabis use (formerly 'Rockingham Drug Project'). Turning Point have identified paper records for CS and named the keyworker who was working with Adult CS at the time. The keyworker is still employed in the substance misuse workforce in Sheffield and has been interviewed and any findings will be fed into the review report. Individuals with dual diagnosis seen within substance misuse services are expected to have care co-ordinated by the Mental Health Trust. This was not the case in this instance and there is some concern about whether intelligence from Turning Point was relayed to the mental health trust. Adult CS was exhibiting what was noted as 'delusional' behaviours whilst at Turning Point in May 2004.

The Care Programme Approach and Carers Assessment:

Adult CS was not on the Care Programme Approach (CPA), and therefore would not have met the criteria for 'dual diagnosis'. There is a question about whether Adult CS should have been considered to meet the threshold for Care Programme Approach in 2004, although it is unlikely that this would have affected the outcome in this case as absence of psychotic symptoms for 8 years would likely have resulted in Adult CS being 'deregistered' from CPA.

The Carers (Recognition and Services) Act 1995 introduced the concept of a carers assessment and the Carers (Equal Opportunities) Act (2004) further set out the statutory duty to inform carers of their rights including the right to a carers assessment. Most carers have a right to a carer's assessment and carers of individuals on the Care Programme Approach have additional rights. There is no evidence that Adult C or Adult CH were offered a carers' assessment by any of the NHS providers they came into contact with. The emphasis of IMR authors of the strong family relationship and bond may have led to expectations that the family were 'coping' with the complex needs of CS, and another close family member with diagnosed severe and enduring mental health difficulties. When Adult C developed her own health problems the question about caring responsibilities was not asked. It is not known whether Adult C would have met the threshold for a statutory carer's assessment because the amount of care she and Adult CH provided was never formally assessed. It is important that those known to be providing care for close relatives are asked about caring responsibility and signposted to non statutory carers support as a minimum.

Independent Domestic Violence Advocate:

Significant development of the Independent Domestic Violence Advocate (IDVA) service occurred from 2010-12. A pilot project for the Independent Domestic Violence Advocate (IDVA) service within Maternity services (Jessop Wing, Sheffield Teaching Hospitals NHS Foundation Trust) in Sheffield ran from April 2010 – March 2011. Following the initial pilot NHS Sheffield approved a business case to continue and expand the pilot to include A&E

from April 2011. A further proposal was then made to expand the health based IDVA service across A&E, G.U.M, and Primary Care. These developments are worth noting despite (or perhaps because of) the lack of involvement or connection in this case. Adult CSP accessed maternity services, giving birth to a child in February 2011, during the period when IDVAs were in place in maternity services but domestic abuse was not identified. The IDVA service does not currently cover mental health services.

Sustainable Unscheduled Care Pathway:

NHS Sheffield has a 'Strategy for sustainable unscheduled care 2010-13' which sets out the vision and commissioning intentions of NHS Sheffield. There is an explicit outcome of 'Reduc[ing] avoidable unscheduled care activity'. The strategy includes a diagram of NHS Sheffield's vision for what the Sheffield unscheduled care system will look like by 2013 which includes appropriate use of NHS Direct, the GP and the Broad Lane urgent care centre. It should be noted that Adult C and Adult CH correctly followed this pathway but that in this instance where escalation to A&E would have been appropriate, this was left as an option or choice for Adult C. A recommendation will be made in relation to the new "111" service which will be delivered by Yorkshire Ambulance Service to ensure that more direct imperatives are given to emergency/urgent care in future cases where a mental health crisis is identified.

Choice:

The concept of 'choice' within the modern NHS is enshrined in the NHS constitution which includes the choices to refuse or accept treatment and to information about treatment. The Individual Management Reviews of NHS providers evidence that information was provided to Adult C and family and that choice was exercised on a number of occasions not to take up offers of treatment or not to escalate concerns about CS but to manage the situation themselves. On the morning of Adult C's death, choice was given about calling A&E if the situation became unmanageable; what cannot be known is whether this was a real option available under the circumstances and whether Adult C made an 'informed' choice not to contact emergency services. The NHS Direct IMR Author acknowledges that had the correct algorithm been used, then advice to seek assessment more urgently would have been given.

Conclusion:

The IMR authors have been thorough in identifying the issues for their own organisations. In the recommendations from all four IMR authors 'global' themes for the NHS providers about screening and identification have emerged as key: screening and identification of risk using the correct tools and algorithms; screening for alcohol using the correct tools; and identification of domestic abuse in wider family relationships using the correct tools.

In this case, with tragic consequences, in the critical call for help to NHS Direct from Adult C in the last hours of her life, the advice to escalate to urgent unscheduled care was left as a choice rather than an imperative. This is the key "missed opportunity" within this case, where different actions may have led to different outcomes and therefore the recommendations include that mental health crises must be escalated to appropriate emergency/urgent care services.

2.5.10. Other relevant information collected from Agencies as part of the Domestic Homicide Review process but not as part of an Individual Management Review

The Yorkshire Ambulance Service provided details in relation to the call to the house and their immediate response in the aftermath of the homicide.

Turning Point Sheffield provided helpful details of their contact with adult CS on referral from Mental Health Services following his psychotic episode in May 2004. The current manager was able to interview the worker involved and provide a brief report along with file notes.

Cavendish Care Centre Sheffield provided a summary of contact with Adult C during her treatment for cancer. No wider discussion of family issues is reported despite a close and regular supportive relationship with Adult C in assisting her cope with her diagnosis and treatment. She cancelled a planned appointment on the day before her death, which may have been indicative of the stresses in the household at that time.

Sheffield Mind were unable to confirm their involvement with Adult CS as records from 2004 had been destroyed in line with their policy of destroying records after 7 years.

All the agencies agreed to review and supply the DHR with their current training for and policy, practice and procedural responses to domestic abuse to support the wider development of awareness and response to domestic abuse which is one of the aims of a DHR.

SECTION THREE: CONCLUSIONS, LEARNING LESSONS

3.1 Findings in relation to the terms of reference

3.1.1 The victim had no known contact with any specialist domestic abuse agencies or services. The review will address whether the incident in which Adult C died was a 'one off' or whether there were any warning signs and whether more could be done in Sheffield to raise awareness of services available to victims of domestic violence including where the abuser is a family member other than an intimate partner.

- The incident which led to the death of Adult C is a one off. Whilst there was evidence of a previous pattern of deteriorating mental health in Adult CS in the days before the fatal incident, there is no way that these emerging symptoms could have been predictive of a fatal risk to Adult C. There is no evidence of any previous incident involving Adult C and Adult CS. The history of explicit threat was from Adult CS to Adult CH.
- Clearly, more could be done to raise awareness of both the issues surrounding and services to support victims of domestic abuse where the abuser is a family member rather than an intimate partner. This applies to both public and organisational awareness.

3.1.2 Whether family, friends or colleagues want to participate in the review and if so whether they were aware of any abusive behaviour prior to the homicide from the alleged perpetrator to the victim.

- Four family members participated in the review, two of whom were subjects of the DHR: Adults CH and CSP. No prior incidents of abuse between Adult CS and Adult C were disclosed. However, Adult CSP did disclose two incidents of domestic abuse, one serious, to the Chair and the Domestic Abuse Manager during interview, which led to her ending the relationship with Adult CS. These were not disclosed to agencies.

3.1.3 Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Sheffield or elsewhere.

- There were no barriers to family, friends or colleagues reporting abuse in relation to Adult C. As previously described, Adult C was a private person, described as someone who would not discuss private family matters with wider family, friends or colleagues. So whilst we cannot be sure that no disclosures were made to friends and colleagues that we did not speak to we felt that we had enough evidence from close family to make it unlikely that we would gain any further information from seeking to progress such interviews.

3.1.4 Whether the victim had experienced abuse in other relationships and whether this experience impacted on her likelihood of seeking support in the months before she died.

- We found no evidence that Adult C had experienced abuse in other relationships.

3.1.5 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

- There were no missed opportunities for professionals to routinely enquire in relation to Domestic Abuse experienced by Adult C. However, there were clearly two examples of missed opportunity: One in relation to Adult C and one in relation to Adult CSP
- The NHS Direct Nurse Adviser failed to speak to Adult CS directly on the morning of the fatal incident and missed the opportunity to escalate the response and advice to the situation.
- There was no routine enquiry recorded in maternity services as expected in relation to Adult CSP and the delivery of her second child when she was also still in contact with Adult CS.

3.1.6 Whether the alleged perpetrator had any previous history of abusive behaviour to an intimate partner or family member and whether this was known to any agencies.

- The previous threat to Adult CH during the first psychotic episode was known by mental health services and the police. The police were aware of an alleged assault by Adult CS on Adult CD but the matter was not progressed. Adult CSP described two incidents of domestic abuse as the reason for ending their relationship to the Chair and the Domestic Abuse Manager during interview but these were not disclosed to any agency.

3.1.7 Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim, or the alleged perpetrator.

- The single opportunity for intervention was by NHS Direct on the morning of the fatal incident as previously described.

3.1.8 Consideration will be given to the alleged perpetrator's history of mental health issues and substance misuse in order to establish whether opportunities for agency intervention were missed, especially around possible aggressive behaviour to others.

- No opportunities around domestic abuse were missed in relation to Adult CS, however more serious consideration should have been given to Adult CS's problematic drinking.

- There are also good examples of multi-agency working in relation to Adult CS's mental health and substance misuse with appropriate referrals and good coordination of support, particularly during his recovery from the first psychotic episode in 2004.

- There is also evidence that this is a family where there were significant mental health and substance misuse issues which led to a number of police calls to this and other addresses following incidents and alleged incidents of violence between family members.

3.2 Lessons Learned in Relation to the Wider Purpose of a DHR

3.2.1 Awareness, early identification and assessment in Health and other Universal Services.

- Since the previous DHR in Sheffield on Adult A in 2011, progress has been made on embedding the ACPO/DASH tool in frontline practice. Further work has been undertaken to develop and support GPs in the use of a simple triage tool to help them assess the level of risk and to respond quickly. A more detailed discussion about how the completion of ACPO/DASH forms when indicated can be supported also needs to take place.

3.2.2 Assessing domestic abuse within the wider family in the context of alcohol misuse and mental health issues with the family.

- One of the features of this review has been the analysis and judgement required to keep a focus on our concerns on Adult C in the context of a number of other incidents within the family; which form an unstable backdrop in the wider environment both at the main address and at other addresses. Further reflection is required as to how best to frame and contextualise incidents of domestic abuse which arise within this context.

3.2.3 Developing pathways to support agencies to address issues of domestic abuse across the city.

As with the promotion of awareness, progress on early identification and assessment has been made since the previous review on Adult A. Processes for identification and action have been further developed with the services who are key to the identification of domestic abuse including A&E and maternity services. The strategic review of domestic abuse services and structures in the city published in November of this year supports the further development of pathways which includes the use of the helpline number, a simple triage system and the use of ACPO/DASH, where risk issues are evident.

3.2.4 Ensuring that the actions and recommendations which follow from the DHR are SMART and can be actionable.

- Useful discussion have been had, as part of this DHR, with representatives from children's and adult's safeguarding in relation to the implementation of the recommendations of individual Serious Case Reviews and how wider thematic issues which arise from more than one review are addressed and taken forward on an ongoing basis. Joint IMR training is now provided to authors undertaking any form of review requiring an IMR and this is an example of good practice.

- Useful discussion also took place in relation to the part played by a range of strategies, commissioning and procurement processes, and partnership arrangements, in requiring and ensuring a range of providers to address issues of domestic abuse and take forward recommendations and whether and how there could be a contractual basis to this requirement.

3.2.5 Sustaining the development of practice and the implementation of recommendations through changes in commissioning and procurement processes and changes to governance and partnership structures.

- There will be major changes to the commissioning arrangements in the NHS in April 2013, both locally and nationally. These are summarised at appendix four and useful dialogue has taken place about the implications of this. These relate to:
    - Understanding responsibility for future service delivery required for sustaining recommendations and actions from current DHRs.
    - Maintaining and ensuring current processes, actions and services effectively support dealing with domestic abuse issues.
- The continuity of learning and actions recommended by NHS Direct need to be carried over into the new 111 service. The wider issues need to form part of the strategic thinking and planning of the newly reformed Strategic Planning Group for Domestic Abuse. A focus for this should be on the nature of the relationship with the Clinical Commissioning group and the Health and Well Being Board

3.2.6 The timing and the process of engaging family members in the DHR:

- Recent Home Office pilot training in relation to DHRs attended by the Domestic Abuse Partnership Manager shared experiences of the challenges of involving family members within the timescales of the DHR. This comes at a time when they are still coping with the trauma of the event and issues such as the criminal trial, changes and challenges to family dynamics, and financial issues which can follow from these fatal incidents.

- The support of South Yorkshire Police, Trauma Assist and Victim Support Homicide Service has clearly assisted Adult CH and support has been provided for Adult CSP, Child CGF and Adult CD through local services they were already in contact with. This has been an important support to family members in coping with the ongoing trauma and consequences which follow from the incident. Adult CS is also receiving treatment in a secure psychiatric environment following sentence.

- In this particular case the outcome of the trial, the press coverage and attempts to engage the family all happened around the time of the *(redacted – sensitive information).*

- The process of undertaking this DHR has also raised a number of other issues within the family which have needed to be addressed as part of a separate but parallel process, including some safeguarding issues.

3.2.7 The role of operational deployment within the military and its impact on domestic abuse

- Although this had no impact on the DHR in question, it is clear from some research into this area that these issues need to be thought about in more detail locally. A closer relationship between local mental health services and the military, including the local TA, would support serving personnel who have had these experiences successfully managing them on their return to the wider community.

3.2.8 Holistic assessments in the context of a focus on particular issues or stresses in the family

- Adult C's frailness and vulnerability as a carer were not picked up in the context of a growing number of stressors in the home environment. In this situation a lot of engagement with the family was driven by Adult CD's very overt distress which could have served to mask the other issues for quieter members of the family such as Adult C and to an extent Adult CS.

3.3 Relevant research summary in relation to issues raised through this DHR

As part of the DHR we undertook a brief overview of any relevant research related to matricide and parricide and into the impact of front line military deployment in relation to incidents of domestic abuse. The Panel decided to include a brief summary of both areas of research within the DHR.

In the case of the research into matricide and parricide the research appears to provide a wider context within which we can understand the actions of adult CS and some shared elements in his background and conduct which he shares with other perpetrators. This information may be of use to mental health services in their assessment of the risks posed by those suffering from psychotic episodes in relation to their immediate family members.

We also decided that we should include the research material we had obtained in relation to frontline military deployment as helpful background material and to raise awareness of the apparent increased risk and the concerns voiced by senior officers in the military about this issue. This material does not have any direct bearing on the review in question. Adult CS's time in the TA was acknowledged by his family to have been beneficial to him and he performed well whilst active in the TA and was not given any specialist training which could have contributed to the fatal incident nor exposed to frontline deployment whilst serving with the TA.

3.3.1 Research relating to matricide and parricide

Parricide: A Comparative Study of Matricide versus Patricide Dominic Bourget, Pierre Gagne and Mary-Eve Labelle Royal Ottowa Hospital Ontario Canada Journal of the American Academy of Psychiatry and the Law Online 2007 35:3

A study by O'Connell identifies that a son who kills his mother is usually an unmarried, unambitious young man with an intense relationship with his mother and a feeling of social inferiority. Campion et al suggested that men who commit matricide feel weak, hopeless and dependant and are unable to accept a mature separate male role.

Almost all of the matricides occurred in the home. Use of a knife was the second most common cause-29%. Three quarters of the matricides occurred without a warning sign. 70% of perpetrators who committed matricide had a psychotic motive. The average mean age was 31.4 years.

A Decade of Child-Initiated Family Violence

Comparative Analysis of Child—Parent Violence and Parricide Examining Offender, Victim, and Event Characteristics in a National Sample of Reported Incidents, 1995-2005 Jeffrey A. Walsh Illinois State University, Normal, and Jessie L. Krienert Illinois State University, Normal Journal of Interpersonal Violence 2009:24

This article examines 11 years (1995-2005) of National Incident Based Reporting System data comparing victim, offender, and incident characteristics for two types of child-initiated family violence: child–parent violence (CPV) and parricide. The objective is to better understand the victim–offender relationship for CPV and parricide and to highlight distinguishing features between the two offences.

Matricide: A Critique of the Literature

Kathleen M. Heide Department of Criminology, University of South Florida, Tampa, Florida and Autumn Frei Department of Criminology, University of South Florida, Tampa, Florida
Trauma, Violence, Abuse 2010 11:3.

Matricide, the killing of mothers by their biological children, is a very rare event, comprising less that 2% of all U.S. homicides in which the victim-offender relationship is known. This paper examines more than 20 years of U.S. homicides to determine the age and gender characteristics of matricide offenders. These data reveal that most mothers are killed by their adult sons.

3.3.2 Research relating to the relationship between domestic abuse and front line deployment and experiences of serving personnel.

Violent behaviour in UK military personnel returning home after deployment
Psychological Medicine / Volume 42 / Issue 08 / August 2012, pp 1663-1673
Article author query.

D. MacManus[a1a2] [c1], K. Dean[a1], M. Al Bakir[a2], A. C. Iversen[a2], L. Hull[a2], T. Fahy[a1], S. Wessely[a1a2] and N. T. Fear[a2]

[a1] Department of Forensic and Neurodevelopmental Sciences, Institute of Psychiatry, King's College London, London, UK [a2] King's Centre for Military Health Research, King's College London, London, UK

The study found that in the weeks after returning home, 12.6% of Army personnel reported being violent. Those who reported antisocial behaviour before joining the Army were 3.6 times more likely to be violent on their return home. But, after eliminating the influence of pre-enlistment antisocial behaviour, socio-demographics and military factors, violence on homecoming was still strongly associated with being deployed in a combat role (2 times more likely to be violent on return home) or having experienced multiple traumatic events on deployment (3.7 times more likely if experienced 4 or more traumatic events on deployment). A third of the victims were someone in the family - often a wife or girlfriend.

Army personnel who experienced mental health problems such as post-traumatic stress disorder (PTSD) were 4.8 times more likely to report violence on homecoming, and those who reported alcohol misuse were 3.1 times more likely to report violence on homecoming.

The study followed 4,928 UK Armed Forces personnel who had been deployed in Iraq in 2003. Data was collected by questionnaire and included information on deployment experiences, socio-demographic and military characteristics, pre-enlistment antisocial behaviour, post-deployment mental health outcomes and a self-reported measure of physical violence in the weeks following their return home.

Key themes identified in Violent Veterans File on 4 on BBC Radio 4 (podcast still available first broadcast 24th July 2012)

Lord Dannatt Head of the Army between 2006 and 2009 said the MoD needed to get a grip on the scale of domestic violence.

"The whole issue of psychiatric injury, which in its extreme form expresses itself in PTSD, is going to be expressed in domestic violence. The scale needs to be quantified and more action needs to be taken," he said. "Cultural change needs to be encouraged. It needs to be driven from the top down, but also from the bottom up so servicemen realise it's not un-macho to put their hands up - in private - and say 'I need help'."

In July of this year an ex-soldier was jailed for shooting dead his landlady, just months after he had returned from serving in Afghanistan with the Territorial Army.
Aaron Wilkinson, 24, killed 52-year-old Judith Garnett, at her farm in Leeds.
Wilkinson had been diagnosed with post-traumatic stress reaction by an Army doctor. It developed into post-traumatic stress disorder (PTSD), but was not monitored or treated.
Wilkinson, who also had undiagnosed Asperger syndrome, admitted manslaughter on the grounds of diminished responsibility. He was cleared of murder.

SECTION FOUR: RECOMMENDATIONS

4.1 Chair Recommendations

4.1.1 That the Domestic Abuse Strategic Board should ensure that discussions with appropriate commissioners and professional bodies continue with a view to agreeing and supporting the implementation of a simple screening system for General Practitioners to help them assess any risk and required response quickly. These discussions should build on the progress made since the last DHR on Adult A, including training delivered to GPs, and should include discussions about how best the completion of ACPO/DASH can be supported when high risk issues are indicated. The progress of these discussions should be reviewed at the Domestic Abuse Strategic Board meeting in February and a more detailed development plan agreed then.

4.12 In addition the Panel and the Chair recommends that the Domestic Abuse Strategic Board contact the Department of Health, the General Medical Council and the Royal College for General Practice to express concern in relation to the National Contract for GPs not including any statutory responsibility in relation to the safeguarding of victims of domestic abuse, vulnerable adults and children. This issue is likely to be an issue in subsequent DHR's and Serious Case Reviews on children and young people.

4.1.3 That the Domestic Abuse Strategic Board note the review of protocols in relation to dual diagnosis of substance misuse and mental health currently being undertaken by the Strategic Health Authority as part of a national review. This is due to be complete in January and the February meeting of the Group should ensure that the revised protocol adequately addresses related issues of domestic abuse.

4.1.4 That the Domestic Abuse Strategic Board should ensure that the pathway development work identified in the recent Domestic Abuse Strategic Review is progressed. The pathway development work should be complete by April 2013 and the work to endorse and critically assess the whole pathway by relevant organisations and partnerships should be complete by September 2013.

4.1.5 That the Domestic Abuse Strategic Board should implement the joint commissioning arrangements proposed in the Domestic Abuse Strategic Review. The Board should also identify the appropriate use of procurement, partnership and contracting processes linked to performance requirements to ensure that issues around domestic abuse in general are taken forward and that recommendations from DHRs will be progressed. This work should be completed by the end of September 2013 for the start of the next commissioning cycle. A variety of arrangements may be acceptable and agreed depending on the services being contracted and commissioned and the range of approaches used.

4.1.6 That the Domestic Abuse Strategic Board assesses changes in commissioning and governance in relation to the maintenance of the effective delivery of domestic abuse support services. The group should consider its relationship with the new Health commissioning structures and strategic boards as part of its strategic and business planning for the next financial year. Particular consideration should be given to relationships with the Health and Well Being Board, with the Clinical Commissioning Group and with the Local Medical Committee.

4.1.7 That the Domestic Abuse Strategic Board satisfies itself that the transfer of services from NHS Direct continues to progress smoothly in relation to the issues identified in this DHR. Good joint work in this area is under way. Progress should be reviewed by the Board in February and again following implementation in April.

4.1.8 That the likely support needs of families and DHR subjects are assessed by future DHR panels when creating terms of reference for future DHRs. These support needs should be actively considered through the process of completing any future DHRs with any relevant learning in relation to supporting families shared appropriately. Engagement of families in the DHR process should be sensitive and responsive to situations family members find themselves in as the timescale of the review unfolds. This requirement should be included in updated guidance when it is issued.

4.1.9 That the Domestic Abuse Strategic Board asks relevant agencies in the city to consider the research highlighted in this review in relation to their policies and procedures and report back any changes made as a result by September 2013.

4.1.10 The Domestic Abuse Strategic Board should support the principle of a whole household approach to assessments. The issues arising from this DHR should be shared with the group developing the family CAF and the Building Successful Families project team to inform their work on developing the whole household approach in the city. The outcome of this should be reported back to the Domestic Abuse Strategic Board by April 2013.

4.1.11 That the Domestic Abuse Strategic Board promotes as good practice that agencies across the city have in place up to date policies and procedures, and awareness and training for staff in relation to domestic abuse, and that agencies are ready to engage with and participate in Domestic Homicide Reviews. This should include the agencies connected to this Domestic Homicide Review: Mind, Turning Point and Cavendish Care. The Strategic Board should develop a plan for taking this work forward by May 2013.

4.2 Agency Recommendations

4.2.1 Sheffield Health and Social Care Trust

1. SHSC should review its domestic abuse policy in line with recommendations provided with the ACPO DASH assessment tool
   Policy review is currently underway and is due for completion in November 2012.

2. The awareness of domestic abuse and the prompt use of the ACPO DASH assessment tool should be embedded into practice in all SHSC services
   Raising awareness is currently being implemented by SHSC's Safeguarding Department via the Trust intranet, safeguarding awareness training and the quarterly safeguarding newsletter.

3. SHSC continue to monitor the use of carers assessments via the Key Performance Indicators ((KPI's)

4. SHSC policy for Dual Diagnosis and referral to alcohol services should be internally reviewed and amended to promote prompt interventions and prompt referral

Review underway for completion 2013

4.2.2 NHS Sheffield – General Practice

For NHS Sheffield

1. NHS Sheffield should provide for GP practices information to increase awareness that Domestic Abuse services include support for non-intimate household members such as parents or siblings.

2. NHS Sheffield should provide for GP practices information to increase awareness of appropriate alcohol services.

3. NHS Sheffield will suggest to GP's that they extend their routine enquiry around depression, that they undertake following a significant diagnosis, to include enquiring about domestic stress and/or abuse.

For General Practice

4 GP practices should have a Domestic Abuse policy that details staff member's responsibilities including how to recognize possible domestic abuse when stress at home is disclosed and how to refer to domestic abuse services.

5 When substance misuse is disclosed during a GP consultation, including alcohol excess, this should be documented and READ coded within the GP records.

6 Any psychotic episode that is known to be drug related should be documented and READ coded within the GP records.

7 When excessive alcohol intake is identified or suspected an assessment of alcohol dependence using a recommended tool e.g. AUDIT-C (8), should be undertaken and an appropriate referral made to specialist alcohol services dependent on the results. This should be documented and READ coded within the GP records. This action should be undertaken by GP's regardless of any actions presumed to be taken by any other service involved with the patient.

4.2.3 The Territorial Army

The recommendations that follow are general, and not specifically related to the case of Adult CS, but the investigation has raised three points:

1. JSP 913: Tri-Service Policy on Domestic Abuse and Sexual Violence provides comprehensive direction for members of the armed forces on this subject. There is a need to ensure awareness of this policy within the unit in order to ensure it

is followed. Unit Adjutants to place information about the policy on Unit Part One Orders in order to achieve this.

2. Post Operational Stress Management (POSM) is a key part of our business as a unit following our recent deployment of soldiers on Operations HERRICK 15 and 16 to Afghanistan. Documenting this process is absolutely crucial, and is currently undertaken with due diligence by the welfare team within *(redacted – sensitive information)*. However, it is always worth re-enforcing it' value across the unit. Unit Welfare Staff are to continue to ensure POSM is carried out within guidelines for all *(redacted – sensitive information)* personnel.

3. Medical checks require access to cross-departmental data between Government Organisations. Specifically, without an ability for army medical staff to access all required fields of data from an individuals civilian medical history, fully comprehensive medical checks cannot take place prior to an individual joining the TA. Under the new RG8, background checks from a civilian GP are mandatory – ROSO's are to ensure this guidance is being followed.

4.2.4 Sheffield Teaching Hospitals NHS Foundation Trust

All actions from the previous DHR (Adult A) have been completed.

The Domestic Abuse Good Practice Guidelines for Midwifery and Nursing Staff and the Domestic Abuse Nursing Care Guideline have been updated in 2012 following the previous DHR.

Both these documents are available on the STHFT Intranet site.

On the front of the current A & E attendance card is a system for recording Special Case codes which can be used to flag or alert staff of similar occurrences. As a result of the recommendations from the previous DHR, the domestic violence coding box was moved to the front of the A & E attendance card in order to ensure that domestic violence can be recorded as a separate concern to the presenting condition.

Recommendations

1. To update the current safeguarding vulnerable adults training needs analysis to reflect the need for specific staff groups to acquire domestic abuse awareness.

2. To develop a variety of methods to ensure domestic abuse awareness is widely disseminated across appropriate staff groups in accordance with the safeguarding vulnerable adults training needs analysis.

Final Comment

Findings from the IMR and the final report of the DHR will be fed back to the staff members involved in this case via the next Safeguarding Leads meetings after the publication of the report. Any relevant actions for STHFT from the DHR Overview report, will be delegated as appropriate and progress monitored by this group.

4.2.5 Sheffield City Council: Children, Young People and Family Services (CYPF).

1. The policies and procedures in place for the reporting and responding to incidents of Domestic Violence remain appropriate.

2. Social Workers need to give consideration to the role of wider family members within their assessments if they are frequent visitors to households even if they are not living at the address. This should be reinforced by managers who are authorising the assessments and should form part of the discussion within case supervision. In order to promote good practice early in a Social Workers career this issue will be raised within NQSW network meetings where different subjects are discussed. This message can be disseminated to Assistant Service Managers within the areas for discussion with the Team Managers, for whom they are responsible, to ensure implementation.

4.2.6 NHS Direct

1. Clinical supervision for registered nurses is not a mandatory undertaking. However it is widely recognised as a beneficial activity that encourages reflection and supports best practice, and is recommended by the Nursing and Midwifery Council (NMC, 2008). The organisation needs to reinforce and remind staff of the availability and benefits of accessing regular clinical supervision. This message will be supported and emphasised at the regular 1 to 1 meetings that all staff have with their line managers from 31 October 2012. To measure this, line managers are asked notify the Education Training & Development Administrator when a member of their team has had clinical supervision, this will then be logged on the training database.

2. Reinforce to staff the importance of following best practice guidance for managing 3rd party calls. This message will be supported and emphasised at their regular 1 to 1 meetings with their line managers. Practice Development Coaches will also reinforce this message when working with colleagues where a work performance issue is identified. This can also be measured in the three random call reviews performed for each member of staff on a monthly basis. Learning from this Independent Management Review will be cascaded to all staff once it is signed off and the scenario used as a training vignette.

3. NHS Direct produces a quarterly internal newsletter ‘Mental Health Direct’. An article on domestic violence and DASH principles will be included in our winter edition.

4.2.7 NHS Overview Author's Recommendations

For NHS Sheffield

1. NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about identification and response to domestic abuse.

2. NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about clinical tools/algorithms which should be used (e.g. ACPO DASH is the recommended risk assessment tool for domestic abuse; AUDIT based tools are the recommended clinical tools for identification of alcohol misuse.)

3. NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about identification, assessment and recognition of carers.

4. NHS Sheffield and future commissioners of NHS services should ensure any signposting directs contacts regarding a mental health crisis to appropriate emergency / urgent care services.

5. NHS Sheffield and future commissioners of NHS services, should ensure that in their directory of services for the implementation of 111, it identifies the disposition for a mental health crisis to an appropriate emergency / urgent care service.

For NHS providers

6. Providers should keep a current domestic abuse policy.

7. Providers should make clear and accessible to staff the clinical pathways and recommended clinical tools/algorithms for domestic abuse, alcohol misuse and mental health.

8. Providers should ensure all staff are aware of the need to recognise carers and offer carers assessments where appropriate.

9. Providers should make the Dual Diagnosis protocols clear and accessible to staff. Individuals confirmed as reaching the threshold for "dual diagnosis" must have their care co-ordinated by the Mental Health Trust.

10. Providers should ensure a formal letter is written to the client's GP to notify them of any health/specialist referral or interventions so that there is a complete record of interventions held by the GP. Communication must be clear and indicate the diagnosis, prognosis and package of care.

SECTION FIVE: ACTION PLAN

Key to status	
RED	Action Required
AMBER	Preparation Underway
GREEN	Preparation complete and action ongoing
COMPLETE	Action Completed

REMEMBER TO PUT VICTIM CODE IN HEADER
SET PRINT AREA TO ROW
11 DOWN

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Direct	1	Promote the benefits of Clinical Supervision	Circulate briefing paper to staff in next months 'News Shot'. Draft an article in our internal newsletter.	Mental Health Leads	01/12/12	Amber	Team managers to notify Education training & Development Administrator when a member of their team has had clinical supervision. This will then be logged on the learning & development database. Article drafted.
NHS Direct	2	An article on domestic violence and DASH assessment to be included in the winter edition of our mental health newsletter.	Newsletter editorial team have proof read the article and accepted it for submission	Mark Barker	01/12/12	Green	Article drafted

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Direct	3	Reinforce best practice guidance for managing 3rd party calls.	A message has been sent out to all line managers to reinforce best practice at their regular 1 to 1 meetings with their team. A message has also been circulated to all practice development coaches to reinforce this when working with individuals when a work performance issue is identified.	Mental Health Leads	01/12/12	Amber	To be measured in the three random call reviews undertaken each month.
STHFT	1	To update the current safeguarding vulnerable adults training needs analysis to reflect the need for specific staff groups to acquire domestic abuse awareness.		CAH	31/04/2013	RED	

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
STHFT	2	To develop a variety of methods to ensure domestic abuse awareness is widely disseminated across appropriate staff groups in accordance with the safeguarding vulnerable adults training needs analysis.		CAH	31/04/2013	AMBER	
Territorial Army	1.1	JSP 913: Tri-Service Policy on Domestic Abuse and Sexual Violence provides comprehensive direction for members of the armed forces on this subject. There is a need to ensure awareness of this policy within the unit in order to ensure it is followed.	Point Brief on this matter to be distributed by 15 (NE) Bde to all units within the Chain of Command.	Adjt 4 YORKS, in conjunction with 15X SO2 G1 Ops & Plans	01/11/12	Amber	TBC

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
Territorial Army	1.2	Post Operational Stress Management (POSM) is a key part of our business as a unit following our recent deployment of soldiers on Operations HERRICK 15 and 16 to Afghanistan. Documenting this process is absolutely crucial, and is currently undertaken with due diligence by the welfare team *(redacted – sensitive information)*. However, it is always worth re-enforcing it's value across the unit.	Point Brief on this matter to be distributed by 15 (NE) Bde to all units within the Chain of Command.	Adjt 4 YORKS, in conjunction with 15X SO2 G1 Ops & Plans	01/11/12	Amber	TBC
Territorial Army	1.3	Medical checks require access to cross-departmental data between Government Organisations. Specifically, without an ability for army medical staff to access all required fields of data from an individuals civilian medical history, fully comprehensive medical checks cannot take place prior to an individual joining the TA.	Point Brief on this matter to be distributed by 15 (NE) Bde to all units within the Chain of Command.	Adjt 4 YORKS, in conjunction with 15X SO2 G1 Ops & Plans	01/11/12	Amber	TBC

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
Children, Young People, and Families (SCC)	2	Social Workers need to give consideration to the role of wider family members within their assessments if they are frequent visitors to the household, even if they are not living at the address. This should be reinforced by Managers who are authorising assessments and should form part of the discussion within case supervision. In order to promote good practise early in a Social Worker's career, this issue to be raised within NQSW Network Meetings, where different subjects are discussed. This message can be disseminated to Assistant Service Managers within areas for discussion with the Team Managers for whom they are responsible to ensure implementation.	Course content to be reviewed with Social Work consultants who deliver the NQSW programme. Message to be disseminated to Assistant Service managers in area for discussion with their Team Managers. Discussion on agenda for ASM meeting 14th November 2012. .Supervision Notes to be audited to consider evidence of discussion as part of ongoing performance management framework.	Matthew Reed	30/11/12	Amber	To be included in course content as part of rolling programme to NQSW's. Minutes of area management meeting to be forwarded to demonstrate information presented to Team Manager. Supervision Audits for part of service Performance Management Framework.

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Sheffield (GPs)	1. (rec 4. from GP IMR)	GP practices should have a Domestic Abuse policy that details staff member's responsibilities including how to recognize possible domestic abuse when stress at home is disclosed and how to refer to domestic abuse services.	We will write to all practices advising them that it is good practice to have a DA policy. We will provide for practices links to the RCGP draft policy: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/Domestic%20violence.ashx	AL	31/03/13	RED	
NHS Sheffield (GPs)	2. (rec 5. from GP IMR)	When substance misuse is disclosed during a GP consultation, including alcohol excess, this should always be READ coded.	We will write to all practices advising them that the recommendation is good practice	AL	31/03/13	RED	
NHS Sheffield (GPs)	3. (rec 6. from GP IMR)	Any psychotic episode that is known to be drug related should be documented and READ coded within the GP records	We will write to all practices advising them that the recommendation is good practice.	AL	31/03/13	RED	

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Sheffield (GPs)	4. (rec 7 from GP IMR)	When excessive alcohol intake is identified or suspected an assessment of alcohol dependence using a recommended tool e.g. AUDIT-C (8), should be undertaken and an appropriate referral made to specialist alcohol services dependent on the results. This should be documented and READ coded within the GP records. This action should be undertaken by GP's regardless of any actions presumed to be taken, by any other service involved with the patient	We will write to all practices advising them that the recommendation is good practice. We will make practices aware of the online AUDIT assessment & associated referral into specialist services.	AL	31/03/13	RED	
NHS Sheffield (commissioning)	1. (rec 1. from GP IMR)	NHS Sheffield should provide for GP practices information to increase awareness that Domestic Abuse services include support for non-intimate household members such as parents or siblings	We will write to all practices advising them of the recommendation & signposting them to information re what DA is.	AL	31/03/13	RED	

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Sheffield (commissioning)	2. (rec 2. from GP IMR)	NHS Sheffield should provide for GP practices information to increase awareness of appropriate alcohol services	We will write to all practices advising them of the recommendation & signposting them to relevant resources.	AL	31/03/13	RED	
NHS Sheffield (commissioning)	3. (rec 3. from GP IMR)	NHS Sheffield will suggest to GP's that they extend their routine enquiry around depression, that they undertake following a significant diagnosis, to include enquiring about domestic stress and/or abuse	We will write to all practices advising them of the recommendation & ask them to undertake what recommended. We will provide the context for the recommendation	AL	31/03/13	RED	
NHS Sheffield (commissioning)	4. (rec 1. from HOR)	NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about identification and response to domestic abuse		MB	31/03/13	RED	

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Sheffield (commissioning)	5. (rec 2. from HOR)	NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about clinical tools/algorithms which should be used (e.g. ACPO DASH is the recommended risk assessment tool for domestic abuse; AUDIT based tools are the recommended clinical tools for identification of alcohol misuse)		MB	31/03/13	RED	
NHS Sheffield (commissioning)	6. (rec 3. from HOR)	NHS Sheffield and future commissioners of NHS services should clarify their expectations of their commissioned providers about identification, assessment and recognition of carers.		MB	31/03/13	RED	
NHS Sheffield (commissioning)	7. (rec 4. from HOR)	NHSS and future commissioners of NHS services should ensure any signposting directs contacts regarding a mental health crisis to appropriate emergency / urgent care services.		MB	31/03/13	RED	

Agency	Rec. No.	Recommendation	Milestones / actions taken	Lead person	Target date	Status	Evidence of outcome
NHS Sheffield (commissioning)	8. (rec 5. from HOR)	NHSS and future commissioners of NHS services, ensure that in their directory of services for the implementation of 111, it identifies the disposition for a mental health crisis to an appropriate emergency / urgent care service.		MB	31/03/13	RED	
SHSC	1 (4.2.1 in OVR)	SHSC should review its domestic abuse policy in line with recommendations provided with the ACPO DASH assessment tool.	Policy review is currently underway and is due for completion in November 2012.		30/11/2012	GREEN	
SHSC	2	The awareness of domestic abuse and the prompt use of the ACPO DASH assessment tool should be embedded into practice in all SHSC services.				COMPLETE	Raising awareness is currently being implemented by SHSC's Safeguarding Department via the Trust intranet, safeguarding awareness training and the quarterly safeguarding newsletter.

SHSC	3	SHSC continue to monitor the use of carers assessments via the Key Performance Indicators (KPI's)			Ongoing	**COMPLETE**	
SHSC	4	SHSC policy for Dual Diagnosis and referral to alcohol services should be internally reviewed and amended to promote prompt interventions and prompt referral.	Review underway for completion 2013.		During 2013	**GREEN**	
Domestic Abuse Strategic Board	1	That the Domestic Abuse Strategic Board should ensure that discussions with appropriate commissioners and professional bodies continue with a view to agreeing and supporting the implementation of a simple screening system for General Practitioners to help them assess any risk and required response quickly. These discussions should build on the progress made since the last DHR on Adult A, including training delivered to GPs, and should include discussions about how best the completion of ACPO/DASH can be supported when high risk issues are indicated. The progress of these discussions should be reviewed at the Domestic Abuse Strategic Board meeting in February and a more detailed	Discussions been held with NHS Sheffield Safeguarding leads on new pathway and DASH Risk Assessor role to be be developed as part of service specification reconfiguration. This role will assist universal health settings to risk assess and / or complete the risk assessment for GPs if necessary.	DACT DA manager	Jul-13	**GREEN**	New DASH Risk Assessor post established and pathway disseminated to GPs and other health professionals

		development plan agreed then.					
Domestic Abuse Strategic Board	2	In addition the Panel and the Chair recommends that the Domestic Abuse Strategic Board contact the Department of Health, the General Medical Council and the Royal College for General Practice to express concern in relation to the National Contract for GPs not including any statutory responsibility in relation to the safeguarding of victims of domestic abuse, vulnerable adults and children. This issue is likely to be an issue in subsequent DHR's and Serious Case Reviews on children and young people.	Head of DACT to send a letter before next Board	Head of DACT	Apr-13	**RED**	
Domestic Abuse Strategic Board	3	That the Domestic Abuse Strategic Board note the review of protocols in relation to dual diagnosis of substance misuse and mental health currently being undertaken by the Strategic Health Authority as part of a national review. This is due to be complete in January and the February meeting of the Group should ensure that the revised protocol adequately addresses related issues of domestic abuse.	DACT Joint Commissioning Manager to bring report to next DAS Board	DACT Joint Commissioning Manager	Apr-13	**RED**	
Domestic Abuse Strategic Board	4	That the Domestic Abuse Strategic Board should ensure that the pathway development work identified in the recent Domestic Abuse Strategic Review is progressed. The pathway development work should be complete by April 2013 and the work to endorse and critically assess the whole pathway by relevant organisations and partnerships should be complete by September 2013.	Draft pathway to be presented to the DA Board in February 13	DACT DA manager	Apr-13	**GREEN**	

Domestic Abuse Strategic Board	5	That the Domestic Abuse Strategic Board should implement the joint commissioning arrangements proposed in the Domestic Abuse Strategic Review. The Board should also identify the appropriate use of procurement, partnership and contracting processes linked to performance requirements to ensure that issues around domestic abuse in general are taken forward and that recommendations from DHRs will be progressed. This work should be completed by the end of September 2013 for the start of the next commissioning cycle. A variety of arrangements may be acceptable and agreed depending on the services being contracted and commissioned and the range of approaches used.	Joint Commissioning Group for DA established and meeting regularly. Commissioning Plan to come to DA Strategic Board in April. Commissioning issues for non specialist providers to be addressed in new Domestic Abuse Strategic Plan for the city.	Head of DACT	Apr-14	**AMBER**	
Domestic Abuse Strategic Board	6	That the Domestic Abuse Strategic Board assesses changes in commissioning and governance in relation to the maintenance of the effective delivery of domestic abuse support services. The group should consider its relationship with the new Health commissioning structures and strategic boards as part of its strategic and business planning for the next financial year. Particular consideration should be given to relationships with the Health and Well Being Board, with the Clinical Commissioning Group and with the Local Medical Committee.	The Clinical Commissioning Group will be invited to nominate a representative to sit on the Domestic Absue Strategic Board	Head of DACT	Apr-13	**AMBER**	

Domestic Abuse Strategic Board	7	That the Domestic Abuse Strategic Board satisfies itself that the transfer of services from NHS Direct continues to progress smoothly in relation to the issues identified in this DHR. Good joint work in this area is under way. Progress should be reviewed by the Board in February and again following implementation in April.	Liaison with NHS Direct / YAS to take place before April Stratetgic Board	DA Manager	Apr-13	**AMBER**	
Domestic Abuse Strategic Board	8	That the likely support needs of families and DHR subjects are assessed by future DHR panels when creating terms of reference for future DHRs. These support needs should be actively considered through the process of completing any future DHRs with any relevant learning in relation to supporting families shared appropriately. Engagement of families in the DHR process should be sensitive and responsive to situations family members find themselves in as the timescale of the review unfolds. This requirement should be included in updated guidance when it is issued.	Updated guidance to be produced to include consideration of this issue	DACT DA Manager	Jun-13	**AMBER**	
Domestic Abuse Strategic Board	9	That the Domestic Abuse Strategic Board asks relevant agencies in the city to consider the research highlighted in this review in relation to their policies and procedures and report back any changes made as a result by September 2013.	DACT DA Manager to write to relevant agencies before next DA Board	DACT DA Manager	Apr-13	**AMBER**	

Domestic Abuse Strategic Board	10	The Domestic Abuse Strategic Board should support the principle of a whole household approach to assessments. The issues arising from this DHR should be shared with the group developing the family CAF and the Building Successful Families project team to inform their work on developing the whole household approach in the city. The outcome of this should be reported back to the Domestic Abuse Strategic Board by April 2013.	The DACT DA Manager is involved in working groups relating to the development of the Family CAF	DACT DA Manager	Apr-13	**GREEN**	Guidance in development for Family CAFs includes information re. domestic abuse supplied by DACT DA Manager
Domestic Abuse Strategic Board	11	That the Domestic Abuse Strategic Board promotes as good practice that agencies across the city have in place up to date policies and procedures, and awareness and training for staff in relation to domestic abuse, and that agencies are ready to engage with and participate in Domestic Homicide Reviews. This should include the agencies connected to this Domestic Homicide Review: Mind, Turning Point and Cavendish Care. The Strategic Board should develop a plan for taking this work forward by May 2013.	To be addressed with individual agencies concerned and included as part of development of new Strategic Plan for domestic abuse for city.	DACT team	Initial work April 13 re. specific agencies. Longer term target April 14	**AMBER**	

APPENDICES

APPENDIX ONE: CHRONOLOGY OF SIGNIFICANT EVENTS AND AGENCY INVOLVEMENT *(REDACTED – SENSITIVE INFORMATION)*

APPENDIX TWO: REDACTION FRAMEWORK FOR DHR

General principles

1. The DHR's aim is to ensure that a proper analysis of the issues relating to a homicide is obtained which enables lessons to be learned without blame being apportioned. The report is produced in accordance with Home Office guidelines

2. Any redaction within the report should seek to properly balance rights to privacy and confidentiality in a way which does not affect the proper analysis of agencies actions and what lessons should be learned.

3. Information already in the public domain should not be redacted retrospectively unless a specific barrier exists in law.

4. Where information is redacted this should be obvious to the reader. The majority of redactions are likely to be in relation to personal data and will in general require no specific explanation. Redactions other than for protection of personal data should be accompanied by a short explanation (at an appropriate place in the report) unless to do so would in itself place a person at risk of harm..

5. The identities of all professionals, family and associates shall be redacted in accordance with a standard scheme which reveals the professional status or family background, but not the name e.g HV1 for Health Visitor 1; GP1 for General Practitioner etc.

Safety Issues

6. Both Executive Summary and Overview Report will be published in accordance with Government guidelines. The nature of the information therefore entering the public domain may be such that children and Adults may be placed at risk of harm

7. If, in the opinion of the report author, facts which might be included in the report could place an individual at risk of harm then s/he shall redact it to remove such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Sensitive Personal Information, including health information

8. If, in the opinion of the report author, the inclusion of sensitive personal information about living individuals would infringe upon their legitimate expectations as to privacy or their rights to privacy under Article 8 The Human Rights Act 1998 or the Data Protection Act 1998, then s/he shall redact it to remove, edit or amend such concerning information as s/he considers in his/her discretion necessary. The principle shall be that the minimum redaction possible shall be applied, including the use of anonymisation or pseudonyms as an alternative if appropriate.

Audit & moderation

9. The DAP manager shall maintain a list of any such specific redactions which shall be submitted to the DHR review panel for moderation on such frequency as is appropriate to the case.

Redaction framework: DHR: Version 1: dated 29.11.11

Author: S G Eccleston, Assistant Director Legal Services, Sheffield City Council

APPENDIX THREE: NATIONAL PICTURE

In *Call to End Violence Against Women and Girls*[2] the difficulty in being able to fully identify the prevalence of violence against women and girls is expressed: it is often a hidden crime. Research however reveals an appalling picture[3]:

- *At least 1 in 4 women in the UK will experience domestic abuse in their lifetime (British Crime Survey 2009/10)*
- *Almost 1 in 5 women will experience sexual assault in their lifetime (British Crime Survey 2009/10)*
- *Almost 1 in 20 women was stalked last year and 1 in 5 women will experience stalking in their lifetime (British Crime Survey 2009/10)*
- *Approximately 66,000 women in England and Wales have had their genitals mutilated and it is estimated that approximately 100-140 million African women have undergone FGM worldwide (FORWARD)*
- *The United Nations estimates that every year 5,000 women are victims of honour-killings internationally*
- *In 2009, the forced marriage unit provided direct support to victims in the UK and overseas in 377 cases*
- *The minimum cost of violence against women and girls in the UK is £37.6bn.*

British Crime statistics in 2009/10 show that:

- *Domestic violence accounted for 14% of all reported violent incidents*
- *Women were the victims in 77% of incidents*
- *Domestic violence had the highest rate of repeat victimisation of any serious crime. 47% of victims experience more than one incident; 30% more than three*
- *7% of women and 4% of men suffered domestic abuse during the year*

There is also a significant impact on children:

- *At least 750,000 children a year witness domestic violence (Department of Health, 2002).*
- *children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life (Stanley 2011)* [4]
- *52% of child protection cases involve domestic violence (Farmer & Owen, 1995)*
- *40% to 70% of men who assault their wives or partners are also directly physically or sexually violent to their children, or abuse or threaten the children to increase their control over their mother (Hester and Pearson, 1998, Humphreys, C. and Mullender, A, 2000)* [5]

The Government's strategic vision and action plan places prevention and awareness-raising, early identification and early intervention at the centre and contains measures for central government to:

---

[2] Call to End Violence Against Women and Girls November 2010. HM Government

[3] Call to End Violence Against Women and Girls November 2010. HM Government

[4] Children experiencing domestic violence: A research review. Research in practice 2011

[5] Hester, M., Pearson, C. and Harwin, N. (2000) Making an impact: A reader, London, Jessica Kingsley. Humphreys, C. and Mullender, A. (2000) Children and domestic violence, Research in Practice Series, Dartington, Devon

- Prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it.
- Provide adequate levels of support where violence does occur.
- Work in partnership to obtain the best outcome for victims and their families.
- Take action to reduce the risk to women and girls who are victims of these crimes and ensure that perpetrators are brought to justice.

APPENDIX FOUR: FUTURE GOVERNANCE AND COMMISSIONING ARRANGEMENTS IN THE NHS

During the course of the DHR it became clear that changes in governance and commissioning arrangements within the NHS could have an impact. There are two areas to consider: the continuity of implementing recommendations and the action plan as well as any impact on the strategic and operational development of services in relation to domestic abuse going forward.

From April 2013, the NHS in England will undergo a significant change in its commissioning structures with the abolition of Primary Care Trusts, to be replaced by:-

- Clinical Commissioning Groups – These will be responsible for commissioning of hospital and community services, either individually or in collaboration with other CCGs.
- NHS Commissioning Board – The Local Area Team of the NHSCB, in our case South Yorkshire and Bassetlaw will have responsibility for Primary Care (for example GPs and Dentists) and some areas of specialised commissioning.

In addition Public Health Services, including Drug and Alcohol Services, will transfer to the Local Authority.

In a separate change, the 111 service will be launched nationally to replace NHS Direct (NHSD) as the non urgent call handling service, including access to an out of hours services from March 2013. Unlike NHSD the 111 service will be able to better reflect local services and arrangements in the decisions it takes, utilising a local directory of services. Some areas including Derbyshire have already implemented 111. For Yorkshire and the Humber Yorkshire Ambulance Service will be the provider of 111 services

APPENDIX FIVE: SUMMARY LOCAL PROVISION SHEFFIELD SERVICES

Sheffield Domestic Abuse Partnership was established in May 2010. Sheffield has a long history of domestic abuse services but by 2007 multi agency working in response to domestic abuse was developing rapidly with the introduction of the Specialist Domestic Violence Court Initiative and Multi-Agency Risk Assessment Conferences (MARAC). SCC recognised that it needed to build on the success of its existing services in light of these national developments and in July 2008 following publication of a feasibility study into the integration of domestic abuse services in Sheffield, established a project board to develop an integrated service with the aim of addressing issues highlighted in the report. The project board was tasked to:

- Build upon current provision to develop and provide a specialist, multi-agency response and proactive interventions to prevent and reduce domestic abuse.
- Develop a professionally staffed helpline and advice service for initial assessment, signposting or referral based on needs and level of risk.
- Develop a citywide community outreach support service.
- Bring together key agencies under one roof to work together to deliver services.
- Develop a common multi-agency risk assessment and support planning approach to identify and understand the needs of those experiencing abuse.

A developmental approach was taken and culminated in the launch of the Sheffield Domestic Abuse Partnership Co-located Team in spring 2010.

Domestic Abuse Co-located Team

The co-located team is based at police headquarters; the Police Public Protection Unit (Domestic Abuse Team) and the Joint Investigation Team (Social Workers, Children and Families) are also based at police headquarters and the close proximity of the three teams has been a critical factor in the development of domestic abuse services.

The domestic abuse co-located team links into the Specialist Domestic Violence Court initiative and MARAC and works closely with the wider partnership which includes refuge providers, outreach and floating support services, sexual violence services and other key statutory services. The co-located team includes:

Helpline – This was a new element of the service set up in 2010 and it is staffed by voluntary sector workers employed by VIDA. The helpline currently operates Monday to Friday from 10am – 4pm and to 7pm on Wednesdays; a community language speaker is available one morning a week. The helpline has access to an electronic database and can search for refuge places nationwide. Police Officers attending incidents ask for victim's consent for the helpline to proactively ring them and offer support.

Independent Domestic Violence Advocacy Service (IDVAS) – The IDVAS work with individuals or families assessed as being at high risk of serious harm or homicide; IDVAS are employed by VIDA. There are a number of IDVA posts funded by NHS Sheffield that work into the Jessop Wing (maternity services), Accident and Emergency and Genito-Urinary Medicine (GUM) Clinic.

Outreach Service – This service offers support to people at low to medium risk or those who need ongoing support after their risk level has been lowered (i.e. following service from IDVAS). The outreach support staffs are employed by the Domestic Abuse Outreach Service (DAOS) and include specialist workers offering services to male victims and people from BME communities. A group programme for adult female victims (Power to Change) and a self help group for current and former clients are also available as part of the outreach service. The outreach service is not based with the rest of the co-located team although the manager does spend some time at the team premises at police headquarters. Funded by Council Grant Aid.

Community Youth team – A Community Youth Team officer sits with the co-located team and picks up referrals of young people living within a family where they have experienced or are experiencing domestic abuse. This specialist role around domestic abuse was identified as the YOS became aware of an apparent increase in offending by young people displaying violence within the family, felt to result from modelling behaviour. As well as working on a one to one basis with young people the YOS officer also runs a group programme to support young people and challenge perceptions of domestic violence; Referrals are received from Children's Services, School's, Youth Justice and through the DV Helpline.

Women's Refuges

In addition to the co-located team, 34 units of refuge accommodation are commissioned from 3 providers (**Sheffield Women's Aid, Haven House and Ashiana**). Refuges offer shared accommodation (own bedroom with shared living room, kitchen, dining room and bathrooms) and some have a few self-contained flats. Refuge workers will assess the case and find a refuge place in another part of the UK if it is thought that the individual/family would be safer away from Sheffield.

Ashiana is also commissioned by Supporting People to provide floating support; Ashiana accept women from Black, Asian, Ethnic Minority and Refugee (BAMER) communities and their children including women experiencing forced marriage and honour-based violence. Ashiana is also funded by the Salvation Army to provide 9 bed spaces for victims of trafficking.

Young Women's Housing Project – is a specialist support project for young women (aged 16-25 yrs) who have been affected by sexual abuse, sexual exploitation or sexual/domestic violence. The YWHP is commissioned by Supporting People to provide 13 units of supported accommodation and floating support, they also receive SCC grant aid for therapeutic support.

Other key services in the city include:

Action Housing – is commissioned by Supporting People to provide a general domestic abuse housing support service; the organisation provides up to 60 units of floating support to both male and female victims of domestic abuse.

Housing Solutions – is the front line for homelessness in Sheffield. In the calendar year January-December 2011 Sheffield Homes awarded 144 domestic abuse priorities and Housing Solutions accepted 215 households for re-housing as homeless due to domestic abuse - a total of 359 households.

Sanctuary Scheme – based in Housing Solutions, this service is offered to domestic abuse victims and designs in additional security features known as target hardening to enable vulnerable individuals to stay safe in their home.

Governance

A Strategic Review of the Sheffield Domestic Abuse Partnership governance and commissioning arrangements has just been undertaken which means that governance structures are changing as may service providers, however service capacity is likely to remain unaffected or even increase.

The new Domestic Abuse Strategic Board will start meeting early in 2013 and will consider strategic issues around domestic abuse for the city. This group will report to the Safer and Sustainable Communities Partnership. There is a newly established Joint Commissioning Group for Domestic Abuse.

There is also a DAP Operational Group which meets bi-monthly. The Operational Group considers practice issues and multi agency working protocols. Sub groups are established as necessary to consider particular issues such as volunteering, service user involvement etc. A Provider Consultation Group is to be established early in 2013.

APPENDIX FIVE: GLOSSARY

A&E Accident & Emergency

ACPO Association of Chief Police Officers

ADCS Association of Directors of Children's Services

BCS British Crime Survey

CPA Care Programme Approach

CCG Clinical Commissioning Group

CPD Continuing Professional Development

DHR Domestic Homicide Review

IDVA Independent Domestic Violence Adviser

IMR Independent Management Review

KPI Key Performance Indicator

LMC Local Medical Committee

NHSCB National Health Service Commissioning Board

PCT Primary Care Trust

PPO Police Protection Order

SHSC Sheffield Health and Social Care Trust

STHFT Sheffield Teaching Hospitals NHS Foundation Trust

S47 Section 47 of the Children Act requires Local Authorities to cause enquiries to be made if significant harm of a child is suspected.

VCO Victim Care Officer

APPENDIX 6 – Letter from Home Office Quality Assurance Panel

Home Office

Violent Crime Unit
2 Marsham Street
London
SW1P 4DF

T **020 7035 4848**
F **020 7035 4745**
www.homeoffice.gov.uk

Alison Higgins
Domestic Abuse Manager
Domestic Abuse Co-ordination Team
Sheffield First Safer and Sustainable
Communities Partnership
New Bank House
Ground Floor
100 Queen Street
Sheffield
S1 2WA

26 July 2013

Dear Ms Higgins,

Thank you for submitting the Domestic Homicide Review (DHR) report from Sheffield to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in July.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report and I am pleased to tell you that it has been judged as adequate by the QA Panel.

However, there were some issues that the Panel felt might benefit from more detail and/or analysis, and which you may wish to consider before you publish the final report:

- including a brief synopsis of how the victim was killed;
- the Executive Summary, Overview Report, and Action Plan should be fully anonymised, and all identifiable references, including the date of death, removed in order to protect identities and comply with the Data Protection Act 1998, in accordance with paragraph 9.2 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews;
- clarification on whether the victim's employer were contacted and asked to participate in the review;
- amending the genogram to remove the cross through the symbol representing the victim so that it may cause less distress to the family;

- revisiting the coding system used for individuals in this report to make it easier to follow;
- including further detail on what is meant by “necessary domestic violence forms/paperwork,” (pages 25- 27 of the overview report); and
- revisit paragraph 3.1.3, to reflect that without approaching the victim’s friends and colleagues to participate in this process, one cannot know whether she disclosed to them or not.

The Panel does not need to see another version of the report, but we would ask you to include our letter as an appendix to the report when it is published.

Thank you.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel
Head of the Violent Crime Unit