OVERVIEW REPORT

Domestic Homicide Review into the death of Rebecca October 2021

Blaby and Hinckley & Bosworth Community Safety Partnership

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Report completed December 2022

Contents

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Rebecca, a resident of Leicestershire prior to the point of her death in October 2021. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By reflecting on practice this process ensures learning is identified across the professional system. For these lessons to be applied in practice, professionals need to understand fully what happened in each homicide and importantly what needs to change in order to reduce the risk of future tragedies.

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 of August 2022, the coroner concluded that Rebecca was unlawfully killed, and Bob had taken his own life.

1.3 The members of this review panel offer their sincere condolences to the families of Rebecca and Bob for their sad loss in such tragic circumstances.

1.4 The review will consider agencies contact/involvement with both Rebecca and Bob from 1st October 2019 and 28th October 2021. This period allowed agencies to fully explore the events in the time preceding the deaths including Bob's worsening head pain and an episode of self-harm by Bob. To be as thorough as possible, agencies were also asked to provide any contextual information outside of the time period, which they believed would be relevant to the review.

1.5 It is important to remember that the review is not an inquiry into how someone died or who is to blame. These are matters for the Coroner's Court and criminal courts. A Domestic Homicide Review also sits outside of all agencies disciplinary processes.

2. Timescales

2.1 The review began on 24th February 2022 and was concluded in December 2022 once the Coronial process had been concluded.

3. Confidentiality

3.1 The findings of this review will be published. To ensure anonymity for the family and to enable wider dissemination and encouraging agency learning, fictitious names are used throughout. The families were invited to choose pseudonyms for their relatives. After meeting with the chair, Bob's family offered a pseudonym. The panel chose the pseudonym for Rebecca as her family had indicated their preference not to be involved in the review process.

4. Terms of Reference

The review panel agreed terms of reference to guide the work. These are included in appendix 1. In summary, the key areas agencies were asked to explore were:

- The presence or suspected presence of domestic abuse within the home environment including harm or threats of harm or control. During their contact with the family, did professionals consider or explore the potential for abuse or coercive control as a factor within this partnership?

- The understanding agencies held about the dynamics of the marital relationship and whether Rebecca was ever spoken to alone/without her husband.

- Consideration of all agencies' responses and quality of support or intervention provided. The extent to which information, messages or advice was provided which may have enabled Rebecca to reach out for help in the future (should she choose to do so) to support her home situation.

- Exploration of Rebecca's state of mind and the extent to which she may have considered or acted upon an intention to take her own life.

- Accessibility of services. Consideration of any barriers to service provision and agencies' sensitivity to protected characteristics within the Equality Act 2010 in respect of Rebecca and her family. Specifically, the extent to which vulnerability or disability featured in this case and agencies' responses.

- Was Rebecca viewed as a 'carer' for her husband? Did she view herself in this way? Did agencies understand the impact of her husband's health on Rebecca? How appropriate were agencies responses?

- Was Rebecca ever subject to a Multi-Agency Risk Assessment Conference (MARAC) or any other multi-agency forum?

- Did Rebecca have any contact with a domestic abuse organisation, charity or helpline?

In relation to Bob, agencies the key focus of consideration were:

- Was Bob ever recognised as, or considered to be, a victim of abuse or a perpetrator of abuse? Did he ever make any disclosures of having been abusive in some way previously within his relationships.

- Was anything known about Bob's history? For example, was he ever managed under Multi-Agency Public Protection Arrangements (MAPPA)? Was he known to any multi-agency forum?

- Was there any evidence that Bob had considered or acted upon any intention to take his own life?

- Were services involved sensitive to the protected characteristics within the Equality Act 2010 in respect of Bob and his family? How were issues of

vulnerability and disability explored? Did either party consider themselves or the other as a carer? What support did they get from agencies?

In respect of practitioners, agencies were asked to reflect on the extent to which:

- practitioners were sensitive to the needs of Rebecca and Bob, and were knowledgeable about potential indicators of domestic abuse and coercive control in older adults and aware of what they could do if they had concerns or suspicions about a victim or potential perpetrator?
- it is reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

In relation to processes, agencies were asked to reflect on:

- the quality of policies and procedures in place at the time for dealing with concerns about safeguarding and domestic abuse?
- the current level of understanding of abuse in older adults and the barriers to disclosure.
- Whether staff utilise procedures and tools for risk assessment and risk management in cases of domestic abuse (e.g., DASH) and how well those assessments were applied in this situation.
- the efficacy of these tools and any amendments or additions which might benefit future practice.

5. Methodology of the Review

5.1 On 2nd December 2021, Leicestershire Police presented a referral to the Case Review Group – Joint Section of Leicestershire & Rutland Safeguarding Children Partnership (SCP) and the Safeguarding Adults Board (SAB). This group is made up of the local agencies charged with safeguarding responsibilities[1]. The group considered the need for a domestic homicide review and agreed the criteria as set out in the national guidance was met.

Specifically, the group agreed that:

- Rebecca's death appeared to have resulted from violence, abuse or neglect by a person to whom she was related or with whom she was or had been in an intimate personal relationship. Whilst there is no presumption of domestic abuse, many domestic homicides do involve such features and includes the

[1] Leicestershire & Rutland Safeguarding Children Partnership and Safeguarding Adults Board: Case Review Group – Joint Section Thursday 2nd December 2021.

potential for coercive control.

The Home Office define this as

> "…a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
> Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

5.2 The statutory requirement to complete a Domestic Homicide Review rests with the Community Safety Partnership (CSP) for the area in which a homicide takes place. In Leicestershire and Rutland, local procedures are in place for the CSPs to commission a review through the joint Safeguarding Adults Board (SAB) and Safeguarding Children Partnership (SCP) Case Review Group.

5.3 They then formally recommended that a Domestic Homicide Review be undertaken. In Leicestershire, the review is commissioned by the relevant district/borough. In this case the Blaby and Hinckley & Bosworth Community Safer Partnership.

5.4 A panel was subsequently appointed to steer the review work. The role of panel members is to ensure that the review is impartial, fair, and balanced. Panel members have a responsibility to challenge and ensure the process is rigorous and thorough and that agencies reflect together and are held to account for their practice.

5.5 In November 2021, local agencies were asked to provide a summary of the information they held on Rebecca and Bob. A total of 19 agencies responded, eight of these reported having had some contact with either Rebecca or Bob.

5.6 The Police liaison service ensured that all family members were kept informed about the review process and provided with Home Office leaflets. The chair also wrote to them to introduce herself and explain a little about the review process, encouraging their involvement. In response, one of Bob's family members (his stepdaughter) provided a written statement. Her brother, (Bob's stepson) also responded and subsequently met with the chair. To further encourage participation in the review process, the families were approached by the chair again in August and September 2022 following the end of the Coronial process.

5.7 The panel adopted a proportionate response in requesting information from agencies. Given some agencies had had minimal involvement with either Rebecca or Bob, it was agreed the panel would utilise an extended chronology format which would provide additional detail, rather than requesting a full Individual Management Review (IMR) from each agency. Each chronology was quality assured and overseen by the submitting agency. The detailed chronologies from individual agencies were collated into a single document to provide a coherent and comprehensive timeline for the period of review.

5.8 In addition, Leicestershire Partnership NHS Trust (LPT) had commissioned (as is usual practice) a Serious Incident (SI) investigation from an independent provider. It was agreed that this would stand as an Individual Management Review for the Trust and contribute to the review's evidence.

5.9 Following the conclusion of the Coronial process (8th August 2022), further efforts were made to achieve a wider participation with additional letters and approaches made in August and September 2022. Sadly, these efforts were not successful.

6. Involvement of Family & Friends, Colleagues and Wider Community

6.1 The panel were very keen for those who were connected to Rebecca and Bob and those who knew them well to contribute their views and to hear about the review and its purpose. Where provided, these are included as part of this report. Significant efforts were made to engage as many different people as possible. Some distant relatives of Rebecca who live abroad were identified and contacted but as they had not seen her for many years, they told us that they did not have anything to contribute.

6.2 The Police family liaison officer in particular, worked hard to encourage their involvement having built a positive relationship with various family members during the investigative process. Unfortunately, on both sides of the family there were dealing with challenging additional pressures.

6.3 Whilst family members had been provided with Home Office leaflets the chair wrote additionally to the family to introduce herself and explain the purpose and focus of the review work. She wrote again at the closure of the Coronial process seeking family involvement and participation. A further attempt was made in October 2023 encouraging contact with the chair but was not successful.

6.4 Bob's stepchildren both contributed to the review. The stepdaughter made a written contribution and the stepson met personally with the chair.

- The couple's next-door neighbours, who apparently knew Bob and Rebecca well, were also provided with leaflets and were approached in person (FLO) and written to by the chair seeking an interview and asking for their participation. They did not feel able to contribute.

- Efforts to reach into the local community (via the Parish Council) were also made. Given the couple's reported interest in Bridge an approach was also made to the local Bridge Society. Unfortunately, those contacted did not feel they could contribute.

- Sadly, the couple's regular holiday companions could not be identified.

7. Contributors to the Review

The panel wishes to thank all those who have contributed their time, patience and cooperation during this work. All those involved have contributed openly and collaboratively; working hard to identify any learning. Recommendations have been designed to support best practice and guide agencies in their day-to-day work.

7.1 The following agencies and individuals contributed to this review

Contributor	**Provided**
Leicestershire Partnership Trust	Individual Management Review (IMR)
Police	Expanded Chronology
GP Medical Practice	Expanded Chronology
University Hospitals of Leicester	Expanded Chronology
EMAS	Expanded Chronology
George Elliot Hospital	Information Report
Coventry and Warwickshire Hospital	Information Report
Mr Thomas (Consultant Neurologist) University Hospitals Coventry & Warwick NHS Trust	Case history information, Findings and conclusions from his knowledge of Bob.
Stepson	Interview with chair
Stepdaughter	Written statement

A comprehensive chronology was received from the following organisations:

- Hinckley & Bosworth Borough Council
- GP Medical Practice – with support from the Clinical Commissioning Group (CCG) Safeguarding Team (now known as Integrated Care Board [ICB][2])
- Leicestershire Partnership NHS Trust (LPT)
- University Hospitals of Leicester NHS Trust (UHL)
- East Midlands Ambulance Service (EMAS)
- Leicestershire Police

Information reports were submitted by:

- George Eliot Hospital NHS Trust
- University Hospitals Coventry & Warwickshire NHS Trust (UHCW)

An Individual Management Review (IMR) was received from:

- LPT
  This report was independent; an external provider having been commissioned by LPT. The final report was received in September 2023 having been endorsed by LPT senior management.

[2] The role of the ICB is to allocate the NHS budget and commission services for the population, taking over the functions previously held by clinical commissioning groups (CCGs) and some of the direct commissioning functions of NHS England.

8. The Review Panel Members

The role of panel members is to ensure that the review is impartial, fair, and balanced. Panel members have a responsibility to challenge and ensure the process is rigorous and thorough and that agencies are held to account for their practice. All panel members confirmed they had no direct involvement with the family, nor did they have management responsibility for any of those who were involved. Often panel members have an organisational role in practice improvement.

8.1 Members of the panel and the agencies they represent are as follows:

- Carol Richardson: Deputy Designated Nurse Safeguarding, Leicester, Leicestershire & Rutland Clinical Commissioning Group (CCG) Safeguarding Team (now known as the Integrated Care Board[3] [ICB]).
- Rachel Burgess: Community Safety and Safeguarding Manager, Hinckley & Bosworth Borough Council (Representing the Blaby and Hinckley & Bosworth Community Safety Partnership [CSP])
- Rik Basra: Community Safety Coordinator, Leicestershire County Council
- Chris Barratt: Detective Inspector, Serious Case Review Partnership Manager, Leicestershire Police
- Sarah Meadows: Matron – Adult Safeguarding, University Hospitals of Leicester NHS Trust (UHL)
- Moira O'Hagan: Independent Review Author and Panel Chair
- Suki Kaur: Chief Executive, Free From Violence and Abuse Leicester (Free VA) (independent domestic abuse expert)
- Liz Cudmore: Children and Young Person Safeguarding Lead, East Midlands Ambulance Service (EMAS)
- Katherine Blake-Smith: Lead Practitioner for Safeguarding (Named Nurse) Leicestershire Partnership NHS Trust (LPT)

The Panel was assisted by Chris Tew, Officer, and Joanna Fowler, Administrator, for the Leicestershire & Rutland Safeguarding Partnerships Business Office (SPBO).

8.2 The panel agreed that whilst a neurologist would have been useful to the panel, it was more realistic to approach them outside of panel meetings at a time they could feasibly manage. The expertise/input from Mr Thomas (Consultant Neurologist from UHCW) was gained by the Chair in a telephone consultation on 20th July 2022. Mr. Thomas also provided referral letter summarising his involvement and review of Bob.

8.3 Several members of the board had expertise in older people and the panel therefore concluded that an additional panel member would not be necessary.

8.4 The panel met remotely utilising Microsoft Teams on the following dates:

- 24th February 2022

[3] During the course of this DHR, the three Clinical Commissioning Groups (CCG) in Leicester, Leicestershire & Rutland (LLR) became an LLR Integrated Care Board (ICB). The ICB and its governance structure became a legal entity from 01.07.22.

- 17th May 2022
- 8th July 2022
- 23rd September 2022

8.5 Once the review work had been completed, the report was subsequently submitted to the Blaby and Hinckley & Bosworth Community Safety Partnership which approved the final version of the report and its recommendations.

9. Author of the Overview Report

9.1 In January 2022, an independent chair and report author was commissioned on behalf of the Blaby and Hinckley & Bosworth Community Safety Partnership[4]. The chair is independent of all agencies and is responsible for coordinating the review work and for writing the final report. The safeguarding office undertakes a focused selection process for chair/authors and must satisfy itself that the applicants have the correct blend of skills and experience for this role. More information about this chair is provided in appendix 1.

10. Parallel Reviews

10.1 The following single agency processes or proceedings are relevant:

- HM Coroner for Leicestershire was notified of the Domestic Homicide Review process and was kept informed of the progress of work on a monthly basis. The inquest concluded on 8th August 2022 and returned a verdict of 'unlawful killing' of Rebecca (by another deceased person found in the house). The inquest found Bob to have taken his own life.

- Following the deaths of Bob and Rebecca, LPT commissioned an external independent investigator to conduct a Serious Incident Investigation. The results of which have been considered as part of this review.

11. Equality & Diversity

The panel has a duty to consider the extent to which services involved were sensitive to those with protected characteristics[5] where they may be relevant to the review. This is intended to ensure that any barriers to accessing services or the quality of services can be addressed. All characteristics were considered. The characteristics of age, gender and disability were assessed as relevant in this case.

[4] A Community Safety Partnership is a statutory forum within each local council area with local organisations including police, health, probation and others collaborating in reducing crime and the fear of crime, anti-social behaviour, alcohol and drug misuse and reducing re-offending. Blaby District Council and Hinckley & Bosworth Borough Council have a combined CSP with co-chairing arrangements.

[5] There are nine protected characteristics outlined in the Equality Act 2010 which are: Age; Gender; Race; Disability; Religion or belief; Sexual orientation; Gender reassignment; Marriage or civil partnerships; Pregnancy and maternity.

The panel asked agencies to reflect on their practice and report back any learning. The findings of this reflection are included in the analysis section.

i) **Age:** Whilst age did not prevent or impede the provision of services, the panel discussed age as a barrier to the understanding of abuse of older people. Research on older people and domestic abuse (Safer Lives: Older People and Domestic Abuse, October 2016[6]) indicates that older people can be a 'hidden group' of victims of domestic abuse. The same research comments: "It has been noted that older women are far less likely to identify their situation as abuse, which acts as a barrier to the uptake of services and presents a challenge to outreach workers. Older victims are likely to have grown up in a time where the home was a private domain, and it would not have been deemed socially acceptable to discuss matters that occurred behind closed doors".

ii) The CCG (now ICB) reported that past learning from reviews undertaken on older victims has been widely disseminated in Leicestershire. A sub-regional event in 2020 included this specific topic. However, it is not possible to assess the extent to which this has been cemented into practice across the relevant agencies. Given the turnover of staff in all public sector services it is wise to ensure this topic is routinely discussed.

iii) **Gender:** The panel discussed Rebecca as a potential unacknowledged 'carer' in relation to her husband's health issues. All the professionals involved as well as family viewed Rebecca and Bob as a partnership. The GP surgery team saw Rebecca as an 'advocate' for Bob. However, no agency appears to have inquired into how Rebecca found living with Bob's condition and whether this was becoming more difficult or whether she needed any support.[7] The identification of carers for busy health and social care professionals can be challenging but is essential to prevent needs being overlooked.

iv) **Disability:** From the evidence presented it appears that, during the last few months of his life, Bob had found his condition disabling. His day-to-day functioning was impeded, and he had been forced to let go of many of his usual activities and hobbies (stamp collecting, playing bridge). Those managing chronic pain deal with many challenges and frustrations in their daily life. It is highly likely that at times Bob similarly experienced strong feelings of powerlessness and vulnerability[8]. Notwithstanding this, Bob was engaged in managing his condition and remained able to take decisions about his health. The panel received no information that allowed any meaningful consideration of disability in respect of Rebecca.

[6] Safer Later Lives: Older People and Domestic Abuse", Safe Lives, October 2016. The report is part of the Safer Lives 'Spotlights' series

[7] https://www.carersuk.org/for-professionals/policy/policy-library/missing-out-the-identification-challenge

[8] https://www.curablehealth.com/infographic/path-of-chronic-pain-download

12. Dissemination

The report has been disseminated to:

Carol Richardson: Deputy Designated Nurse Safeguarding, Leicester, Leicestershire & Rutland Integrated Care Board.

Rachel Burgess: Community Safety and Safeguarding Manager, Hinckley & Bosworth Borough Council (Representing the Blaby and Hinckley & Bosworth Community Safety Partnership [CSP])

Rik Basra: Community Safety Coordinator, Leicestershire County Council

Chris Barratt: Detective Inspector, Serious Case Review Partnership Manager, Leicestershire Police

Sarah Meadows: Matron – Adult Safeguarding, University Hospitals of Leicester NHS Trust (UHL)

Suki Kaur: Chief Executive, Free From Violence and Abuse Leicester (Free VA) (independent domestic abuse expert)

Liz Cudmore: Children and Young Person Safeguarding Lead, East Midlands Ambulance Service (EMAS)

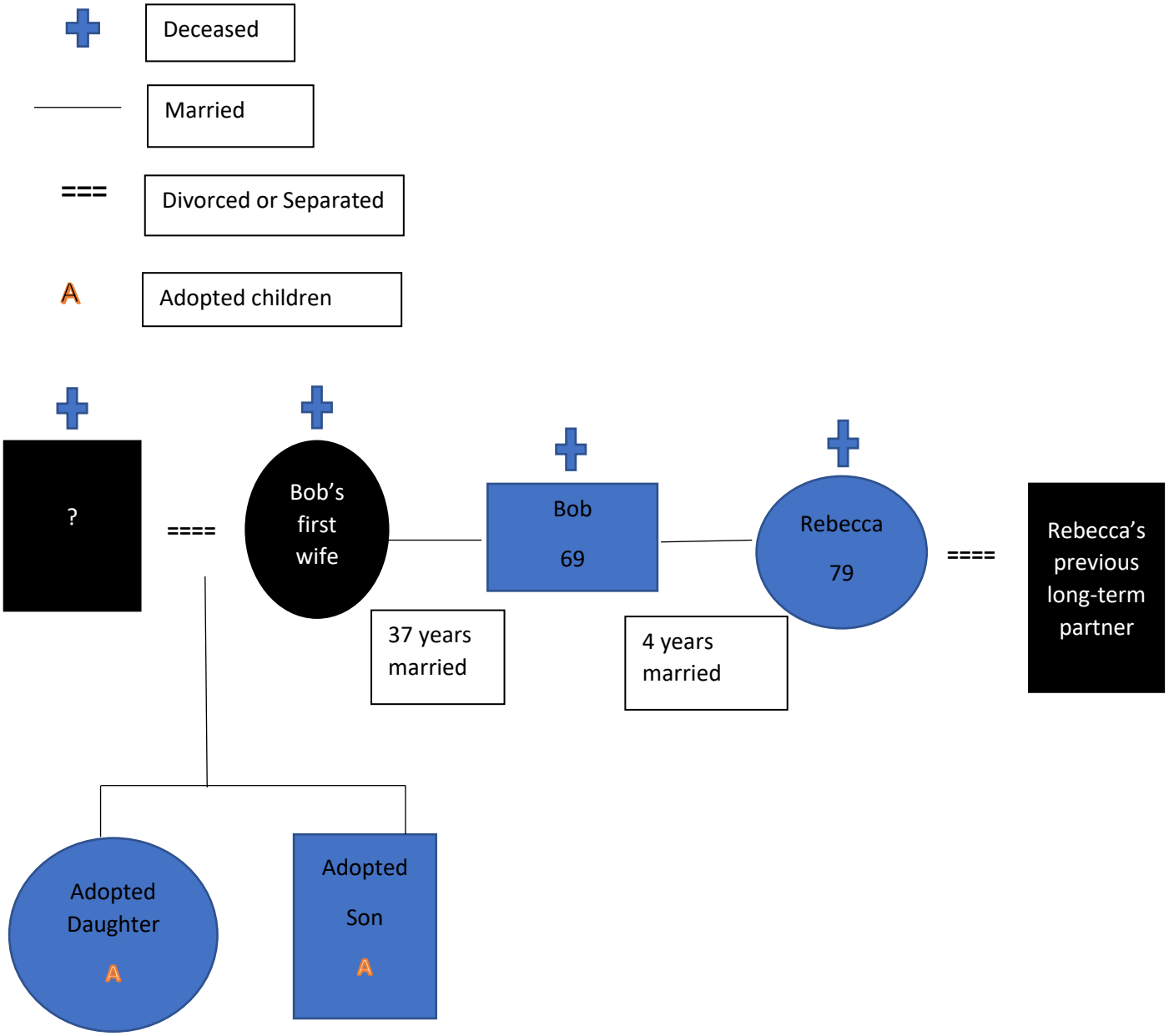
Katherine Blake-Smith: Lead Practitioner for Safeguarding (Named Nurse) Leicestershire Partnership NHS Trust (LPT)

Mr Thomas (Consultant Neurologist) University Hospitals Coventry & Warwickshire NHS Trust.

13. The Family Genogram

13.1 The following genogram identifies the family relationships.

Genogram Key



14. Background Information The Facts:

Summary of events

14.1 Rebecca and Bob were married in 2017 but had known each other for many

years. Bob had suffered for more than 20 years with chronic and severe head pain. He had received a diagnosis in 1998 whilst working in Germany of trigeminal neuralgia[9]. He was subsequently treated by neurology services at Coventry Acute Trust (University Hospitals of Coventry & Warwickshire). There were lengthy periods when the condition was well managed with medication, but other periods when the condition would worsen and was not responsive.

14.2 During 2021, Bob's head pain worsened. He was admitted to Coventry Acute Trust in August 2021. Whilst there he underwent a thorough assessment by the neurology team over the course of two weeks. The consultant in charge of Bob's care reported that, on admittance, Bob's drug regime was reviewed fully. At this time Bob was taking a large number of drugs at a high dosage but reported he still had pain. The consultant later found toxic levels of drugs in Bob's bloodstream. Bob was discharged 14 days later with 'ongoing support from neuropsychology'.

14.3 The hospitalisation allowed clinical staff to test the efficacy of different medications including a nerve block. These approaches are usually found to be effective with trigeminal neuralgia or very similar conditions. However, Bob reported that none of these helped his level of pain. After detailed observations, the conclusion was reached that Bob's symptoms did not fully fit with the earlier diagnosis of trigeminal neuralgia. His consultant gave a diagnosis of 'right-sided atypical headache with functional overlay'[10].

14.4 The consultant, a specialist in migraine and headache disorder, explained that he believed there was a psychological element to Bob's pain. They had noted that when Bob was distracted or absorbed in an activity, his pain appeared to reduce. This is not unusual and can be harnessed to help patients develop pain management techniques alongside drugs. Although not received well initially, the consultant believed both Bob and Rebecca had adjusted to this amended diagnosis and were more accepting of this by the time of discharge. It is not clear what pain management education Bob had been offered or received previously.

14.5 Bob received input from neuropsychology[11] whilst in Coventry Acute Trust. This taught him specific techniques which he was supported and encouraged to practice during his time on the ward. He was urged to continue to practice on his discharge home. When Bob was discharged, it was with a reduced programme of medication.

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[9] Trigeminal neuralgia is a sudden severe facial pain. Often described as a sharp shooting pain or like having an electric shock in the jaw, teeth or gums. It usually happens in short, unpredictable attacks that can last from a few seconds to about 2 minutes. The attack stops as suddenly as it starts. www.nhs.uk

[10] 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 and Holmes H, "Taxonomy of Pain Patient Behaviour", Pract Pain Manag. 2002;2(5).

[11] https://www.nice.org.uk/guidance/ng193/chapter/Recommendations

A referral for a pain management course to help reinforce his learning was made the next day.

14.6 Unfortunately, Bob was not able to sustain the plan and, after approximately a week, reverted to his previous use of prescription drugs to manage pain. Over the next few months, Bob's usage escalated as he unsuccessfully sought to manage his head pain. One week later, Bob was admitted to Glenfield Hospital (UHL) with shortness of breath and feeling unwell but was discharged the same day. Bob continued to talk to his GP who liaised with Coventry Acute Trust in relation to increasing medication.

14.7 On one evening in mid-October, Police Officers attended the home address following an emergency call from Rebecca who had reported a concern for the safety of Bob. Rebecca reported Bob had cut himself with a knife, injuring his head and hands. She had managed to remove the knife, but he was attempting to get another knife to try to hurt himself again. Police were advised by the mobile mental health triage service that Bob was not known to mental health services. It was agreed that physical health (head pain) should take primacy (over mental health concerns) and an ambulance was called.

14.8 Prior to police attendance, and whilst removing the knife from Bob to prevent him hurting himself, Rebecca had suffered a minor injury to her hand.

14.9 Bob was admitted to the Accident and Emergency department at University Hospitals of Leicester (UHL) and then moved to an acute medical admissions unit to assess his head pain. Due to his self-harm Bob was also assessed by two Mental Health Liaison Service (MHLS) Practitioners (Registered Nurses in Mental Health) who work for Leicestershire Partnership Trust (LPT). Bob did not report being low in mood but had cut himself "wanting to get out of pain".

14.10 A few days later, Bob received a further assessment by psychiatrists with specialist expertise in old age psychiatry. Bob reported that he had "wanted to end his life by cutting his veins". He reported the reason he wanted to end his life was because of the pain which was unbearable. He said the action was unplanned, impulsive, and he had not set his affairs in order. Bob denied any ambivalence – despite the careful and tentative nature of the cuts. He stated he only regretted the hurt he had caused his wife. He denied overdosing on his pain relief.

14.11 Bob was seen with his wife Rebecca present as this was his preference. Bob was reticent about future ideas regarding risk but said that his actions were impulsive, and he had no plans to end his life and that he and his wife would "keep each other safe." When assessing the risk of suicide, the practitioners asked Bob and Rebecca about whether they had considered ending their lives together. Rebecca had reacted saying "no, definitely not". There is no reference to Bob's response. Bob and Rebecca spoke of their plans to go on a cruise around Christmas time.

14.12 The incident of self-harm was assessed to be 'impulsive and secondary to' (i.e., caused by) pain. They found "no evidence of mental illness such as clinical depression, hypomania/mania, anxiety disorder or psychosis". Clinicians noted the

presence of some specific personality traits referred to as 'cluster B[12]' personality traits. Their findings were supported by examples of Bob's behaviour displayed during the assessment which they assessed to be 'histrionic[13] and egocentric'[14]. Mental Health Doctors found Bob's interaction 'dramatic' at times with 'exaggerated emotions, swinging from humour to tears.' They found Bob to be 'regularly short tempered with his wife' but then also held her hand when he was getting emotional. They felt this showed 'an intensity to their relationship with high expressed emotions'.

14.13 Mental Health Doctors felt that, overall, there remained a risk of impulsive self-harm and suicide through misadventure, they assessed that this would be 'secondary to pain' (meaning as a result of) and was not linked to any mental illness. Risk was assessed as low. Doctors noted Bob was also open to the idea of seeing a neurological specialist from London which they felt indicated some degree of hope for the future. The UHL chronology advises that both adults were happy with discharge plans after seeing the mental health team. The Adult Accident and Emergency Discharge summary was sent to the GP on the same day. The discharge summary detailed the recent admission and advised no change in medication prior to review in headache clinic and no active support was needed from health and social care once home.

14.14 The next day the GP spoke to Bob to clarify his medication dosage as he was over-ordering Oxcarbazepine. Four days later the GP received a letter from Rebecca suggesting additional medication for Bob to cope with pain. The next day the GP wrote to Bob's neurology consultant as per Rebecca's request.

14.15 Four days later, the GP surgery rang to ask if the couple would like a home visit to receive Covid booster vaccinations. Bob told her they planned to come into the surgery the following day for appointments, so declined with thanks.

14.16 The next day at about 9.00pm neighbours, concerned they had not seen the couple since the previous day, alerted the police to their absence. The Police conducted office-based enquiries and authorised a home visit the following morning. At just after 9am the following morning, the same neighbours rang the Police and confirmed no change, with no sightings of either of the couple.

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[12] A person with a cluster B personality trait may find it more difficult to regulate their feelings and swings between positive and negative views of others. This can lead to patterns of behaviour others describe as dramatic and unpredictable. https://mentalhealth-uk.org/

[13] Those with histrionic traits are more anxious about being ignored. As a result, they feel a compulsion (overwhelming urge) to be noticed and the centre of everyone's attention. NHS Inform

[14] The term egocentric is a concept that originated within Piaget's theory of childhood development. Egocentrism refers to someone's inability to understand that another person's view or opinion may be different than their own. It represents a cognitive bias, in that someone would assume that others share the same perspective as they do, unable to imagine that other people would have a perception of their own. American Psychological Association. Egocentrism.

14.17 At 10:12am the next day, Leicestershire Police entered the home and found Rebecca and Bob dead. Rebecca had knife wounds to her chest and wrists. Bob had knife wounds to his wrists.

14.18 A typed note found at the scene, indicated that Rebecca 'wanted to go first' and Bob's intention was to join her shortly. The names of Bob and Rebecca were at the end of the note (typed). There is no evidence of whether Rebecca was aware of the note.

14.19 As part of their subsequent investigation, Police reported the results from the examination of Bob's computer. They found that, six days before, Bob had conducted a number of online searches and accessed websites using his laptop computer and the Google account registered to him. These included searches related to poisoning and the impact of injecting insulin to a non-diabetic.

15 The Facts: Postmortem Information: Rebecca

15.1 The examination noted that Rebecca died as a result of a combination of stab wounds to her chest and an incised wound to her left wrist. She died sometime between 20.00hrs and midnight two days before the Police discovered their bodies. Rebecca's injuries were not typical of self-infliction, but no so-called "defensive" injuries were identified.

15.2 The examination identified a group of five stab wounds to the central chest area and a single incised wound to the left wrist. The severing of the arteries at the left wrist would account for the type of blood spatter pattern found at the scene.

15.3 The close grouping of the chest stab wounds and the relative lack of bleeding from these implies that they may have been inflicted at a time when Rebecca was perhaps already subdued (perhaps due to blood loss from the wrist injury). However, these injuries caused significant internal bleeding and would have contributed to death.

15.4 At least two of the chest wounds had cut through ribs. The examiner states that significant force must have been used.

15.5 When Rebecca's body was examined, there was an area of bruising to the left abdomen associated with an injection site. The yellow colouration of this bruising indicates that the mark must have occurred some hours prior to death, rather than immediately before.

15.6 When Rebecca was found on the bed in her bedroom there was a needle in a syringe next to her. Rebecca's DNA was found on the needle end with Bob's DNA found on the plunger end. There were a number of capped needles on the bed along with some vials of insulin. Whilst there was no toxicology evidence to support potential insulin use, it is possible that any insulin injected had already metabolised.

15.7 Blood pattern analysis conducted by a forensic expert shows that Rebecca is unlikely to have moved from the position she was found in on her bed. She was injured in that position and remained there until she died. Some of Rebecca's blood was found downstairs in the home. It is believed that this would likely have been transferred by Bob as he moved around the house.

16. Post-Mortem Information: Bob

16.1 Bob died from apparently self-inflicted incised wounds to both of his wrists shortly after 00.00 hours one day before the Police discovered their bodies. The examination found multiple incised wounds to both wrists. These were typical of self-infliction. There were no so-called "defensive" injuries or other injuries to indicate that the deceased was assaulted or restrained prior to his death. Other areas of bruising and abrasion were identified which were consistent with the position of the deceased at the time of his discovery.

17. The Facts: Background Information: Family Overview

17.1 This section of the report provides information relating to the lives and deaths of Rebecca and Bob.

17.2 Bob and Rebecca were both white British and English speaking (first language). The couple lived together in a medium sized village in west Leicestershire, having married in 2017. Their family was small with members living in England, Canada and Germany.

17.3 Rebecca had never previously been married nor had children. She had previously lived in Brent, London with a long-term partner. Rebecca met Bob through their shared love of bridge. They became friends and he lodged at her home for many years during his work as a computer systems programmer when he would lodge from Monday to Friday returning home at weekends. The family report that he was hardworking and only took annual leave at Christmas.

17.4 Bob and his first wife were married for 37 years. Prior to meeting Bob, his first wife (and her previous husband) had adopted two children. Although there was no formal process, Bob was said to view his stepchildren as his own children. His stepson went to live with his mum and Bob from the age of about 5 years. His stepdaughter opted to live with her father. They each spent weekends with the other parent. The arrangement worked well, and the stepson recalls that his adopted father never undermined Bob in his parenting. Both stepchildren viewed Bob as a father. In her contribution to the review, the stepdaughter stated,
'Bob was my stepdad for 43 years. He was strict but fair and would always help when we needed it'.
The couple were involved in the Scouts and involved the children in this when they were young. The stepson recalls the couple worked as a team and his stepfather always supported his adopted mother.

17.5 The stepson remembers Bob as *'a quiet, intelligent man who was well read'*. Bob was known as '*the oracle'* in the family. At family gatherings he would contribute but was not a flamboyant or charismatic character. His first wife did not enjoy good health and his stepson recalled they took holidays in the UK as she was reluctant to travel too far.

17.6 The stepdaughter described Bob as being 'devastated' by his first wife's sudden death. She says she was very surprised when at Christmas that year, Bob told her

he had a friend who would be moving in with him. The stepchildren then came to understand that Rebecca and Bob had been in a relationship for six years prior to marrying in 2017. Although initially surprised, both stepchildren came to accept Rebecca and became fond of her. Rebecca was described as 'kind' and that Bob was *'a completely different person, so happy and we were made to feel very welcome'.* The stepchildren visited the couple regularly and enjoyed these family times and kept in regular contact through the week via text messages.

17.7 The stepdaughter described Rebecca as a keen gardener, creating wonderful flower borders over the years. She loved car boot sales and buying trinkets and clothes. She had asthma but this was well controlled. She also suffered from arthritis.

17.8 Bob was a keen cook and vegetable gardener and enjoyed entertaining his family. The couple enjoyed many cruises together – some of which were orientated to their shared bridge playing hobby. Bob was also an avid stamp collector. His stepdaughter reports that many of these interests had been de-railed in the last six months because of Bob's deteriorating health. At the time of the deaths the couple had two holidays booked.

17.9 Bob had some significant health problems and was known to a number of medical professionals. Bob had had Type 1 diabetes[15] since childhood, controlled with insulin.

17.10 The stepson described how Bob's condition began when Bob was working away in Munich, Germany. An initial diagnosis was provided in 1998 of trigeminal neuralgia and was reiterated in 2019 by a neurology specialist at University Hospitals of Coventry & Warwickshire NHS Trust. Bob had lengthy periods of time where the pain was controlled and when the pain was reported to be unbearable. His stepdaughter said, *'The pain he had been in for the last twenty years was awful to see'.* His stepson described how Bob could sense when the attacks were imminent and used prescribed drugs to delay the attacks so he could better manage his day-to-day functioning. He was worried by his stepfather's approach and in particular the fact that Bob continued to drive despite the unpredictability of pain attacks. As the attacks worsened over time, Bob's use of prescribed medication increased. There is a sense, from talking to the stepson, that Bob was feeling increasingly that people had stopped listening to him and that he needed to 'work harder' to get them to pay attention.

17.11 By the time of his hospital admission in August 2021, Bob was on significant doses of various medications including Carbamazepine (600mg am + 800mg pm), Gabapentin (1200mg 3x daily), Baclofen (10mg x2 daily) and Phenytoin (100mg 2x daily + 50mg at lunchtime).

17.12 There is no formally reported history of domestic abuse for either Rebecca or Bob in their time together nor with their previous partners.

[15]The two main types of diabetes are type 1 and type 2. In type 1 the body completely stops making insulin. People with type 1 diabetes must take daily insulin injections (or use an insulin pump) to survive. https://www.joslin.org/patient-care/diabetes-education/diabetes-learaning-center

17.13 Both stepchildren have known Bob since they were young children. Both are clear that there were never any issues around abuse in their family life. The stepson described Bob as a calm, measured man. He was firm and *'straight'*, a man who paid attention to detail – a planner. He recalls no major frictions between Rebecca and Bob beyond on occasion *'sniping at each other'*. He was clear that Rebecca was well able to stand up for herself and was not *'meek and mild'*.

17.14 The stepdaughter reports talking to Rebecca in the months prior to the deaths, about the potential of her stepfather taking his own life. At that time, Rebecca had been unable to rule it out and had also told the stepdaughter that said she would not want to go on without him. The stepson recalls his stepfather in this latter period as lying on the settee with a pillow over his head with the TV on.

17.15 The stepson reported that he believed Bob had felt obliged to 'engineer' his hospital admissions because of his frustration in the management of his condition. The stepson reported that Bob had confided it was the only way he would get the help he needed. The stepson recalled that the approach taken by clinicians during the admission in August 2021 was not well received by the couple, in particular the view that the condition held a psychological element and that medications were reduced or eliminated. However, Bob had agreed to follow the approach advised by the team who had warned him that it would be hard at first. Subsequently, Bob confided to his stepson that he believed that reducing his drug regime was ill-advised. In the first week following discharge Bob reported he felt well and had suffered no attacks. However, when he subsequently suffered attacks of head pain, he did not feel he could continue with the advised approach. The stepson reported that Bob quickly began using his medication – and he was experimenting with dosage and timings as he had been used to do. Bob gradually increased his dose of Oxcarbazepine to the maximum dose of 2400mg daily in three divided doses and admitted to taking more than prescribed. The stepson did not believe that Bob had put any store in the referral to the specialist in London. He recalls his stepfather as being very certain in his ideas about his condition. He felt he knew his own body best and was confident in his own management, regardless of others' possible reservations. He noted that the couple's death was the anniversary of their marriage.

17.16 The Police Family Liaison Officer reported that no member of the family that she spoke to had thought Bob capable of killing and all were shocked and horrified by the circumstances of the couple's deaths. The stepson said he was particularly shocked that there was no note from Rebecca. Bob's family are of the opinion that, Bob's actions may have been as a result of the effect of his ongoing pain. They speculated that this may have impacted negatively on Bob's mental health.

17.17 All those family members from both sides who have expressed their views via the Police Family Liaison Officer were clear that they did not view the relationship between Rebecca and Bob as abusive and at times some struggled to accept the nature of the police investigation as being one of a homicide enquiry.

18. The Facts: Chronology of Agency Involvement

18.1 A combined and comprehensive chronology was created from the information received from agencies. The chronologies provided by agencies were full and detailed. They provided a clear and comprehensive understanding of each agency's involvement and their practice.

18.2 Local agencies did not know this couple well. The GP surgery is the agency with the longest relationship; their main contact was with Bob. The other agencies had either single or sporadic contact with Bob.
The information from each agency is summarised below.

GP Surgery

18.3 Staff at the GP surgery were shocked by events and had no indication of any problems in the couple's relationship. They saw nothing to suggest controlling behaviour in the relationship. Bob was seen as capable and able to manage his health care needs. There were no issues about his mental capacity and his decision-making abilities. He did not have a diagnosis of a mental illness.

18.4 The surgery provided the following information to assist the panel.

'Bob was a 'gentleman' and when he came into the surgery for appointments or to pick up medications, he was always polite and thankful. He was frustrated by his medical conditions, but we never saw anything other than his good nature. He would listen and take onboard information and not always say much. Bob showed kindness and thoughtfulness. He noticed dragon pictures drawn and displayed at the surgery by a team members son and soon after he brought into the surgery his collection of dragons and mythical figures for them. He took the time to think about others. As Bob became increasingly unwell with his medical conditions, he was accompanied by Rebecca to his GP appointments. Rebecca was his advocate and she spoke up for him. The impression we had, of Rebecca, was that she was confident and had leadership qualities. She was clear and direct on what she wanted on behalf of Bob. She would chase up appointments, send emails and write letters in relation to Bob's medical needs. Rebecca did not ask much for herself and we usually saw her in her supportive role with Bob.'

George Eliot Hospital NHS Trust

18.5 Bob was seen in the Neurology Outpatient clinic at the George Eliot Hospital NHS Trust on seven occasions between October 2016 and August 2018. These were routine follow up appointments in relation to his head pain. All more recent appointments were at UHCW.

University Hospitals of Coventry & Warwickshire (UHCW) – Coventry Acute Trust

18.6 Bob was known to the Neurology Team at Coventry Acute Trust following his diagnosis of trigeminal neuralgia and a functional gait[16] disorder in early November 2019.

18.7 In early August 2021, Bob was admitted to Coventry Acute Trust and remained there for 15 days. The consultant in charge of Bob's care reported that on admittance Bob's drug regime was reviewed fully. Bob was taking a large number of drugs at a high dosage. The hospital stay allowed clinical staff to test drugs including a nerve block. These approaches are usually effective with trigeminal neuralgia or very similar conditions but had no impact for Bob and were therefore discontinued. After detailed observations the conclusion was reached that Bob's symptoms did not fully fit with the first diagnosis of trigeminal neuralgia. His consultant gave a diagnosis of 'right-sided atypical headache with functional overlay'[17]. This was explained to the couple and advice given to each on how best to respond to pain attacks. The consultant, a specialist in migraine and headache disorder, explained that there was a psychological element to Bob's pain. Although not received well initially, the consultant believed both Bob and Rebecca had adjusted and were more accepting of this by the time of discharge.

18.8 During his time in hospital, Bob received input from neuropsychology who taught Bob specific techniques which he was supported to practice during his time on the ward. Bob was discharged in mid-August 2021 with a reduced programme of medication and referral for a pain management course.

18.9 Following reported worsening in pain in October 2021, a referral was made to a consultant neurosurgeon at the National Hospital for Neurology and Neurosurgery in London for a second opinion. Bob was waiting for an appointment at the time of his death.

18.10 In mid-October 2021, following Bob's admission to Leicester Acute Trust for self-harm, the clinicians liaised by phone and email the UHCW Neurology team in Coventry. The doctors in Leicester were provided with the updated diagnosis for Bob and information on the planned referral to the specialist London Neurology clinic, which was due to local treatment options having been exhausted.

East Midlands Ambulance Service (EMAS)

18.11 EMAS attended the family address on four occasions. One of these related to the deaths of Bob and Rebecca. The most significant other occasion was in mid-

[16] Functional movement disorder means that there is abnormal movement or positioning of part of the body due to the nervous system not working properly (but not due to an underlying neurological disease). A variety of gait (walking) problems can occur as part of a functional disorder. https://www.neurosymptoms.org/en_GB/

[17] See www.neurosymptoms.org

[17]Taxonomy of Pain, Patient Behaviour (Lechnyr R, Holmes H) cited earlier provides a useful synopsis of 'functional overlay' and the disabling impact on patients of chronic pain.

October 2021 in response to the self-harm by Bob. On that occasion EMAS found Bob to have mental capacity. The EMAS crew attending understood Bob's physical health (intense head pain) to be the primary concern (as opposed to mental health). Bob was offered morphine for his head pain but refused stating it was 'futile'. He did agree to be conveyed to hospital and EMAS confirmed to the police officers that they would take Bob to Leicester Acute Trust (Emergency Department) and would complete the necessary paperwork.

18.12. Rebecca did have minor cuts, but these did not need treatment. There were no suspicions of domestic abuse. Advice was provided to the attending police officers and ambulance crew by the street triage team.

18.13 The EMAS chronology author indicated policies and procedures were complied with and made no agency recommendations.

University Hospitals of Leicester NHS Trust (UHL) – Leicester Acute Trust

18.14 Bob attended UHL for several different health issues. From January 2020 these were:

- Appointments with the diabetes specialist dietician for advice
- Fever and dental problems
- Attendance at sleep clinic
- Admission following self-harm

18.15 There are no records held by UHL indicating any concerns being raised about domestic abuse within the family. There were no concerns about the mental capacity of Bob to make decisions and to consent to care and treatment.

Leicestershire Partnership NHS Trust (LPT) – Leicester's Mental Health Trust

18.16 Bob had three episodes of assessment and diagnosis provided by LPT.

- In 2008 following some short-term memory problems Bob was assessed by adult mental health services and found to have mild cognitive impairment linked to his poor diabetes control and recurrent episodes of hypoglycaemia. Bob was described as 'a detailed man' who reportedly redacted sections of the initial report written about him and gave advice to the Clinical Psychologists. Detailed psychometric testing found that Bob's 'long standing problems with language (from potential dyslexia) combined with difficulties in controlling his diabetes, along with frustration at having cognitive difficulties could account for significant aspects of his cognitive problems.' At the time of this assessment, Bob told clinicians he 'rarely lost his temper'. This assessment would not have been available to clinicians as it was on paper and not on the electronic system. Whilst it would have been useful in providing additional context, the Trust judged it to be highly unlikely that it the assessed cognitive impairment would have had any impact upon Bob's actions in relation to either his wife's or his own death, and therefore on the

assessments directly relevant to this review.

- Between 2016-2018 Bob was assessed by community healthcare services due to falls and mobility issues linked to his diagnosis of trigeminal neuralgia.

- In October 2021, Bob was assessed by a multi-disciplinary team known as the Mental Health Liaison Service (MHLS). This is a team of mental health specialists who work for Leicester's Mental Health Trust and support patients in the Emergency Department in Leicester's Acute Trust, as well as the general wards. The service is designed to provide assessment, care and treatment to people with mental ill health during their stay in hospital. This includes assessing those admitted having self-harmed as in Bob's case. The service contains old age psychiatry specialists. This assessment took place days before the violent deaths of Rebecca and Bob. The details of that assessment are set out below.

The LPT Mental Health Assessment (mid-October 2021)

18.17 Following the self-harm incident at his home, Bob attended the Emergency Department at Leicester's Acute Trust and then moved to an acute medical admissions unit. This was due to the recurrence of his head pain. Bob was then assessed by two LPT MHLS Practitioners (Registered Nurses in Mental Health). Bob did not report being low in mood but had cut himself "*wanting to get out of pain".* During this first interview, Bob told practitioners that he had suffered 22 years of pain and implied that he would rather be dead than have this extreme pain. He did not say that he wanted to die but stated that there was little to live for. The clinical records record that Bob "boasted" that he had watched nursing staff put medication in a locker and had subsequently gained the code for this then had taken additional pain medication. This was reported by Trust staff and Bob had become angry about having been reported.

18.18 Following this assessment, the MHLS Practitioners phoned and spoke to Rebecca. Rebecca reported that *"events on Sunday were out of the blue'*; she said that Bob was in 'constant pain with no relief from his medication' and described the pain being 'like constant electric shocks behind his eye'.

18.19 Rebecca told practitioners that she did not believe Bob to be depressed but did say his condition had an adverse effect on his usual activities. Until two months ago Bob had continued to enjoy playing bridge daily, however this was no longer possible as concentrating triggered a painful attack. Rebecca described Bob's appetite as being good and that he was sleeping well. Rebecca reported no previous attempts at self-harm. She was clear that Bob did not have any cognitive problems and that his memory was very sharp with no confusion or word finding problems and had voiced no unusual thoughts. Bob managed his own medications and Rebecca reported she was unaware of Bob over medicating at home.

18.20 The two nurses found Bob 'defensive'. He tended to avoid answering direct questions about his life, future, suicidal thoughts and ideas. They found him to be elusive and that he 'skirted around the edges.' They found him to be an articulate man who held good eye contact but did not give yes and no answers to direct

questions. The MHLS reviewed the assessment of Bob at a clinical meeting and agreed that he would be further assessed by the team's psychiatrists due to his "nuanced presentation".

18.21 In late October 2021, Bob was still on the ward as the Acute Trust was attempting to manage his reported high levels of pain. Bob was assessed by a doctor (registrar) and a Consultant Psychiatrist specialising in old age psychiatry.

18.22 The psychiatrists reviewed Bob's medical history and spoke with the Leicester Acute Trust's medical staff who had noted inconsistencies in Bob's presentation and reported pain levels, noting that his pain was not present when Bob was distracted or engrossed in an activity or well engaged in a discussion.

18.23 Bob was seen with his wife Rebecca and the Registrar and Consultant found "no evidence of mental illness such as clinical depression, hypomania / mania, anxiety disorder or psychosis". However, they found some inconsistencies in Bob's presentation of pain, and his report of events immediately prior to the incident, about which Rebecca could not remember any detail.

18.24 Bob reported that he had "*wanted to end his life by cutting his veins*". The reason he wanted to end his life was because of the pain which was unbearable. He said the action was unplanned, impulsive, and he had not set his affairs in order. Bob denied any ambivalence – in spite of the careful and tentative nature of the cuts. He stated he only regretted the hurt he had caused his wife. He denied overdosing on his pain relief.

18.25 Bob was reticent about future ideas regarding risk but said that he had no plans to end his life and that he and his wife would *"keep each other safe."* Bob and Rebecca spoke of their plans to go on a cruise around Christmas time. Doctors noted Bob was also open to the idea of seeing a neuro specialist from London which they felt indicated some degree of hope for the future.

18.26 The Consultant Psychiatrist who observed and oversaw the assessment of Bob described him as having "personality vulnerabilities". They described Bob as trying to take control of the assessment and that he was more comfortable talking about physical illness. When assessing the risk of suicide, Bob and Rebecca were asked about whether they had considered ending their lives together. Rebecca reacted saying "*no, definitely not*". There is no reference to Bob's response.

18.27 At times Bob was provocative referring to the assessment process as *'witchcraft'*. The medics noted a theme running through the interaction of Bob wanting to wrestle control in his relationships. They noted that he 'was often speaking for his wife, for example giving her the responsibility of keeping him safe'. He also referred to an excellent relationship with his GP as "*they prescribe what I tell them to."* They also believed Bob wanted to control the neurologist and other medics in terms of his management and medications with Bob tending to become 'discontent when things didn't go according to plan'.

18.28 The incident of self-harm was assessed to be impulsive and secondary to (caused by) pain. Mental health clinicians noted the presence of some specific personality traits referred to as 'cluster B' personality traits. These findings were supported by examples of histrionic and egocentric behaviours displayed by Bob.

Mental health doctors found Bob's interaction dramatic at times with exaggerated emotions, swinging from humour to tears. They found Bob to be 'regularly short tempered with his wife' but then also held her hand when he was getting emotional. They felt this showed an intensity to their relationship with high expressed emotions.

18.29 Mental health doctors felt that, overall, there remained a risk of impulsive self-harm and suicide through misadventure. They assessed that this would be secondary to pain and was not linked to any mental illness. Risk of suicide was assessed as low. The hospital report says both adults were reportedly happy with discharge plans after seeing the mental health team.

Police

18.30 Leicestershire Police's first involvement with the family was on the evening of a day in mid-October 2021. Police Officers attended the home address following an emergency call from Rebecca reporting a concern for safety of her husband Bob. Rebecca reported Bob had cut himself with a knife, injuring his head and hands. She had managed to remove the knife, but he was attempting to get another knife to try to hurt himself again. Bob was experiencing severe head pain.

18.31 Prior to police attendance and whilst removing the knife from Bob to prevent him hurting himself, Rebecca had suffered a minor injury to her hand.

18.32 Officers found Bob lying face down on the floor and Rebecca sitting on a chair in the kitchen close by. Both parties were offered support – both practical and emotional. Officers did not assess the situation as a domestic incident as Rebecca's injuries had not been deliberately caused by Bob but as a result of her taking the knife from him. They also witnessed affection and support between the couple.

18.33 Body worn video shows the approach taken by officers. The camera was turned off after 20 minutes, as the incident was assessed to be fully controlled and there was a need to save the battery.

18.34 Officers were provided with advice by the mobile mental health service. This resource partners a police officer and an LPT mental health nurse who work as a team to respond to people with mental health problems in the community. They attend incidents or give direction and advice as required. In this situation the team decided that Bob's physical health (intense head pain) took precedence.

18.35 The Police contacted EMAS which subsequently attended and took Bob to the Leicester Acute Trust. EMAS staff confirmed they would complete the necessary paperwork and would refer for treatment.

18.36 Whilst waiting for the ambulance Rebecca told the attending police officer that she and Bob were 'very happy' that this behaviour was 'out of the blue'. The officer described Rebecca comforting Bob as she knelt beside him. Officers overheard words to the effect of 'never do anything like that again. If you do, make sure that you do away with me first and then you can do what you like with yourself'. Whilst with hindsight this appears a worrying statement, police officers felt Rebecca was seeking to scold her distressed husband and was berating him for causing her concern.

18.37 The following day, as part of standard checks to ensure compliance with the national crime recording standard (NCRS)[18], a Leicestershire Police Dedicated Decision Maker recorded a crime of assault with Rebecca as the victim. This was as the result of the unintentional yet reckless actions of Bob, trying to harm himself with the knife and Rebecca being injured whilst trying to protect him.

18.38 A DASH[19] assessment is a requirement under the current Domestic Abuse Policy in situations of suspected or actual domestic abuse. Officers did not complete a DASH (Domestic Abuse) risk assessment with Rebecca. Officers reported that they

> 'did not feel that this was a domestic incident that had taken place. No disclosure of abuse had been made. Rebecca's injuries had not been caused by Bob but by Rebecca trying to restrain him. Rebecca stated that Bob had not intended for her to come to any harm and that she had caused the injuries herself.'

18.39 Officers took the view that a DASH assessment was neither appropriate nor proportionate in these circumstances. Rebecca's injuries were not perceived to be 'as a result of violence between the couple as per the domestic abuse definition'.

18.40 Rebecca was spoken to two days later, in line with the set guidance under the Victim Code of Practice. No action was taken against Bob due to there being no complaint from Rebecca; the incident arising from a medical episode, and the injury was unintentional. Rebecca said that she would like to thank the officers who attended the incident for being so good with them both.

Hinckley & Bosworth Borough Council

18.41 Only two contacts were identified, and these were routine council business returns/notifications with no relevance to this review.

19. Additional Information

19.1 As part of its investigations the Police provided information relating to the post-discharge period when Bob returned home from hospital. Police reported that, six days before they attended the address and discovered the bodies, Bob conducted a number of online searches and accessed websites using his laptop computer and the Google account registered to him. These included searches related to poisoning and the impact of injecting insulin to a non-diabetic.

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[18] NCRS: National Crime Recording Standard is a standard for recording crime in accordance with the law to maintain a consistent data set of recorded crime allegations across all forces. https://www.gov.uk

[19] DASH assessment tool is the Domestic Abuse, Stalking, Harassment and Honour based violence assessment tool. This is a checklist assessment tool used by a range of agencies when identifying and assessing victims.

19.2 Two days before the Police entered the address, the GP surgery rang to ask if the couple would like a home visit to receive Covid booster vaccinations. Bob told them they were out in the car. He was reported as 'jovial' throughout the conversation. He told them they planned to come into the surgery the following day for appointments, so declined with thanks.

19.3 At 21.16hrs, the night before the Police attended, neighbours, concerned they had not seen the couple since the previous day, alerted the police to their absence. The Police conducted office-based enquiries and authorised a home visit the following morning. At 09.16hs the following morning the same neighbours rang the Police and confirmed no change, with no sightings of either of the couple. At 10:12hrs Leicestershire Police entered the home and found Rebecca and Bob dead.

20. Analysis

This section of the report seeks to explore how and why events occurred, the quality of information shared, decisions made, and actions taken or not taken. It considers whether different decisions or actions may have led to a different course of events. It will also address the areas of exploration set out in the Terms of Reference and highlight any examples of good practice.

In any analysis it is difficult to avoid the application of hindsight. However, the panel have worked hard to limit this and view the events and the circumstances as they would have been seen and understood at the time.

20.1 Analysis: The couple

i) The limited knowledge of this couple available to the panel is a limiting factor in this review. The couple appear to have had a very small circle of friends and limited local contacts. This is suggestive of a self-contained couple who perhaps relied heavily on each other for emotional support.
ii) Efforts to identify friends who holidayed with the couple have been unsuccessful. These friends may have been able to shed greater light on the nature of the relationship.
iii) Neighbours who also may have seen something of the couple's relationship did not feel able to contribute.
iv) The marriage between Rebecca and Bob was relatively recent (2017). No one on Rebecca's side of the family knew Bob. The only relatives who held a detailed understanding of the couple's life together or had a view on the nature of their relationship were on Bob's side of the family. The couple's stepchildren did provide some insight into their relationship.
v) All family members contacted by the Police Family Liaison Officer expressed their shock and distress at the circumstances surrounding the couple's deaths. None of the family could believe that Bob was capable of killing; they were not aware of nor were they able to identify any 'abusive' or 'controlling' behaviours from Bob in his relationship with Rebecca.
vi) There is no formally reported history of domestic abuse for either Rebecca or Bob in their time together nor with their previous partners.
vii) There is nothing in the evidence presented to the review that indicates that Rebecca viewed herself as experiencing victimisation or undue control from Bob.

viii) There was no evidence available that shed light on how well Rebecca was coping with Bob's deteriorating health.

ix) This report has not benefited from any input by people who were Rebecca's friends or family. The very small circle of people identified does pose a query about Rebecca's potential isolation.

20.2 Analysis: Good Practice and Learning Points

This section describes aspects of good practice demonstrated by agencies. It also identifies specific learning points to highlight opportunities to enhance and develop current practice. At the time these events took place there was a pandemic (Covid 19). A governmental 'roadmap' had been announced in February 2022 to continue lifting lockdown. This was actioned in the subsequent months. No barriers to service provision were identified which occurred as a result of the pandemic.

GP Surgery:

Good practice:

- The GP practice worked hard to support Bob in the management of his pain.
- The action to check and verify Bob's requests for additional medication by reception staff and the GP.
- The home visit undertaken to assist with insulin injection when Bob was alone and too ill to manage this himself.
- The expedition of referrals and reviews on same day as the patient was seen or concerns emerged.
- The offer to provide Covid vaccine boosters at home given Bob's chronic pain.

Learning points

- It is understandable that, given her strength of presentation to them, the surgery staff viewed Rebecca as an advocate rather than a formal 'carer' for Bob. However, the focus on Bob's health did mean that staff did not consider or explore how Rebecca as a 79-year-old woman was coping (practically and emotionally) with Bob's ill-health and what the impact may have been on her daily life. Making inquiries into how she found living with Bob's condition and whether this was becoming more difficult or whether she needed any support to manage or to address potential developing or increasing isolation[20] [21] would have been good practice. The identification of carers is challenging but is a requirement under legislation. A referral for a carer's assessment (assuming Rebecca agreed) would have ensured that Rebecca's needs were fully explored.

- The panel noted the research[22] finding that between one-third and one-half of the UK population (just under 28 million adults) are affected by chronic pain. For those suffering from moderate to severely disabling pain the figures are

[20] World J Psychiatry. 2016 Mar 22; 6(1): 7–17.

[21] https://www.carersuk.org/for-professionals/policy/policy-library/missing-out-the-identification-challenge

[22] Fayaz, 2016.

between 10-14%. It may be timely for GPs to review the NICE guidance in relation to the management of those suffering from chronic primary pain and how it is being applied locally.

University Hospitals of Coventry & Warwickshire (UHCW) – Coventry Acute Trust

Good practice

- The thorough and systematic assessment in its re-evaluation of Bob's condition.
- The psychological support provided to help Bob manage his chronic pain.
- The provision of information both verbally and in writing to Bob on discharge.
- The information sharing with Leicester Acute Trust. This was initiated by a Leicester Acute Trust Doctor who contacted Coventry medical staff to obtain collateral history.
- The Neurologist referral for expert opinion to a specialist neurological clinic when local treatment options were exhausted.

East Midlands Ambulance Service (EMAS)

Good practice

- The stickers alerting people to the issue of domestic abuse on equipment carried by EMAS paramedics. This non-verbal signal helps to raise awareness and potentially can 'sow seeds' with victims – seeing ambulance crew as people they could raise concerns with and would be heard.

Leicestershire Partnership NHS Trust (LPT)

Good practice

- The model of mental health nurses and Police officers working together in the triage car. This is an excellent resource and is a valuable asset for the local community. As well as providing mental health expertise it allows nursing staff to cross check information (with the Police system) to provide information which properly informs those at the scene of an incident.
- The thorough and detailed assessment of Bob's mental state with a clear evidence-based assessment outcome undertaken by MHLS. The independent investigation on behalf of the Trust concluded that the mental health assessments and risk management plans were comprehensive and robust, consistent with national and local guidance and policy.
- The quality of assessments and decisions and the identification of personality traits. The recording of specific behaviours helped to illustrate findings and conclusions being drawn.
- The inclusion of Rebecca at the assessment of Bob which enabled a better insight into the couple's relationship.
- A nurse spoke to Rebecca separately by phone.

Learning Points

- The mental health assessment understandably focused on Bob as the patient. However, efforts to broaden the assessment parameters by exploring Rebecca's experience of living with Bob and the impact of his condition or any adverse moods or behaviours on her may have been useful. There was an opportunity to do this either in the joint interviews or individually via the phone call. This would have added additional context and a deeper understanding of the impact of the chronic pain on the family.

- Training in domestic abuse would support clinicians to consider the impact of patient behaviours on those living with them.

- The mental health mobile triage team respond to live police incidents and provide information and advice to officers. In the self-harming incident of October 2021, information relating to the incident was not recorded on hospital records since Bob was not known to mental health services. It would be worthwhile to review this standard operating procedure to explore any unintended consequences and to satisfy themselves that risk is minimised across a range of scenarios.

- Whilst it would not have affected the outcome, access to GP letters would help mental health doctors understand patients' wider health issues and inform their assessments and response. However, this is dependent on system compatibility at a local and national level.

x) Police

Good practice

- Co-working with mental health specialist is excellent practice. The use of the mobile mental health triage service provides specialist expertise as well as the ability to share information easily and quickly with those managing at the scene.
- The positive relationship officers established with Rebecca at the scene at a time of crisis and the care and sensitivity they displayed in a highly charged and distressing situation.
- The appointment of a different officer to contact Rebecca to complete the documentation under the Victims' Code of Practice (VCOP).

20.3 Analysis: Organisational Factors: Policy and Procedural Issues

i) All agencies involved have in place a process for dealing with concerns raised by practitioners about safeguarding and domestic abuse.

ii) Following the deaths of Bob and Rebecca, LPT commissioned external independent investigators to conduct a Serious Incident Investigation. The report highlights the lack of effective policies, procedures and training to support staff to understand and implement safeguarding priorities. The report also identifies the policy and procedural changes that are underway to address these issues.

20.4. Analysis: Organisational Factors: Use of bespoke tools

i) The completion of the DASH assessment by practitioners is a procedural requirement across agencies. Whilst the Police had training in place for staff, LPT did not. Such tools are useful in contributing to risk assessment and management but, without adequate training and support, staff may struggle to understand and utilise it effectively.

ii) The police officers in this judged that a DASH was not warranted. This is consistent with their view that this was not an assault or a domestic abuse scenario. The panel agrees that the use of DASH would not have indicated any ongoing risk and was not likely to have contributed to the management of the situation in any meaningful way. In this situation, officers acted to address the needs of the couple and were supported appropriately by the remote mental health specialists.

iii) The independent investigation commissioned by LPT found that, although mental health clinicians were sensitive to the signs of domestic abuse, they did not have the necessary education and training expected to develop their knowledge and skill base. A more in-depth understanding may have provided additional lines of exploration, adding deeper insight into the couple's relationship including any indications of excessive control. However, in this case this can only be speculation as the observations of irritability and seeking control over others at times of high stress could be a reaction to the experience of chronic pain and feelings of powerlessness. Similarly, the desire to take charge of those around you may be explained by being caught up in an alien medical system exacerbated by professional jargon and unsettling procedures.

20.5 Analysis: Organisational Factors: Multi-Agency risk management processes (MARAC and MAPPA)

As part of the review the panel considered whether those involved ought to have been subject to a Multi-Agency Risk Assessment Conference (MARAC) or Multi-Agency Public Protection Arrangements (MAPPA). All agencies agree that the threshold for referral to either MARAC or MAPPA was not met.

20.6 Analysis: Organisational Factors: Training

i) All agencies are expected to develop their own training programmes relating to domestic abuse. The Safeguarding Adults Board (SAB) provides some basic materials which agencies can use as well as hosting single events focused on highlighting specific issues.

ii) Information on agencies' training programmes shows that training is available to professionals in all the relevant agencies. During this period, training programmes were affected by the Covid pandemic and most training transferred temporarily to an on-line platform.

iii) General Practitioners have a clear training matrix in place with a schedule of expectations which follows the Intercollegiate Guidance[23] in terms of content

[23] https://northyorkshireccg.nhs.uk/wp-content/uploads/2021/03/training-standards-adults.pdf

and competency levels. GPs are required to attend 20 hours of safeguarding training over three years with a mix of training methods, eight of which are for adults. The GP Safeguarding Leads are required to undertake an additional four hours of training. The CCG/ICB Safeguarding team provide a GP Forum for safeguarding leads across Leicester, Leicestershire and Rutland which has an educative function including the dissemination of the learning from Domestic Homicide Reviews.

iv) University Hospitals of Leicester NHS Trust has a tiered approach to staff training across the organisation in line with the required competencies set out in the intercollegiate guidance. Some specific staff groups such as those in Emergency Medicine or Maternity Services receive additional training. Domestic abuse in older adults is specifically covered in the Level 3 training. Policy and training have been refreshed to reflect the Domestic Abuse Act 2021.

v) During this period the safeguarding training in Leicestershire Partnership NHS Trust was not adequate. However, it has now been fully reviewed. A new programme was launched in autumn 2022 which is reported to be compliant with the intercollegiate guidance. A dynamic risk assessment approach in situations of domestic abuse is designed to ensure that the issues impacting on risk and vulnerability such as older age, disability, mental ill health, and dementia are addressed. It will, however, take a long time to train 5,000 members of staff.

vi) The Police have in place a clear programme for all police officers and staff including taught materials and role play exercises, with refresher training on changes to legislation and procedures. Staff also have access to an approved professional practice (APP) which provides best practice guidance updated by the College of Policing. Training covers all aspects of domestic abuse, with a full day co-delivered with Women's Aid, dedicated to coercive control and its links to homicide. The programme also provides input on vulnerabilities and risk as well as effective partnership working.

The review found several aspects of good practice linked to training across agencies:

i) Very good levels of training on adult safeguarding matters by the majority of agencies.
ii) The adoption of the Intercollegiate Guidance to set standards in NHS training.
iii) The tailored support to a wide range of professionals in Leicester's Acute Trust and additional input for some key teams which helps address the 'systematic invisibility' of older people in domestic abuse service provision[24].

[24] Spotlights Report #Hidden Victims. Safe Later Lives: Older People and Domestic Abuse. October 2016.

iv) The support to GP learning by the CCG (now ICB) which sets clear expectations and ensures GPs are aware of local resources for domestic abuse services. Details of past domestic abuse homicides involving older adults are widely disseminated to agencies.

v) The Police training programme in place which includes co-delivery with Women's Aid. It also plans to develop an independently accredited domestic abuse safeguarding qualification with Safe Lives[25].

20.7 Analysis: Communication between agencies

i) Overall communication between agencies was good. The review did not identify any issues that impacted on the situation or that may have altered the course of events. Historical information is useful for staff to analyse or enrich their assessments, but it is not possible if the patient has not consented. The review noted that some historical information has yet to be digitized and therefore would not be readily or routinely available had Bob consented.

ii) The independent review undertaken for LPT notes that information on the self-harm incident of October 2021, precipitating Rebecca calling for emergency services, was not made available via the Criminal Justice Liaison & Diversion Service (CJLDS). This was because Bob was not an open case nor was recently known to the Trust.

iii) The Individual Management report from LPT states that the mental health doctors noted that there were no notes or clinical letters available to them on the patient's record regarding his neurological diagnosis and treatment from Coventry Acute Trust. However, UHL report that details of the care received from Coventry Acute Trust were present and available within their medical records.

iv) There is a plethora of recording systems used by local NHS teams and services. LPT has 65 different units linked to 'SystmOne' tailored to each service area. Sharing information between units can be problematic, making access to patient information across teams and services challenging. It is not clear if this is in relation to access controls or the complexities of IT. Regardless of cause, this may militate against good information sharing which is key to efficient service delivery.

21. Conclusions

This Domestic Homicide Review describes a very sad set of circumstances leading to the deaths of Rebecca and Bob. Based upon the evidence and information provided to the review, this terrible incident could not have been foreseen by agencies or indeed the family. The conclusions reached are set out in detail below.

[25] SafeLives is a charity organisation which train professionals on domestic violence and provides support and knowledge to front line staff and commissioners.

21.1 Quality of Care & Agency responses

Overall, the quality of care and agency responses were good:

i) Bob received good care from his GP and the neurological services in relation to his chronic condition, which had proved very difficult to completely diagnose. Medication was reviewed and repeatedly adjusted in response to reported symptoms.

ii) Where progress stalled Bob was referred to the highly specialist services for his medical condition, which was believed to be the root cause of his pain. This referral to a consultant neurosurgeon at the National Hospital for Neurology and Neurosurgery was appropriate and good practice.

iii) Bob received psychological input to teach or reinforce positive self-care techniques to manage his pain and reduce the debilitating impact on his daily life.

iv) Bob's mental health was thoroughly assessed during his most recent period in hospital. He was seen by qualified mental health nurses and by psychiatric doctors. Whilst he had been distressed and frustrated when he cut himself, he did not have a mental illness and there was no reason to keep him in hospital against his will.

v) The EMAS response to the emergency call-out in October was timely (within 20 minutes). Morphine pain relief was offered by paramedics, but Bob refused.

vi) Police officers attending the same incident formed positive relationships quickly and were praised by Rebecca for their care and sensitivity. Overall, it is felt that the officers dealt with the concern for safety incident sensitively, appropriately, and professionally.

21.2 Domestic Abuse

There is insufficient evidence to indicate that domestic abuse was a factor in this homicide.

iv) The issue of abuse within the home environment is often difficult to identify. No agency identified any signs indicating the presence of domestic abuse. Whilst the dynamics witnessed on one occasion at hospital between the couple and indeed with clinicians could be categorised as potentially indicative of 'controlling' behaviour[26], this is insufficient information to be confident that it constituted domestic abuse and to assert that this was a factor in Rebecca's death.

v) The family are certain there was no abuse, never had been any abuse and that the couple enjoyed a close and supportive partnership. They saw no

[26] Coercive and controlling behaviour is "…a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

pattern of behaviour they would categorise as threatening, humiliating or intimidation from either party. The GP also witnessed an apparently close and supportive relationship. Hospital staff referred to Rebecca and Bob as being 'partners in care'.

vi) Whilst it is clear that Bob killed Rebecca, there is nothing in the evidence presented to the review that indicates that Rebecca viewed herself as experiencing victimisation or undue control from Bob prior to her death. She made no disclosures of abuse, threats, or control to either family or agency professionals. No agency viewed or suspected that Rebecca was a victim or a potential victim of any form of domestic abuse.

vii) Whilst the suicide note is from Bob and Rebecca, it is not possible to assess the actual level of any involvement Rebecca may have had in a plan to jointly take their lives. The note was type written and placed in an envelope with Bob's handwriting on it. Analysis of digital devises showed that Bob was the author. The note indicated that Rebecca was already dead, and he would also die shortly.

viii) There were two reported references in the past when Rebecca stated her wish not to go on without Bob. However, the Police found no evidence to suggest that she did want to take her own life. There are no internet searches in relation to joint enterprise suicides. She did not leave a separate note or individually sign the note typed by Bob. She also denied any thoughts of this when asked in Bob's mental health assessment in October.

ix) Agency training programmes on domestic abuse were reviewed. Overall, the review found several aspects of good practice linked to safeguarding training across agencies but found some room for improvement. Specific recommendations are made to strengthen the offer across the area.

21.3. Avoiding the Tragedy

There were no professional missteps or omissions identified which may have contributed to the death of Rebecca. The review was not able to identify any specific 'triggers' or 'tipping points' that signalled an increased risk of homicide.

i) It is not possible to say with any certainty what Bob's thinking was at the time of Rebecca's death. There were no signs identified by professionals or family that were indicative of past abuse, violence, or indeed homicidal intent by Bob.

ii) During his mental health assessment in October 2021, Bob had denied feeling low or a wish to end his life when talking with clinicians and assured them the couple would 'keep each other safe'. He agreed to tell staff if he felt like that again.

iii) During Bob's previous hospital stay in Coventry in August 2021 the Consultant Neurologist had begun to explain to the couple the common psychological aspects involved in conditions of chronic pain, and the role of self-care techniques in long-term pain management. It is clear from the stepson's feedback/understanding that it had been difficult for both Bob and Rebecca to accept this new information. It appears they both remained resistant to the ideas presented, and soon after discharge Bob reverted (unsuccessfully) to using drugs to manage his pain as before.

iv) Mental health professionals identified that Bob had a particular set of personality traits. These may have made it more difficult for Bob to accept challenge. Clinicians believe that these traits may have made him more prone to impulsivity than others in the general population and they saw examples of this during his hospital stay.

v) Based on his presentation and responses to doctors and nurses just prior to the deaths, Bob's risk of future harm was assessed as low.

vi) Bob's internet searches after discharge had a focus on different methods of homicide and belied his presentation in hospital. This information only emerged after death.

vii) The majority of the professionals who had contact with Rebecca and Bob did not know them well. The GP surgery staff were the exception to this, and the staff were shocked by the couple's deaths having seen no warning signs. Their last contact with Bob, the day before the deaths, was reported to be 'jovial' and indicated the couple's intention to visit the surgery for their vaccination appointment the following day.

viii) The couple's actions and words and their outward presentation (for example booking holidays for later in the year) would not have raised any 'red flags' for their families. The couple's behaviour clearly indicated the capacity to look forward and to plan.

21.4 Communication between agencies

Overall communication between agencies was good.

This review did not identify any issues that impacted on the situation, or which could have altered the course of events. Of particular note, is the cross-Trust communication with good liaison between medical staff in UHL in Leicestershire and UHCW in Coventry.

i. There may be value in the relevant personnel reviewing how best information could be shared from emergency services through to a mental health assessment, including the role of the NHS Trust's Criminal Justice, Liaison and Diversion Service and the guidance around recording relevant risk information on people's records even when the person is not a Trust patient.

21.5 Identification of carers

Professionals' understanding of their duty to identify potential carers appears to be underdeveloped.

i) There was insufficient professional curiosity about Rebecca and her ability to cope with the family circumstances at the age of 79 years. There was a lack of exploration regarding the impact on Rebecca of caring for someone with a chronic and debilitating condition and the potential for isolation. There was a missed opportunity to refer Rebecca for a carer's assessment where such issues could have been explored in some depth with her consent.

22 Addressing Family Concerns

23.1 Some family members have expressed a concern that something was missed at the time of the self-harm incident and that had Bob remained in hospital or had a different discharge plan, events would have been different. This is an understandable viewpoint and was considered very carefully by the panel as they weighed the various points set out below:

i) Bob's mental health was thoroughly assessed during his most recent period in hospital. He was seen by qualified mental health nurses and by psychiatric doctors. Whilst he had been distressed, and frustrated when he cut himself, he did not have a mental illness and could not have been kept in hospital against his will. Both Bob and Rebecca agreed to a discharge home. Both left the hospital accepting of the care plan, albeit possibly with some scepticism.

ii) There is a possibility that in later years of his condition Bob may not have had strong emotional resilience and was showing an inability to cope with his experience of daily pain, evidenced by his escalating requests for medication. The positive and distracting activities he had previously enjoyed, (bridge and stamp collecting for example) were significant for Bob and would likely have acted as a 'protective' factor in the past. With hindsight it is possible to view these losses as potential warning signs of reduced coping. Whilst the self-harm incident was a significant signal that Bob was not coping, it was the only such behaviour in years of managing his poor health. There were no known previous concerns, incidents or significant life events which might have signalled the risk of violence from Bob to Rebecca. None of these factors taken separately or together indicated a risk for homicide.

iii) It is very difficult to confirm a direct causal link between Bob's pain and the subsequent actions that led to the deaths. The panel debated this but concluded it must remain an unanswered question. It is not clear what pain management education Bob had been offered or felt able to accept over the years prior to the timescale covered by this review. However, it does appear that during 2021 Bob's self-management skills as an adjunct to medication were not strong. Whilst chronic pain is very common in the general population

the experience is different for everyone and medical responses will always need to be individually tailored.

iv) After careful consideration, the panel could not identify any professional missteps or omissions which may have contributed to the death of Rebecca. It was not able to identify any specific 'triggers' or 'tipping points' that signalled an increased risk of homicide. Nor were there any identified opportunities where different evidence-based interventions by professionals would have altered the tragic outcome.

23. Learning Points and 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 2022-2025[27],[28] was presented at the Leicestershire Cabinet in early December 2022 and was approved. This is a sub-regional strategy (Leicester, Leicestershire & Rutland [LLR]).

[27] https://www.leicestershire.gov.uk/adult-social-care-and-health/looking-after-someone (main page)

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

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.

Single Agency Recommendations

- Leicestershire Partnership Trust (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.

- 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.

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Additional Resources

https://www.curablehealth.com/infographic/path-of-chronic-pain-download

Chronic-Pain-Infogr
aphic-printable-cta.

Appendix 1 AUTHOR OF THE OVERVIEW REPORT

Moira O'Hagan was appointed as the Independent Overview Report Author and Panel Chair. At the time of this appointment, she undertook this role as an Independent Practitioner who specialises in domestic and sexual abuse.

The appointment panel agreed that her prior experience evidenced her fulfilling the criteria set out in the statutory guidance for Domestic Homicide Reviews. She has completed the Home Office Domestic Homicide Review training packages, including the additional modules on chairing reviews and producing overview reports.

Moira O'Hagan has over forty years' experience in both children's social work and children's mental health. She has operated for many years at a senior level across children's services in the public sector including NHS, Social Care and in Education. She has a long history of multi-agency working and improvement work to drive up standards of care.

She has not worked for Leicestershire County Council since 2020 and in Leicestershire Partnership Trust since 2007. In both agencies Ms O'Hagan worked exclusively within children's services.

She now works independently and has no links to past employers.

Ms O'Hagan undertakes voluntary work with a local children's charity, but this poses no conflict of interest.