DHR W06 2020

EXECUTIVE SUMMARY

Domestic Homicide Review

Into the death of 'Rose'

and her husband

'John'

both aged 66 years

Report by: Malcolm Ross M.Sc.

Date: June 2022

Contents

List of Abbreviations

[2]gether	*NHS Foundation Trust* that provided mental and social health care services
A&E	Accident and Emergency
AMHAT	Acute mental Health Assessment Team
ASC	Adult Social Care
CBS	Central Booking Service – NHS
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPN	Community Psychiatric Nurse
CWPT	Coventry and Warwick Partnership Trust
DASH	Domestic Abuse Stalking and Harassment – risk assessment form
DHR	Domestic Homicide Review
EDT	Emergency Duty Team – Social Services
G.P.	General Practitioner
HAU	Harm Assessment Unit – Police
H.M. Coroner	Her Majesty's Coroner
HOG	Home Office Guidance
IAPT	Improve Access to Psychological Therapies
ICB	Integrated Care Board
IMR	Individual Management Review
MAPPA	Multi Agency Public Protection Arrangement
MARAC	Multi Agency Risk Assessment Conference
NEOP	North Older People Team of Social Services.
OPAT	Outpatient's Parenteral Antibiotics Therapy
PVP	Protecting Vulnerable Persons (Unit) –Police
SWCSP	South Warwickshire Community Safety Partnership
SWCSPB	South Warwickshire Community Safety Partnership Board
STORM	System for Tasking & Operational Resource Management – Police Command and Control System
SWFT	South Warwickshire NHS Foundation Trust
UTI	Urinary Tract Infection
WDC	Warwick District Council
WMAS	West Midlands Ambulance Service

SOUTH WARWICKSHIRE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

INTO

THE DEATH OF ROSE

AND HER HUSBAND

JOHN

BOTH AGED 66 YEARS

The Domestic Homicide Review Panel express their sincere condolences to the family of Rose and her husband John.

The Pseudonyms Rose and John have been chosen by family members

1. Introduction

1.1. This Domestic Homicide Review (DHR) deals with the death of a 66 year old woman, Rose who was found hanged alongside her 66 year old husband, John in their home. Both were pronounced dead at the scene. A Police investigation commenced. H.M. Coroner for Warwickshire was informed. A postmortem revealed that both Rose and John had died from hanging.

1.2 South Warwickshire Community Safety Partnership (SSWCSP) was informed by Warwickshire Police of the deaths, and it was considered that the circumstances met the criteria for a Domestic Homicide Review which was confirmed by the Home Office on 5th January 2021. H.M. Coroner held an inquest and determined that both Rose and John had taken their own lives by suicide.

1.3 The SWCSP held an initial meeting in November 2020 and identified agencies that potentially had contact with both Rose and John prior to their deaths and the agencies were contacted and asked for details of their involvement with them.

1.4 The CSP and the report author have had continued contact with family members. They were provided with details of the Home Office Guidance and also an AAFDA leaflet offering support. The family members chose not to seek support from any support service.

1.5 Ten agencies confirmed contact with either Rose or John and they were asked to secure their files in preparation of the submission of an Individual Management Review (IMR), of a helpful report.

Contributors to the Review

1.6 The following agencies were requested to submit an IMR

- Adult Social Care (ASC)
- Clinical Commissioning Group (ICB)
- Coventry and Warwickshire NHS Partnership Trust (CWPT)
- South Warwickshire Foundation Trust (SWFT)
- Warwickshire Police
- West Midlands Ambulance Service (WMAS)
- Warwick District Council (WDC)

1.7 All IMR Authors confirmed their independence in that they had no practitioner dealings with either Rose or John

Review Panel Members

1.8 In accordance with the statutory guidance[1], a panel was established to oversee the process of the review. Mr Ross chaired the panel and also attended as author of the overview report. Other members of the panel and their professional responsibilities were:

- Marianne Rolfe – Head of Health and Community Protection, Warwick District Council
- Liz Young– Community Safety Manager, Warwick District Council
- Cheryl Bridges – Community Safety Manager, Warwickshire County Council
- Jonathon Toy – Group Manager, Trading Standards and Community Safety, Warwickshire County Council
- Emma Guest – Domestic Abuse Commissioner, Warwickshire County Council
- Rupert Pulling – Operations Manager, Adult Social Care, Warwickshire County Council
- Julie Vaughan – Lead Nurse for Adult Safeguarding, Safeguarding Team, Coventry and Warwickshire Partnership Trust
- Maxine Nicholls – Lead Professional for Safeguarding Adults, South Warwickshire Foundation Trust until July 2021 – Head of Safeguarding (Children and Adults) Coventry and Warwickshire Partnership Trust from July 2021.
- Fran Walsh – Named Professional for Safeguarding, Warwickshire Clinical Commissioning Group
- Jim Essex – Police Staff Manager, Statutory and Major Crime Review Unit, Warwickshire Police
- Julie Timerick – Detective Constable, Warwickshire Police
- Rachel Shuter – Refuge Manager
- Elaine Wallace – Housing Needs Manager, Warwick District Council
- Maureen Edwards – Business Coordinator, Independent Investigations, NHS England and NHS Improvement, Midlands and East of England
- Stavroula Sidiropoulou – Domestic Homicide Review Officer, Warwickshire County Council

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

- Malcolm Ross – Independent Chair and Author, Domestic Homicide Reviews
- John Ross – Independent Chair and Author, Domestic Homicide Reviews (Observer)

1.9 All panel members confirmed they had no direct involvement in the case, nor had line management responsibility for any of the practitioners involved. The panel was supported by a DHR administration officer. The business of the panel was conducted in an open and thorough manner. The meetings lacked defensiveness and sought to identify lessons and recommended appropriate actions to ensure that better outcomes for vulnerable people in these circumstances are more likely to occur as a result of the review having been undertaken. The DHR panel met on the following occasions

- 20th January 2021 (virtual meeting due to Covid19)
- 8th February 2021 (virtual meeting due to Covid19)
- 16th July 2021 (virtual meeting due to Covid)

Author of the Overview Report

1.10 The Home Office Guidance[i] (HOG) requires that:

- *"the review panel should appoint an independent chair of the panel who is responsible for managing and coordinating the review process and for producing the final overview report based on IMR's and any other evidence the review panel decides is relevant"*, and *"the review panel chair should, where possible, be an experienced individual who is not directly associated with any of the agencies involved in the review".*

1.11 The Independent Author, Mr Malcolm Ross, was appointed at an early stage of this review. He is a former Detective Superintendent with West Midlands Police where, as a Senior Investigating Officer, was responsible for the investigation of around 85 murders many involving domestic abuse. Since retiring in 1999, he has 23 years' experience in writing over 80 Serious Case Reviews, and post 2011, performing both roles of Chair and Author on over 60 Domestic Homicide Reviews. Prior to this review he has had no involvement either directly or indirectly with members of the family concerned or the delivery or management of services by any of the agencies. He has attended the meetings of the panel, the members of which have contributed to the process of the preparation of the report and recommendations and have helpfully commented on it.

Terms of Reference

1.12 The Terms of Reference for this review can be found at Appendix A.

2. Summary

2.1 This Domestic Homicide Review concerns the death of a couple who had been married for approximately 40 years. Each of them had medical issues and it is known that Rose had a history of alcohol abuse. It is also known that Rose had a history of drug abuse as well as a mental health history.

2.2 Evidence from health agencies support the fact that Rose had threatened or attempted suicide in the past. It is also known that on one occasion not long before their actual deaths John stopped a passer-by in front of his house and informed that there was to be a suicide. That resulted in the Police and health agencies attending and it was clear that the couple needed some assistance as they were finding life hard to cope with.

Following an assessment by the Crisis Team, it was decided that there was no mental health service follow up required. A senior Police officer arranged for numerous officers to contact the couple over that weekend to ensure their safety and offer support.

2.3 A lady who regularly delivered prescribed medicine and medical support equipment to the house entered the house and found both Rose and John hanging from a loft hatch in one of the ceilings in their ground floor flat.

2.4 Found at the scene were two sets of small step type ladders, both of the couple had some form of nooses around their necks. Rose was found to have wide sticking plaster around one wrist but with a length of the same plaster hanging loose. The Pathologist is unable to say whether the hanging piece of sticking plaster had at some stage been wrapped around her other wrist.

2.5 In these circumstances it is impossible to say what actually happened moments before the death of the couple, whether one of them prepared the other, whether they prepared themselves, whether one of them helped the other onto the steps and who stepped off the steps first are questions that will never be answered.

2.6 From information gleaned from agencies, family and friends, it would appear that prior to Rose and John meeting, John was a fun loving, family orientated man who was well regarded by his sisters.

2.7 Prior to Rose meeting John, information indicates that she married and two daughters. Her husband died. It appears that there was no engagement post adoption between the daughters and their mother but there is a suggestion that one of the daughters attempted to contact her mother not long before her mother's death. This cannot be verified. Neither of the daughters can be traced.

2.8 According to John's relatives, once they were married the couple's lifestyle changed in that they ignored the rest of the family and moved from the Coventry area into Warwick. One of John's sisters indicates she hadn't seen her brother for 10 years when he suddenly turned up at her house saying that his wife had thrown him out of the house and he was sleeping on park benches. This apparently was not an unusual situation.

2.9 Evidence from the local Salvation Army and Homeless agencies suggest he was a regular attender at night shelters and he often slept on benches in a local park. However, information from people he spoke to indicates that John was extremely fond of his wife and would do anything to help her with her quite serious mental ill health.

2.10 Evidence from one of the homeless hostels indicates that John would sleep rough and away from home for anything between one day and two weeks whilst Rose was having one of her 'episodes'. He would only return when she asked him to but he would phone her every day and make sure she was alright. On occasions, he stated he would never want his own tenancy as he couldn't leave his wife as she needed him. A manager of another shelter described John as 'an absolute pleasure to have around and mostly in a joyful mood, known to us for all of his singing'.

2.11 John would report to shelter staff that Rose would get verbally and physically aggressive towards him which would lead to her throwing him out on the streets. After a few weeks, when she had calmed down and had taken her medication she would allow him to return home. It appears that she was often non-concordant with her medication. It is also apparent that John would attend soup kitchens for periods of sometimes between 3-6 months. If the staff at the soup kitchens noticed he hadn't attended, they assumed his wife had let him back into the house.

3. Chronology

3.1 The integrated chronology for this review amounts to over 160 pages. It is not intended to repeat the Overview Report in this Executive Summary but the below is considered pertinent information to illustrate the lifestyle of Rose and John and their numerous engagements with agencies, especially heath agencies and the support they were offered, which was often declined.

3.2 Prior to the scoping dates of this review there are events that are of interest and worthy of mention. Rose was known to have mental health problems which included suffering with acute psychotic state and had a history of illicit substance misuse, alcohol dependent, eating disorders and had made several suicide attempts. It is noted that her mental health was exacerbated by alcohol use and amphetamine use. She also had physical health problems. She believed that John was a paedophile and she had hurt him by cutting his arms. Rose's brother had taken his own life by hanging some years before.

3.3 During 2011, there were several engagements with Rose with health practitioners. In April she disclosed that she had not been taking her medication but had been using amphetamines instead. She had told John to leave the household in April, only to have him back again in May but to exclude him again in July.

3.4 In August 2011, Rose was discharge her from the Community Mental Health Team for non-attendance and her case was closed. There is nothing to indicate that there were attempts to engage with her. She had no more contact with Mental Health Services from that date in August 2011 until July 2012.

3.5 In July 2012, Rose self-referred to the Crisis Team feeling low and depressed and not knowing what to do. She reported being disabled and unable to leave the house because John was not allowing her to use her mobility scooter.

3.6 Rose stated that she couldn't cope with John 'going off' and 'clearing off' to walk around parks and streets of Leamington. He didn't do anything around the home, he was verbally abusive towards her, he prevented her from talking to neighbours and she claims he would hide bills that were in her name so they wouldn't get paid. She reported to the Crisis Team that she did not feel at risk from John but he was a controlling person. No imminent risks were identified and a follow up appointment was made with the Crisis Team. She was given contact details for a mental health helpline.

3.7 CWPT made a home visit later in July 2012 and Rose reported that John was staying at the Salvation Army Hostel in Leamington and sleeping rough in the park. She said that she would not let him back into the flat and she wanted to end the relationship. She was offered information regarding Mental Health Matters and also domestic abuse agencies but she intimated that she would not be calling these support services. She was however encouraged to consider contacting the diabetes nurse for a review.

3.8 In September 2012, Rose called the Police saying there were seven people inside her flat who had come through her television and they were trying to hand her over to a vicar. She threatened to jump out of the window from the first floor if the Police didn't attend. When Police arrived at the flat, they found that Rose had barricaded herself into the property. The Ambulance and out of hours GP were asked to attend and the incident was tagged for The Protecting Vulnerable People Team and the Safer Neighbourhood Team.

3.9 The following day, an out of hours GP made a call to Rose to make a medication review. The GP spoke to John who told him that Rose was better and resting but she was unable to talk about the previous day's events and she described that day as a 'bad one'. She declined a home visit but agreed to have a telephone conversation the following day.

3.10 At a meeting in September 2012 with the Crisis Team Rose said she was getting on much better with her husband and her main concern was her physical health and that she would require no more crises follow ups and that if she needed help, she would ring for support. The CWPT case was closed.

3.11 In February 2013, Rose self-referred to the Crisis Team. She reported being scared of John who was threatening her and she was distressed about their relationship. She was reluctant to call the Police when she was advised to do so, and she declined a home visit.

3.12 Later in May 2013, the Adult Safeguarding Team called the Crisis Team stating that Rose had disclosed several areas of concern about her husband and that he was selling her medication, driving without insurance and watching children in the park. The Crisis Team Nurse considered that when Rose was unwell she would become suspicious about John. Rose was offered an appointment for a mental health assessment but she declined and said she would call the Crisis Team if she felt the need.

3.13 Rose's suspicions about John continued into 2014, she thinking he was selling her medication. She felt threatened by his and she was referred to '[2]gether' [2] and the Community Psychiatric Nurse.

3.14 In May 2014, a neighbour called the Police as she could hear a female screaming for help from Rose's property. The neighbour could hear somebody screaming 'you've killed her'. The Police attended and spoke to Rose who was alone in the property and had been dreaming. To reassure her, Police Officers searched the flat and the incident was tagged for the Harm Assessment Unit (HAU).

3.15 During May, June and September 2014, Rose reported several more incidents of John threatening her and attacking her. None of the allegations were supported or found to be true and, on most occasions, John was out of the house at the time. Later in September Rose ran from her house while members of the Crisis Team and her GP were visiting her. She had no shoes on at the time. The police mounted a search with dogs and a helicopter. Rose was found and detain under Section 136 Mental Health Act and taken to a place of safety.

3.16 In March 2015, Rose went to a neighbour's house with a knife saying that she had killed John. Rose was shouting for her mother and someone was outside calling for her baby. An ambulance attended and Rose went voluntarily for a mental health assessment. Rose was referred to the Integrated Practice Unit (IPU) of the Mental Health Recovery Team. Following the assessment, she declined a referral to the Recovery partnership for support regarding amphetamine use. Due to her mental health improving she was deemed not to require a mental health follow up.

3.17 In May 2015, Rose called the Police stating a man was sitting in a car outside her flat and that he had a stick with number 7 on it and an infra-red light. She said she had already put a knife up to him. Police requested an Ambulance. It was deemed she lacked capacity and required treatment so further officers were called to get Rose into the Ambulance as she had become aggressive. A Vulnerable Adult incident was created, tagged for the Harm Assessment unit and a referral made to mental health services. Rose's neighbour reported the incident to the housing authority. Rose was admitted to hospital and discharged two days later back into the care of her GP.

3.18 In June July and August 2015, Rose called the police stating there were men in her house and other similar allegations, none of which proved to be true. On each occasion

[2] [2]gether *NHS Foundation Trust* ([2]gether) - an *NHS Foundation Trust* that provided mental and social health care services

she was referred for Mental Health Assessment and treatment. Rose did not have any further contact with mental health services until March 2016.

3.19 During the remainder of 2016, Rose made numerous calls to the police stating men were in her house, John was attacking her and other complaints including her wish to die, all of which indicated that her mental health was deteriorating.

3.20 In November 2016, a home visit from CWPT was made. Both Rose and John were present. She admitted using amphetamines as a coping strategy but denied any recent substance use. She declined psychological support although admitted occasionally hearing voices. She indicated her main stress triggers was anxiety caused by arguments between her and John. She said her pain from her physical health issues sometimes made her feel like she wanted to end her life. Later that day the GP received feedback from the earlier meeting saying that Rose had been assessed and there were no concerns regarding her mental state and there was no role at this time for the Crisis Team. Rose had not been allocated a Care Coordinator and her GP was advised that a referral to the Community Referral Team had been closed.

3.21 In January 2017, Rose called the police concerned about a yellow van parked outside her house. Nothing untoward was found. Later that day Rose turned on a neighbour who was sitting with her and threatened to stab her. The Crisis Team and the police attended. Rose calmed down having been deemed she was safe to leave at home on her own.

3.22 During the remainder of 2017, Rose had numerous visits to hospital for a variety of treatment regarding her medical conditions.

3.23 In March and again in May 2017, Rose called the police in crisis. On the latter occasion police found knives in the house and in the garden and an air weapon on the lounge floor. Police destroyed all of the weapons with Rose's consent. She was taken to the local hospital. A urine drugs screen proved positive for amphetamines, methamphetamine (crystal meth) and benzodiazepines. Upon her discharge from hospital, Rose knocked the door of a random house. The occupant invited her in for a cup of tea. Rose said the Police were looking for her. After Rose had left, the occupant called the Police. Rose was seen at home by the Police.

3.24 In January 2020, Rose was admitted to hospital for investigations into abdominal pain and suffering from anxiety, depression and suicidal ideations. John was allowed to stay with her. However, just after 10.00pm one evening, the hospital called the Police as it was alleged that John had dragged Rose out of bed and she had discharged herself. The hospital were complaining that John was verbally abusive towards staff. Police were unable to attend until 6.00am the following morning where they saw Rose at home. She said she wanted to leave hospital and that John hadn't dragged her anywhere. The hospital confirmed that she did not need to return for further treatment.

3.25 Throughout 2020, Rose was admitted to hospital on several occasions for treatment for her illnesses. In April 2020 after having a 'feeling in her head', she took 50 paracetamol tablets. Rose was referred to the Acute Mental Health Assessment Team (AMHAT) who advised a referral to Adult Social Care as Rose had disclosed to staff that she and John had intended to overdose together, but it was only Rose who took the overdose.

3.26 In July 2020, an ambulance was called as Rose was in severe abdominal pain. She was not taken to hospital but advised to see her GP the following day which she did where she expressed the opinion that she wished she 'was not here'.

3.27 Rose had an already scheduled assessment with Recovery team. Both Rose and John declined the offer of a care package saying that they didn't want anybody to come to

the house. John did however agree to Carer's referral as he was getting older and having to care for Rose whilst having to support Rose with her physical and mental health problems.

3.28 In September 2020, an ambulance attended the home address of Rose and John as a result of a triage nurse from Mental Health Services calling the police saying that she had been speaking to John who said he was going to kill both himself and also Rose if he 'couldn't find a way to solve this' problem. The nurse had tried to speak and take details from John for a referral and John had ended the call saying that he was being a pain. Rose could be heard in the background saying that they needed help. An Adult Risk Assessment was completed which was graded as Standard. No referrals were made. The ambulance staff considered that John was fine and they didn't have any concerns for his welfare and that John and Rose were looking after each other. A referral was made to MIND[3]. MIND attempted to contact Rose and John but their phone was constantly engaged.

3.29 John made a similar call to the Central Booking service of the NHS a few days later. The Mental Health Team called their GP and they were seen by the Crisis Team. No mental health concerns were identified. However later that afternoon John ran into the street outside his house and handed a complete stranger a note saying 'Please phone CRISIS. Suicide about to happen. Do not phone. Knock the door'. The police were called and attended with the Mental Health Triage Team and a CPN, (Community Psychiatric Nurse). The EDT (Emergency Duty Team) also attended. They found a double noose that had been made hanging from the loft hatch. A Vulnerable Adults referral was made, and an Adult Risk Assessment was made that measured High Risk.

3.30 Both Rose and John were acknowledged as having significant medical and mental health needs and that John was Rose's carer. Rose indicated that she had asked John to suffocate her due to her chronic situation. He had reportedly tried but couldn't go through with it. John was not arrested. Consideration was given to that, but no benefit could be seen as the couple were in crisis. It was deemed that the couple were in need of multi-agency support and safeguarding and resorting to a criminal justice outcome was not deemed appropriate.

3.31 A Multi-agency Adult Safeguarding Strategy Meeting was held to consider the welfare of both John and Rose. The consensus was that the crisis had passed, and that Rose was in a better place mentally with the operation to remove her catheter bag to look forward to. It was decided that they would benefit from a Social Worker to arrange emotional support and this was to be actioned on the following Monday. A Section 42 Safeguarding Enquiry was opened by Adult Social Care. Police officers were tasked to maintain regular contact with John and Rose over the forthcoming weekend, which they did and ensured that they were safe.

3.32 During October 2020, IAPT[4] was discussed with Rose several times but she declined that service. She was assessed by the Older Persons Team as having no care and support needs. A District Nurse attended the family home. Rose was distressed and disclosed previous suicidal attempts. She was feeling depressed. The District Nurse suggested a referral to Mental Health Services but both Rose and John declined that suggestion. The District Nurse contacted Rose's GP. Both Rose and John consented to a referral being made to a Dietician and Continence Team.

[3] Mind is a mental health charity in England and Wales. Founded in 1946 as the National Association for Mental Health. Mind offers information and advice to people with mental health problems and lobbies government and local authorities on their behalf.

[4] IAPT – **I**mproving **A**ccess to **P**sychological **T**herapies

3.33 Towards the end of October Rose was admitted to hospital with breathing problems. She was discharged home two days later after being prescribed medication.

3.34 Rose's Social Prescriber called at the home address to deliver medical supplies. She let herself into the flat and found both Rose and John hanging from the loft hatch. Police and an ambulance attended. Both were pronounced dead at the scene. Several suicide notes were found addressed to family members and one was addressed to a Detective Officer who had visited them over the weekend.

3.35 A police investigation commenced and Postmortem examinations were conducted. Both had died from hanging. The Police were unable to conclude that any criminal act had taken place. The matter was referred to H.M Coroner for Warwickshire who held an inquest into their deaths and determined that both Rose and John had taken their own lives by suicide and they had both intended to do so.

4. Analysis and Recommendation

4.1 The initial Police enquiry considered whether both John and Rose had either taken their lives simultaneously, or one of them had assisted the other in their death and then taken their own life. This hypothesis was based on the apparent immobility of Rose and whether or not she would have been able to step onto a small set of steps in order to end her life. After an investigation, the Police were unable to conclude that any criminal act had taken place. The matter was referred to H.M. Coroner for Warwickshire.

4.2 There is a suggestion that Rose was a controlling influence on John and this review examined all of the information obtained from agencies, family, friends and colleagues to ascertain if the controlling behaviour by Rose on John met the definition of coercive and controlling behaviour as described by The Serious Crimes Act 2015.

4.3 There is no doubt that some if not all of this definition could pertain to the relationship between Rose and John but it has to be considered at the same time that it was known that Rose had significant physical and mental conditions to which her drug abuse exacerbated the situation between them.

4.4 What is known for certain is that information from friends and family members indicates that John and Rose were very much in love but Rose's mental health and medical conditions pushed them both to the limit of toleration which resulted in friction between them. That is when John left, or was ordered to leave by Rose, to let the situation calm down and each of them had time and space from each other.

4.5 It is not known where Rose obtained her illegal supply of drugs but she admitted that she used such substances, sometimes instead of her prescribed medication.

4.6 It is clear that during her numerous attendances for medical treatment, Rose disclosed that living with her conditions took its toll on her and she was often at the end of her tether. She said often that she wished she 'was not here' and described how she and John would plan to take their own lives. On one occasion she disclosed that she had asked John to suffocate her but he could not go through with that.

4.7 When the circumstances of the various disclosures are examined it is clear that there was a lack of professional curiosity among health professionals to consider the wider issues of possible domestic abuse between Rose and John. With that John was often sleeping rough and either asked or told to leave the house by Rose when she was having, what is described, as one of her 'episodes'. Again, there seems to have been an absence of thinking domestic abuse but rather situations arose because of Rose's mental ill health, often caused by illegal substances. The accepted practice of making

routine enquires regarding the possibility of domestic abuse does not appear to have been adopted.

4.8 It is hence the reason why the following recommendations are made:

Recommendation No. 1.

The Clinical Commissioning Group to provide assurance and evidence to the South Warwickshire Community Safety Partnership that the training for all staff includes professional curiosity and holistic and person-centred assessment, to ensure that in such circumstances in the future robust and immediate action will be taken to safeguard vulnerable individuals.

Recommendation No. 2.

The Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust to provide reassurance to the South Warwickshire Community Safety Partnership that the recommendation of Warwickshire's Violence Against Women and Girls Board that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Social Prescriber, chronic pain and medication

4.9 Rose's support was a short-term care package, but there was recognition of the need for some form of on-going support, hence the Social Prescriber was arranged for her. Social Prescribers have an important role in the health care system, but in this case it appeared that Rose's Social Prescriber was the sole individual making house visits to both Rose and John. The delivery of medicines and equipment is important but Social Prescribers are not trained or alert to the need to ask and observe signs regarding non-compliance with medication and therefore would be unaware of stockpiling particularly when pain and or mental health medication is involved. (It is known that the family members recovered a significant stockpile of unused medication from the home after the death of Rose and John).

4.10 Social prescribing complements other approaches, such as active signposting. This is a 'light touch' approach where existing staff in local agencies provide information to signpost people to services, using local knowledge and resource directories'[5]

4.11 Rose suffered from chronic pain for a long time caused by a combination of her numerous medical conditions. It is known that chronic pain is a significant risk factor for death by suicide. NICE[6] published guidance[7] for assessing and managing chronic primary and chronic secondary pain in people over 16 years of age in April 2021.

4.12 Rose had a complex medical history and there are 33 references throughout this report to her pain, many linked to different ailments and many acute rather than chronic. There is also reference to her self-management of her pain and it is clear that

[5] NHS Social Prescribing www.england.nhs.uk/personalisedcare/social-prescribing

[6] National Institute for Clinical Excellence

[7] Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain NICE guideline [NG193] Published: 07 April 2021 and Guidance on Neuropathic Pain Sept 2020.

compliance with her medication was on her own terms, using prescribed and illegal medication.

4.13 Better oversight of her medication from health agencies may have helped professionals understand her physical challenges separately from her mental health ones. This is acknowledged with the development of the MARAM mentioned below. Good practice would have been for the GP surgery to have discussed and proactively managed them as part of their Multi Discipline Team meetings, which they now recognise and have been implemented for complex individuals, again mentioned below.

Recommendation No 3

The Clinical Commissioning Group and acute providers in Coventry and Warwickshire give assurance to the South Warwickshire Community Safety Partnership that the NICE Guidance of 2020 and 2021 regarding the management of primary and secondary chronic pain and Neuropathic pain is being adhered to locally and that any learning from this Domestic Homicide Review is shared throughawareness raising and training.

4.14 The Review Panel has caused enquiries to be made with ICB Pharmacy colleagues as to whether the assorted medication prescribed to Rose and to John could have impacted on their actions and the outcome of their lives. The opinion is that the prescribed medication cannot be identified as an obvious cause for their suicide.

4.15 In addition to the overview Recommendations, agencies have also been encouraged to make their own recommendations and/or to identify lessons learned from this case.

Warwickshire Police

4.16 Warwickshire Police had significant dealings with Rose and John since 2008 and record that on at least 20 occasions, incidents were referred to Mental Health Services by the Police Harm Assessment Unit. There were no incidents of domestic abuse reported to the Police and from the dealings that the Police had with Rose and John, neither of them considered themselves to be the victim of domestic abuse.

4.17 Warwickshire Police have a structured process to deal with mental health issues. This includes training officers in responding to people with mental health issues and the creation of Mental Health Triage Teams which consists of two officers and a mental health nurse having the nurse on board gives access to the necessary NHS records.

4.18 Warwickshire Police IMR make five internal recommendations which include:

- The continued use of the Mental Health Triage Team
- The creation of the Adults at Risk Team who will manage risk using Problem Solving Plans
- To agree terms of reference/protocol between the Police and other agencies to ensure the most appropriate agency responds in a timely manner to calls for services.
- To create a clear indication of what is required of the Safer Neighbourhood Team Officers by either tagging or the use of the Storm Log (command control system)
- To ensure that ‘adults at risk’ or ‘vulnerable adults’ tool kits are readily available on the Force intranet system.

Coventry and Warwickshire Clinical Commissioning Group

4.19 The ICB IMR indicates that they had significant contacts with Rose during the period of the scope of this review which amounts to in the region of 700 consultations between 2011 and 2020.

4.20 Whilst John was also known to the ICB, the number of contacts with him was considerably less.

4.21 The ICB IMR indicates numerous lessons that have been learnt from this case which include:

- Both John and Rose had significant difficulties in their earlier years including abuse and drug dependence and Rose's diagnoses of psychosis may have impacted on their resilience and ability to cope with their deteriorating health. This was evidenced by increasing contact with many agencies.
- Whilst there were red flag warnings, i.e., previous overdoses (Rose) and suffocation attempts (John on Rose), they also demonstrated improving mental health on occasions which indicated a chaotic, erratic, and changing picture.
- The GP practice were very responsive to the needs of both.
- On at least two occasions, the couple were in telephone contact with different GPs at the same time and it is not evident whether the practice were aware of this and took a joint management approach.
- There is no evidence of routine enquiry in relation to domestic abuse raised by the GPs.
- It is not clear how a decision was reached by Social Services that there were no safeguarding concerns.
- Rose's medication was changed by Rose and John without the GP being consulted.
- The lack of oversight of their care and medicine use may have affected the mental health of either or both Rose and John.
- On occasions, Rose was unwilling to accept help which may have improved her mental health/social support.
- The impact of the Covid pandemic on the number of face-to-face contacts contributed to a lack of oversight, possibly making them feel isolated.
- No one agency had clear oversight and took the lead to manage their complex situation.
- Despite so many agencies being involved, the interventions used did not keep them both safe and the degree of risk was underestimated.
- The availability of respite requested by Rose a week before their deaths may have been a timely intervention.

4.22 ICB IMR make six internal recommendations:

- Review how vulnerable adults are identified from the practice lists.
- Review how vulnerable adults are flagged within the practice.
- Review how processes for information sharing within the practice contributes to the ongoing management and timely referrals of vulnerable adults.
- Review processes for flagging patients with previous drug dependencies and/or multiple medications.

- Review how escalations in number of patient attendances are picked up.
- Plan an update of Domestic Abuse Training for all staff using case study examples to imbed routine enquiry into clinical practise.

Coventry and Warwickshire Partnership Trust

4.23 Coventry and Warwickshire Partnership Trust had known Rose since she was 15 years of age and that she had a significant long history of mental health problems. She also had a diagnosis of drug induced psychosis and paranoia. She was treated for a long time for depression and had significant urinary problems which resulted in a catheter being fitted. This caused extensive health problems.

4.24 Records indicate that Rose sought support from the mental health Crisis Team when other appropriate support had been offered but declined. She was also referred to CRUSE bereavement support and domestic abuse services, Recovery Partnership, Mental Health Matters, Samaritans, and a variety of psychological support but Rose declined all of these offers preferring to rely on the mental health Crisis Team.

4.25 Despite disclosures and insinuation from both Rose and John of abusive behaviours from each other, their relationship was observed to be loving and supportive and there is evidence that John appeared to be very caring towards Rose, particularly in the last months leading to their deaths. The CWPT author is of the opinion that both Rose and John appear to have normalised these behaviours as they had been going on for several years and were further complicated by Rose's use of illicit drugs and fluctuating mental health.

4.26 There is evidence however, that Rose was offered information and telephone numbers for domestic abuse services, but she declined these always stating she would rather contact the mental health Crisis Team. The risks to John from Rose were noted but these risks were not considered in the context of domestic abuse. Disclosures made after 2014 should have considered the use of a DASH form, but as domestic abuse was not considered within the context of their behaviour, this did not happen. However, identified risk factors were shared between CWPT professionals by a multi-disciplinary meeting and were entered on the Trust's electronic system. Externally, information was shared with other agencies such as the GP, Police, Ambulance Service, and Local Authority services.

4.27 From the review of this case, CWPT has put the following training in place:

- CWPT now provide a four-hour level 3 domestic abuse training module for front line staff which includes the use of the DASH risk assessment form. All front-line staff are still receiving training at level 2 or 3 on domestic abuse and adult/child safeguarding.
- CWPT has worked with SWFT to deliver a level 3 safeguarding training package – Domestic Abuse and Older people.

4.28 The CWPT IMR makes one formal agency recommendation:

- CWPT level 3 domestic abuse/DASH training to be amended to include guidance for staff on managing disclosures made when an individual is unwell, ensuring that disclosures are revisited when the patient has improved. Staff to ensure that the needs of the other members of the household are also taken into consideration and appropriate support is offered.

South Warwickshire NHS Foundation Trust (SWFT)

4.29 Rose was known to numerous departments of SWFT in both the community and Warwick hospital. CWPT IMR, records indicate that staff describe them as being devoted and besotted with each other and had openly stated that they could not live without one another. Rose was described as the more dominant of the two. It is also evident SWFT staff appear to view Rose and John not as perpetrators or victims of abuse but as vulnerable individuals due to their circumstances.

4.30 SWFT IMR indicates that staff recognised any risks and escalated them appropriately but describes the lack of confidence to act autonomously as practitioners regarding the completion of a DASH risk assessment and referring to MARAC. To remedy this, SWFT from the 1st April 2021 have introduced mandatory DASH training and there is now a Named Nurse for Domestic Abuse and in addition to DASH training there is Domestic Abuse in Older Adults training.

4.31 The IMR makes two formal recommendations for SWFT:

- Review and inform staff of the process for Safeguarding advice forms
- A process for ensuring additional notes/risks are incorporated with original patient's admission notes for day surgery.

Warwick District Council

4.32 Warwick District Council returned the IMR indicating that there were 312 pages of records regarding housing benefit and council tax between 2010 and 2020 concerning Rose and John. The IMR indicates that the case has not led to any specific learning. However, it reinforces the view that the Council is suitably equipped to deal with safeguarding concerns and refers to a specific safeguarding policy which is in force and applies to all Council staff, members, volunteers and contractors employed by the Council.

West Midlands Ambulance Service

4.33 The IMR confirms that all policies, procedures and guidance tools were followed correctly by attending clinicians throughout their contact with Rose and John. WMAS have a clear and robust domestic abuse guidance document in place which is accessible to all staff alongside a single point of contact referral line.

Warwickshire County Council Adult Social Care.

4.34 Adult Social Care were advised in May 2013 of a meeting between Rose and CWPT. She had been referred to an Independent Advocate for support regarding accommodation as she was struggling. There was no risk identified during the visit and Adult Social Care Safeguarding Team was advised of this meeting.

4.35 In June 2014, a member of staff from 2gether contacted the Crisis Team. It was reported that Rose had alleged that John had been trying to get access to her flat and had hit her in the face. Adult Social Service Safeguarding Team was informed.

4.36 Adult Social Care became involved again with Rose and John in September 2020, as a result of the incident when a member of the public had been passed a 'suicide note' by John. John later disclosed that he had tried to smother Rose with a pillow at her request and, when that had been unsuccessful, the following day he had tried again this time with cling film wrapped around the pillow.

4.37 Warwickshire County Council has a Suicide Prevention and Partnership Manager who has made comment about Adult Social Care's involvement with those who take their lives by suicide or who are at risk of taking such action. The focus of the Suicide Prevention Partnership is on wider population-level interventions to help reduce deaths

by suicide rather than referrals for specific individuals. The Partnership Manager's advice to Adult Social Care, in circumstances where they become aware of someone at risk of suicide, is to make an urgent referral into the CWPT Access Hub or, of course, call 999.

4.38 With regard to such circumstances the Partnership Manager suggests that Adult Social Care staff are aware of the referral routes into CWPT andmakes the following recommendation .

Recommendation No. 4

Adult Social Care to ensure that all their staff are made aware of the referral routes into Coventry and Warwick Partnership Trust in cases where individuals are deemed at risk of suicide, by being trained appropriately in suicide prevention.

4.39 Following a visit to the couple on 11th September 2020 it was determined that there was no requirement for formal Adult Safeguarding Care Services but a Section 42 safeguarding enquiry to provide short term social care support would be opened. Neither Rose nor John were identified as being victims or perpetrators of domestic abuse.

4.40 The Adult Social Care IMR author considers that it was clear that eligibility thresholds were not met in order for Rose and John to receive statutory services, however it was clear that they required support, albeit on an emotional level which was available via mental health and physical health organisations.

4.41 The Adult Social Care IMR makes 5 learning points:

- Rose was spoken to alone on two occasions and this could have been done on other visits
- There was a significant delay in the completion of the DASH risk assessment (4 weeks from the initial referral date). This delay may have altered the responses that Rose gave. The outcome of the DASH was a low score therefore no referral to MARAC was required or necessary. This learning applies to all agencies involved as any agency who visited Rose upon the initial contact could have undertaken the DASH risk assessment.
- The DASH risk assessment may not however have been the most appropriate tool to have used in this specific case, as Rose did not see herself as being a victim, her husband as being a perpetrator nor consider herself subject to abuse. When working with individuals who are suicidal, a tool such as STORM would be far more appropriate. This would have enabled a dialogue to open to explore suicidal intent and plans. Protective factors could have been established along with a risk management plan. Consideration could also have been given to a working with a risk tool, to explore thoughts relating to suicide thereby allowing Rose and John to establish how they would manage these risks in future.
- Online support groups and virtual support for them both could have been considered although other forms of support had been offered and

were turned down as these did not appear to address the central issue of Rose's pain.

- Other community support networks could have been explored such as a visiting buddy, MIND Mental Health support workers, forums for people who experience specific physical health issues and associated pain, as detailed above.

4.42 It appears there could have been a stronger multi-disciplinary approach to consider Rose's clinical and social needs more holistically. For Rose there are clear impacts on her mental health from her physical health conditions but there is little evidence of physical health, mental health and social care practitioners having a collective conversation to review her situation. Given the level of complexity here this may have been beneficial.

Recommendation No 5

The Clinical Commissioning Group and Adult Social Care consider the use of Multi-Disciplinary Team meetings in complex cases where there are mental health, physical health and social care needs, to ensure a full exchange of information between agencies regarding people at risk.

Independent Office for Police Conduct

4.43 Following the deaths of Rose and John, and because Warwickshire Police Officers had been in contact with the couple a short time before their deaths, Warwickshire Police rightly made a referral to the Independent Office of Police Conduct (IOPC). A comprehensive report was submitted by Warwickshire Police which was examined by a Senior Case Work Manager at the IOPC.

4.44 The IOPC replied to Warwickshire Police. The IOPC had concluded that

> "There is nothing to indicate or suggest that any officer in their dealings with [Rose and John], behaved in a manner which would constitute criminal or misconduct proceedings."

The reply went on to say:

> "The actions of the police in this instance were caring and compassionate. They sought assistance from other agencies, putting a plan in place and clearly looked for longer term support for the couple." and…
>
> "This case clearly demonstrates the compassion and care displayed by the officers who had dealings with this couple prior to their demise. I feel that all officers should be commended for their diligence in the manner in which they dealt with the couple"

5. Conclusions

5.1 Both John and Rose were elderly people with significant medical health issues. Rose in particular indulged in the use of illegal drugs. Rose was ill for years with chronic pain

and was waiting for hospital treatment. On occasions Rose found living with her painful conditions unbearable.

5.2 Information from all who knew Rose and John commented on how, when things got too much for Rose, she would ask/tell John to leave the house. He would then sleep rough, sometimes for weeks at a time, before he was allowed back into the family home.

5.3 However there was a lack of professional curiosity shown by practitioners when Rose indicated that she wanted to end her life, and a more assertive response could have been shown towards the consideration of support for both her and John. Similarly, when Rose disclosed that John had tried to suffocate her, (at her instigation) and could not go through with it, there was another missed opportunity to take positive action. There were also missed opportunities to make Routine Enquiries of Rose when she attended at her many medical appointments, and when it was discovered that she had been non-concordant with her medication.

5.4 The Overview Recommendations are made with a view to preventing these circumstances occurring again and for practitioners to be reminded of the importance of professional curiosity and routine enquiries.

5.5 The Individual Agency Recommendations are made in order to address those issues agencies have identified and the DHR panel endorses those recommendations.

Bibliography

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews – Home Office 2016

Overview Report Recommendations

Recommendation No. 1.

The Clinical Commissioning Group to provide assurance and evidence to the South Warwickshire Community Safety Partnership that the training for all staff includes issues around professional curiosity and holistic and person-centred assessment, to ensure that in such circumstances in the future robust and immediate action will be taken to safeguard vulnerable individuals.

Recommendation No. 2.

The Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and South Warwickshire NHS Foundation Trust to provide reassurance to the South Warwickshire Community Safety Partnership that the recommendation of the Warwickshire's Violence Against Women and Girls Board that Routine Enquiry into Domestic Abuse is embedded into training, policy and procedure.

Recommendation No. 3

The Clinical Commissioning Group and acute providers in Coventry and Warwickshire give assurance to the South Warwickshire Community Safety Partnership that the NICE Guidance of 2020 and 2021 regarding the management of primary and secondary chronic pain and Neuropathic pain is being adhered to locally and that any learning from this Domestic Homicide Review is shared in awareness and training.

Recommendation No. 4

Adult Social Care to ensure that all their staff are made aware of the referral routes into the Coventry and Warwick Partnership Trust in cases where individuals are deemed at risk of suicide, by being trained appropriately in suicide prevention.

Recommendation No 5

The Clinical Commissioning Group and Adult Social Care consider the use of Multi-Disciplinary Team meetings in complex cases where there are mental health, physical health, and social care needs, to ensure a full exchange of information between agencies regarding people at risk.

Individual Agency Recommendations

Warwickshire Police

- The continued use of the Mental Health Triage Team
- The creation of the Adults at Risk Team who will manage risk using Problem Solving Plans
- To agree terms of reference/protocol between the Police and other agencies to ensure the most appropriate agency responds in a timely manner to calls for services.
- To create a clear indication of what is required of the Safer Neighbourhood Team Officers by either tagging or the use of the Storm Log (command control system)
- To ensure that 'adults at risk' or 'vulnerable adults' tool kits are readily available on the Force intranet system.

Warwickshire Clinical Commissioning Group

- Review how vulnerable adults are identified from the practice lists.
- Review how vulnerable adults are flagged within the practice.
- Review how processes for information sharing within the practice contributes to the ongoing management and timely referrals of vulnerable adults.
- Review processes for flagging patients with previous drug dependencies and/or multiple medications.
- Review how escalations in number of patient attendances are picked up.
- Plan an update of Domestic Abuse Accredited Training for all staff using case study examples to imbed routine enquiry into clinical practise.

Coventry and Warwick Partnership Trust

- CWPT level 3 domestic abuse/DASH training to be amended to include guidance for staff on managing disclosures made when an individual is unwell, ensuring that disclosures are revisited when the patient has improved. Staff to ensure that the needs of the other members of the household are also taken into consideration and appropriate support is offered.

South Warwick NHS Foundation Trust

- Review and inform staff of the process for Safeguarding advice forms
- A process for ensuring additional notes/risks is incorporated with patient's original admission notes for day surgery.

Warwickshire County Council Adult Social Care

- Rose was spoken to alone on two occasions and this could have been done on other visits

- There was a significant delay in the completion of the DASH risk assessment (4 weeks from the initial referral date). This delay may have altered the responses that Rose gave. The outcome of the DASH was a low score therefore no referral to MARAC was required or necessary. This learning applies to all agencies involved as any agency who visited Rose upon the initial contact could have undertaken the DASH risk assessment.

- The DASH risk assessment may not however have been the most appropriate tool to have used in this specific case, as Rose did not see herself as being a victim, her husband as being a perpetrator nor consider herself subject to abuse. When working with individuals who are suicidal a tool such as STORM would be for more appropriate, this would have enabled a dialogue to open to explore suicidal intent and plans. Protective factors could have been established along with a risk management plan. Consideration could also have been given to a working with risk tool, to explore thoughts relating to suicide and allowing Rose and John to establish how they would manage these risks in future.

- Online support groups and virtual support for them both could have been considered, although other forms of support had been offered and were turned down ad these did not appear to address the central issue of Rose's pain.

- Other community support networks could have been explored such as a visiting buddy, MIND Mental Health support workers, and forums for people who experience specific physical health issues and associated pain, as detailed above.

Appendix No 1

DHR W06

TERMS OF REFERENCE

1. Supporting Framework

1.1. The Domestic Homicide Review (DHR) is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

1.2. In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

A person to whom he was related or with whom he was or had been in an intimate relationship; or

A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

1.3. Where the definition, set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

2. Purpose of the DHR

2.1. 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.

2.2. 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.

2.3. Apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

2.4. Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a coordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

2.5. Contribute to a better understanding of the nature of domestic violence and abuse.

2.6. Highlight good practice.

3. Methodology

3.1. This DHR will primarily use an investigative, systems focuses and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author to show comprehensive overview and alignment of actions.

3.2. This will ensure that practical and meaningful engagement of key frontline staff and managers will be carried out by the IMR author on a more experiential basis than solely being asked to respond to written conclusions or recommendations.

3.3. This is more likely to embed learning into practice and support cultural change where required.

4. Scope of the DHR

4.1. Deceased 1 Rose

4.2. Deceased 2 John

Timeframe

4.3. The scope of the DHR will be from 1st January 2011, (the year that the deceased moved into their last accommodation) to the date of death.

4.4. In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of this adult and include information around wider practice at the time of the incident as well as the practice in the case.

4.5. The Terms of Reference will be a standing item on the agenda of every panel meeting in order that we can remain flexible in our approach to identify learning opportunities.

5. Agency Reports

5.1. Agency Individual Management Reports will be commissioned from:

- Warwickshire Police
- Warwickshire Clinical Commissioning Group
- Coventry and Warwickshire Partnership Trust
- Adult Social Services
- South Warwickshire Foundation Trust
- West Midlands Ambulance Service
- Warwick District Council

Other reports for those agencies having contact with the Victim and Perpetrator:

- Housing (Warwick District Council)
- Leamington Night Shelter
- Salvation Army
- Helping Hands

5.2. Agencies will be expected to complete a chronology and IMR. Template and guidance attached.

5.3. Any references to the adults, their family or individual members of staff must be in full and later redacted before submission to the Home Office or published.

5.4. Any reasons for non-cooperation must be reports and explained.

5.5. All agency reports must be quality assured and signed off by a senior manager within the agency prior to submission.

5.6. It is requested that any additional information requested from agencies by the DHR Independent Author is submitted on an updated version of the original IMR in red text and dated.

5.7. It is requested that timescales are strictly adhered to and it should be noted that failure to do so may have a direct impact on the content of the DHR and may be referred to in the final Overview Report to the Home Office

5.8. Agencies will be asked to update on any actions identified in the IMR prior to completion of the DHR which will be fed into the final report. Updates will then be requested until all actions are completed.

6. Areas for consideration

Rose

6.1. Was deceased 1 recognised or considered to be a victim of abuse and did she recognise herself as being an object of abuse?

6.2. Did deceased 1 disclose to anyone and if so, was the response appropriate?

6.3. Was this information recorded and shared where appropriate?

6.4. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of both of the deceased?

6.5. When, and in what way, were deceased 1's wishes and feelings ascertained and considered?

6.6. Is it reasonable to assume that the wishes of deceased 1 should have been known?

6.7. Was deceased 1 informed of options/choices to make informed decisions?

6.8. Were they signposted to other agencies?

6.9. Was consideration of vulnerability or disability made by professionals in respect of the victim and perpetrator?

6.10. How accessible were the services for both of the deceased?

6.11. Were either deceased subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?

6.12. Did deceased 1 have any contact with a domestic abuse organisation, charity or helpline?

John

6.13. Was deceased 2 recognised or considered to be a victim of abuse and did deceased 2 recognise themselves as being a victim of abuse?

6.14. Did deceased 2 disclose to anyone, and if so, was the response appropriate?

6.15. Was this information recorded and shared where appropriate?

6.16. Was anything known about deceased 2? For example, were they being managed under MAPPA, did they require services, did they have access to services.

6.17. Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of both of the deceased?

6.18. Were services accessible for deceased 2? And were they signposted to services?

6.19. Was consideration of vulnerability or disability made by professionals in respect of deceased 2?

6.20. Did deceased 2 have contact with any domestic abuse organisation, charity or helpline?

Practitioners:

6.21. Were practitioners sensitive to the needs of both of the deceased, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about either of the deceased?

6.22. Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

Policy and Procedure:

6.23. Did the agency have policies and procedures in place for dealing with concerns about safeguarding and domestic abuse?

6.24. Did the agency have policy and procedures for risk assessment and risk management for domestic abuse (e.g., DASH) and were those assessments correctly used in the case of this victim/perpetrator?

6.25. Where these assessment tools, procedures and policies professionals accepted as being effective?

7. Engagement with the individual/family

7.1. While the primary purpose of the DHR is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in, and across, agencies and services, it is imperative that the views of the individual/family and details of their involvement with the DHR are included in this.

7.2. South Warwickshire Community Safety Partnership, through the Independent Chair, are responsible for informing the family that a DHR has been commissioned and an Independent Chair has been appointed. The DHR process means that agency records will be reviewed and reported upon, this includes medical records of both of the deceased.

7.3. Firstly, this is in recognition of the impact of the death of both of the deceased, giving family members the opportunity to meet the review panel if they wish and be given the opportunity to influence the scope, content and impact of the review. Their contributions, whenever given in the review journey, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process focus on their perspectives rather than just agency views.

7.4. All IMRs are to include details of any family engagement that has taken place, or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the DHR in addition to the Police Family Liaison Officer, FLO, in respect of criminal proceedings.

8. Media Reporting

8.1. In the event of media interest, all agencies are to use a statement approved and provided by South Warwickshire Community Safety Partnership.

9. Publishing

9.1. It should be noted by all agencies that the DHR Overview Report will be published once completed, unless it would adversely impact on the adult or the family. Publication cannot take place without the permission of the DHR Home Office Quality Assurance Panel.

9.2. The media strategy around publishing will be managed by the DHR Panel in consultation with the chair of South Warwickshire Community Safety Partnership and communicated to all relevant parties as appropriate.

9.3. Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware, in advance, of the intended publishing date.

9.4. Whenever appropriate and 'Easy Read' version of the report will be published.

10. Administration

10.1. It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via secure email account (GCSX) or through the Local Authority's Secure Communication System (SCS). Failure to do so will result in a data breach and must be reported to the Data Protection Commissioner.

10.2. The Domestic Homicide Review Officer will act as a conduit for all information moving between the Chair, IMR Authors, Panel Members and the DHR Panel.