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EXECUTIVE SUMMARY
Domestic Homicide Review
Case V

Report into the death of Rebecca

The members of this review panel offer their sincere condolences to the family of 'Rebecca' and 'Bob' for their sad loss in such tragic circumstances. Throughout the report pseudonyms 'Rebecca and Bob' are used to protect individual and family identities.

1. Introduction & Background.

1.1 This report outlines the process and conclusions of the Domestic Homicide Review into the death of Rebecca. The review was commissioned by the Blaby and Hinckley & Bosworth Community Safety Partnership.

1.2 On the morning of 28 October 2021, following alerts from neighbours, Leicestershire Police entered the home of Rebecca and her husband Bob. They found the couple dead. Rebecca had knife wounds to her chest and wrists. Bob had knife wounds to his wrists. On the 8th August 2022, the coroner concluded that Rebecca was unlawfully killed, and Bob had taken his own life. A note was found at the scene.

1.3 In November 2021, 19 agencies in Leicestershire were asked to provide a summary of the information they held on Rebecca and Bob.

- 11 agencies responded as having had no contact with either Rebecca or Bob.
- Eight agencies responded with information indicating some level of involvement with either Rebecca or Bob.

In December 2021, the group of agencies responsible for considering all domestic homicides met and agreed that the criteria were met to undertake a formal review.

1.4 In January 2022, an independent chair and report author was commissioned. The chair is independent of all agencies and is responsible for coordinating the review work and for writing the final report[1]. The terms of reference for the work are summarised in the full report.

2. Summary of Events

i. Rebecca was a white British 79-year-old woman, who lived with her husband, Bob aged 69 years, also white British. The couple lived together in a village in Leicestershire, having married in 2017. The couple had two adult stepchildren.

ii. Bob had suffered for more than 20 years with chronic and severe head pain. The condition was managed by drugs. During 2021, Bob's head pain worsened and in August 2021 he was admitted to hospital (University Hospitals Coventry & Warwickshire). Following a neurological assessment Bob received a diagnosis of 'right-sided atypical headache with functional

[1] Information about this author can be found in Appendix 1

overlay'[2]. Bob received input from neuropsychology and was discharged on 18th August 2021 with a reduced programme of medication, and referral for a pain management course to help reinforce the advice, guidance and techniques given to him during his hospital stay. Unfortunately, Bob was not able to sustain the plan and after approximately a week reverted to the use of medications to cope. Over the next few months Bob's use of his medications escalated as he sought to manage his head pain.

iii. On the evening of the 17th of October 2021 following an incident of self-harm, Bob was admitted to hospital in Leicester. During his time in hospital Bob's mental state was assessed. Risk of suicide was assessed as low by clinicians, who stated that, 'there is still a risk of impulsive self-harm and suicide through misadventure' and as a reaction to his head pain. The team assessed that Bob's presentation was not linked to any mental illness. He was discharged on 21st October 2021.

iv. Table of Key Events

Date	Key Event	Location/Type
1998	First diagnosis of trigeminal neuralgia	Germany
4 August 2021	Bob admitted to hospital – diagnosis re-evaluated. Neuropsychological input received.	Coventry Acute Trust
18 August 2021	Discharged with revised diagnosis of 'right- sided atypical headache with functional overlay'	Discharged home
26 August 2021	Bob's reliance on medication escalates resulting in admittance to hospital with shortness of breath and feeling unwell. Nothing found, discharged same day.	UHL
17 October 2021	Self -harm incident. Police and Ambulance services attended. Physical health (head pain) took primacy (over mental health concerns). R had minor cuts sustained as she removed a knife from Bob.	Admitted to UHL (A&E then moved to acute medical admissions unit).
21 October	Whilst in hospital Bob assessed by mental health specialists	LPT staff at UHL
21 October	Discharged	Discharged home
22 October	Discussion between GP and Bob regarding medication dosage – Bob over-ordering.	Telephone
26 October	Letter to GP received from Rebecca requesting additional medication to manage pain. GP to write to neurologist	Correspondence
26 October	GP surgery staff phone to ask if couple would like a home visit for vaccinations	Telephone

[2] See www.neurosymptoms.org
Functional overlay is a generic term. It can be defined as whatever else the patient brings along with their organic (real) pathology. These elements include psychological, emotional, coping, and interactive styles. The patient's response and coping style which results in this overlay is an attempt to handle the fear and anxiety of the changes impacting their life and physical functioning. These can be positive or negative. Lechnyr R, Holmes H. Taxonomy of Pain Patient Behavior. Pract Pain Manag. 2002;2(5).

27 October	Neighbour phones police at 9pm - concerned not to have seen couple all day.	Telephone
28 October	Police enter home and find Rebecca and Bob deceased.	Home visit

3. Conclusions

The review has reviewed a very sad set of circumstances leading to the deaths of Rebecca and also Bob. The panel did not identify any professional missteps or omissions which may have contributed to the deaths of either Rebecca or Bob. The panel was not able to identify any opportunities where different evidence-based interventions by professionals would have altered the tragic outcomes which occurred. Based upon the evidence and information available to the panel this terrible incident could not have been foreseen by agencies or indeed the family.

The main conclusions are:

- **Overall, the quality of care provided, and agency responses were good.**
- **There is insufficient evidence to indicate that domestic abuse was a factor in this homicide.**
- **There were no professional missteps or omissions identified which may have contributed to the death of Rebecca. No specific 'triggers' or 'tipping points' were identified that signalled an increased risk of homicide.**
- **Overall communication between agencies was good.**
- **Professionals' understanding of their duty to identify potential carers is underdeveloped.**

4. Learning Points and Review Recommendations

Learning Point 1: Domestic Abuse and Safeguarding

Dedicated training on domestic abuse is critical and must not be overlooked. Agencies should satisfy themselves that their training remains effective for their workforce.

Recommendation:

1.1 All bodies with responsibility for oversight of domestic abuse training to continue to ensure ongoing compliance and adherence to the required professional standards, monitor such compliance and provide rigorous and prompt challenge if this falls below required standards.

Learning Point 2: Hidden carers

Many in our society are unacknowledged carers. Staff working across agencies are often well placed to identify those in a caring role. Learning and recommendations have been identified in recently published Safeguarding Adult Reviews (SARs) including awareness raising and the requirement to undertake carer assessment for those who are advocating and supporting vulnerable family members. The Carer's

Strategy refresh[3], 2022-2025 was presented at Leicestershire County Council Cabinet in early December 2022 and was approved. This is a sub-regional strategy (Leicester, Leicestershire & Rutland [LLR]).

Recommendation:

2.1 The relevant body to satisfy itself that the LLR Carer's Strategy is making timely and sufficient progress in relation to the stated priorities to ensure carers get the assessment and support they need.

5. Single Agency Recommendations

5.1 LPT to continue to ensure the correct level, complexity depth of domestic abuse training for each profession is in place with the right balance of both on-line and face to face bespoke training. Training requirements to be explicit for all staff groups. Any non-compliance is rapidly remedied.

5.2 Regarding the Criminal Justice Liaison and Diversion service recording protocol; revise where appropriate the standing operating procedure taking into account those situations of risk even when the person is not a Trust patient.

[3] https://www.leicestershire.gov.uk/adult-social-care-and-health/looking-after-someone (main page) https://www.leicestershire.gov.uk/adult-social-care-and-health/looking-after-someone/are-you-a-carer (carers page)