DOMESTIC HOMICIDE REVIEW - OVERVIEW REPORT

Derbyshire Safer Communities Board

REPORT INTO THE DEATH OF June and Peter

September 2023

Report produced by Chris Ward – Foundry Risk Management Consultancy

Report Completed August 2024

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Foreword

Derbyshire Safer Communities Board (DSCB) would like to express their condolences to all those affected by the sad loss of June and Peter. We sincerely hope the learning and recommendations gained from our enquiries and deliberations will help agencies to prevent similar incidents from happening again in the future. The Independent Chair of the review panel would like to thank all agencies who contributed to the process in an open and transparent manner.

This review has demonstrated that more needs to be done to raise awareness and change attitudes towards domestic abuse and that it is crucial to offer appropriate and timely help and advice to victims, their families, and friends, and professionals. The panel is confident that the learning points and recommendations will provide a platform to help national, regional, and local agencies to implement measures designed to prevent what happened to June and Peter from happening to others.

Following June and Peter's deaths, there is emerging evidence of positive change at a local level, and we all must do our utmost to take immediate action both to protect the vulnerable and the chair would urge everyone to take note and act on the findings of this review.

The following is a tribute supplied by Sally, the Daughter of June and Peter:

"I am so lucky as I have so many amazing memories of my mum and dad and our wonderful life together and am so sad that their lives ended in the way that they did. I hope that this review will highlight anything that could be dealt with differently in terms of mental health support in the future. It is really important that no other family has to go through such a painful experience as we have."

The following is a tribute from Peter's Brother, Simon:

"Peter and June were a wonderful couple and I loved them both so much. It was always a pleasure to be in their company. They were devoted to one another and to their daughter Sally and son in-law . Peter was a wonderful brother to me growing up. When he met June all the family took to her and it wasn't long before they were married. I visited them regularly and I had many a long conversation with him about football which was his favourite subject, Man Utd and Chesterfield the main topics. All our family are fans. He was a very knowledgeable man and had such a great memory. Peter was a kind big hearted guy who I loved so very much and I miss them both every day."

The names used in the foreword and tribute are pseudonyms and explained in section 3.5 of the report.

1. Introduction

1.1 This Domestic Homicide Review was established under Sec 9(3) of the Domestic Violence Crime and Victims Acts 2004.

1.2 This Domestic Homicide Review (hereafter 'the review') examines agency responses and support provided to June and Peter, both resident in Derbyshire, prior to her homicide and his suicide in 2023.

1.3 In 2023 police were called following the discovery of the bodies of June and her husband, Peter, at their flat in Derbyshire . A police investigation concluded that it was highly probable that Peter had killed June and then taken his own life. The Police confirmed that they were not looking for anyone else in relation to this tragic set of events.

1.4 The review will consider agency contact/involvement with June and Peter for the two years prior to their deaths. The reason for this timeframe was to allow the review to consider any history or pattern of known domestic abuse, whilst trying to avoid considering policies, protocols, and practices, which are no longer in use and could be viewed as being outdated. That said, the chair of the panel encouraged agencies to collate and report any matters outside of this timeframe which it considered relevant in assisting the review process. This time frame also ensures that opportunities for learning and the recognition of good practice were relevant to current methods, policies, and processes.

1.5 The key purpose of undertaking this review is to enable lessons to be learned, and for them to be understood as widely and as thoroughly as possible. Professionals need to be able to understand fully what happened and most importantly what needs to change in order to reduce the risk of such tragedies happening in the future.

1.6 This review process does not take the place of the criminal or Coroner's Courts, nor does it take the form of a disciplinary process.

1.7 The review panel wishes to express its sympathy to the family of June and Peter for their loss and thanks them for the contribution in supporting this process.

2. Timescales

2.1 Derbyshire Safer Communities Board initiated this review in accordance with the Multi-Agency Statutory guidance for the Conduct of Domestic Homicide Reviews (hereafter 'the guidance").

2.2 Following a review of the circumstances leading up to the death of June and Peter, a referral was made to the Derbyshire Safer Communities Board. This came from The East Midlands Special Operations Unit (EMSOU), a regional police team, who conducted a homicide investigation and the subsequent Coronial report. Detective Inspector Paul Bullock was appointed as the Senior Investigating Officer.

2.3 The conclusion of that investigation was that there was no third-party involvement in the incident. On that basis, and given that just one such act would constitute Domestic Abuse, the referral recommended a Domestic Homicide Review, would be appropriate

2.4 In October 2023 the Derbyshire Safer Communities Board informed the Home Office of their intention to hold a Domestic Homicide Review. A letter of reply and agreement was received on the 10th October 2023.

2.5 Chris Ward was commissioned as the Independent Chair (hereafter 'the chair') for this review on 24th November 2023 . The completed report was agreed by the review panel on 28th August 2024 and passed to the Derbyshire Safer Communities Board for review by the Derby and Derbyshire Domestic and Sexual Abuse Partnership Board. It was then submitted by the DCSP to the Home Office Quality Assurance Panel on the 23rd October 2024.

2.6 Home Office guidance states that a review should be completed within six months of the initial decision to establish one. This timeframe has, broadly, been achieved.

3. Confidentiality

3.1 The findings of each review are confidential and remain so until the Overview Report has been approved for publication by the Home Office Quality Assurance Panel. Information is publicly available only to participating professionals/officers and their line managers.

3.2 Details of confidentiality, disclosure and dissemination were discussed and agreed between panel member agencies during the first panel meeting. All information discussed was treated as confidential and not disclosed to third parties without the agreement of the responsible agency's representative.

3.3 All agency representatives were personally responsible for the safe keeping of all documentation that they possessed in relation to this review and for the secure retention and disposal of that information in a confidential manner.

3.4 The chair advised that confidential information must not be sent through any other email system unless they were protected by a password.

3.5 This review has been suitably anonymised in accordance with the statutory guidance. The specific date and location of the death has not been recorded in this report and pseudonyms were selected by the chair and agreed with Sally and are used in the report to protect the identity of the individuals involved.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
June	Wife (Deceased)	70 yrs	White, British
Peter	Husband(Deceased)	72 yrs	White, British
Rachel	Sister of Peter	N/A	White, British
Simon	Brother of Peter	N/A	White, British
Sally	Daughter of June and Peter	N/A	White, British

4. Terms of Reference

4.1 Following discussions at the initial panel meetings, the chair circulated the Terms of Reference (ToR), along with the templates for completing IMR's, to the agencies that had contact with June and Peter. Details of the Terms of Reference are contained in Appendix 1. The review aims to identify learning from June and Peter's deaths and for actions to be taken in response of that learning.

4.2 The Review Panel consisted of agencies from Derbyshire Safer Communities Board as both June and Peter were living in the area at the time of their deaths. Agencies were contacted as soon as possible after the review was established to inform them of the creation of the review and inform them of the need to secure records.

4.3 The Review Panel considered the Key Lines of Enquiry upon which the process should focus. Consideration was given to the content of the Combined Chronology and Individual Management Reviews, before deciding upon these case specific issues:

- Responding to crisis
- Mental health and links to domestic abuse
- What advice was given about worsening symptoms of mental health and the side effects of sertraline?

4.4 At the second meeting the panel shared brief information, obtained from the initial 'trawl for information', which had been carried out at the start of the process. At this stage, it was agreed that the review process should look back two years into the history of involvement between panel agencies, June and Peter, for the reasons explained in paragraph 1.4.

5. Methodology

5.1 Throughout the report the term 'domestic abuse' is used interchangeably with domestic violence and the report uses the definition provided by the Domestic Abuse Act 2021 i.e.

- The Behaviour of a person (A) towards another person (B) if.

  I. A and B are each aged 16 or over and are personally connected to each other and.

  II. The behaviour is abusive.

- Behaviour is abusive if it consists of any of the following -

  1. physical or sexual abuse.
  2. violent or threatening behaviour.
  3. controlling or coercive behaviour.
  4. economic abuse (see subsection (4)).
  5. psychological, emotional, or other abuse.

It does not matter whether the behaviour consists of a single incident or a course of conduct.

5.2 Two people are Personally Connected to each other if any of the following applies.

1. They are, or have been, married to each other.
2. They are, or have been, civil partners of each other.
3. They have agreed to marry one another (whether or not the agreement has been terminated).
4. They have entered into a civil partnership agreement (whether or not the agreement has been terminated).
5. They are, or have been, in an intimate personal relationship with each other.
6. They each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2).
7. They are relatives.

5.3 It is further defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse, psychological physical, sexual, economic and emotional.

5.4 This review has followed the statutory guidance. On notification of the deaths, agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to initially seek chronologies of events from each agency followed by Individual Management Reviews (IMRs) from all the organisations and agencies that had contact with June and Peter.

5.5 Fifteen agencies were contacted to check their involvement; ten agencies confirmed that they had had no contact. Five agencies submitted chronologies and two of those produced IMR's. In addition, the East Midlands Ambulance Service NHS Trust (EMAS) and Derbyshire Community Healthcare Services provided short reports.

5.6 Independence and Quality of IMRs: IMRs were written by authors independent of case management or delivery of the service concerned. The reports were comprehensive and enabled the panel to analyse the contact with June and Peter and to produce learning for this review. Where necessary the chair held separate meetings with individual agencies, including panel members and report authors. Both IMR's made recommendations and produced action plans of proposed and ongoing activity.

5.7 The Chair completed a face-to-face interview with the only child of June and Peter, Sally in January 2024.

5.8 Details of the research completed by Chair and sources of their analysis are contained in Appendix 5.

6. Involvement of Family, Friends, and Community

Details of how Sally was informed of the DHR.

6.1 Contact with Sally was made through the Police Family Liaison Officer (FLO), and with the support of an advocate from Victim Support. The advocate does not wish to be named in the report, but the chair wishes to express his gratitude for her assistance and professionalism in the care she has offered Sally and the assistance she has given to this review.

6.2 Sally is the only child of June and Peter. She is, understandably, devastated by the events examined within this review. Sally is unaware of the exact details of her parents cause of death. She has chosen, understandably, to be protected from these, whilst she deals with the trauma of the events. Her husband, John, was present during the interview. He is aware of the details and has been hugely supportive of both his wife and to the process of this review.

6.3 The chair met with Sally in January 2024, and she was supported by the Victim Support advocate and her husband. Sally had been provided with details of the Home Office DHR leaflet, information of the advocacy services provided by AAFDA and the Terms of Reference.

6.4 There were no communication issues between Sally and the chair and interaction was carried out via a face-to-face meeting and email exchange between the chair and the Victim Support advocate, supporting Sally.

6.5 June had no other surviving family members. All other family members were related to Peter. The remaining family members are also immensely traumatised by these events, as detailed in the Background Information at 13.1 of this review. They declined to be interviewed to prevent re traumatisation. This is fully understandable and respected by the chair.

Summary of Interview with Sally

6.6 The chair met with Sally along with her husband and the Victim Support advocate. Sally explained her huge sense of loss and grief and how she was struggling to come to terms with what had happened.

6.7 She explained that her parents had been hugely supportive, loving, caring and that she had a traditional upbringing. Her parents had always been there for her both during her childhood and, latterly as an adult, during her happy marriage. Both June and Peter had an excellent relationship with John, her husband. In fact, John and Peter would go to football matches and they all shared time on family holidays. Sally said her parents treated John like their own son. Sally and John do not have children.

6.8 Sally described her parents as being happily married for fifty-one years and had celebrated their wedding anniversary four months prior to their deaths. Sally described how her parents had met on a night out. They married a short time later and moved into the flat, which was to become their family home until their deaths.

6.9 The chair asked about their life together, and Sally explained that June was an only child and had lost her own father at a young age. Sally said that June was a caring person and would always seek to help other people in the community. She had various jobs as Sally was growing up, most of these roles were part-time, in order that June could focus on Sally's upbringing.

6.10 Sally explained that Peter was also a loving and caring father. She describes him as a gentle man, that never raised his voice or got annoyed. She never saw, or was aware of, any conflict between her parents. In fact, Sally described quite the opposite and was keen to stress that Peter was placid and kind.

6.11 Sally described Peter as a hard-working man, who had initially worked in the coal industry, prior to taking up a role in finance in a large organisation, which was based locally. He remained in this role until his retirement several years before his death.

6.12 She described her parents as having a wide circle of friends. Both June and Peter would enjoy nights out with friends at their local pub, taking part in quiz events and also trips on coaches and short breaks away. Sally described both her parents as being very popular and very active socially in their community.

6.13 Peter had been involved in a serious car crash nearly forty years prior to his death. The accident had initially caused him serious injuries, which he recovered from but the injuries necessitated the use of a stoma. Sally did not think that it had affected the overall quality of his life and his ability to be active.

6.14 Since both June and Peter's retirement, Sally described them as being busier than ever. This was until the Covid 19 Pandemic. Sally describes both her parent's frustration at not being able to socialise with their friends and take part in the normal activities that kept them busy. Sally highlighted that during the pandemic, Peter began to lose weight and he became more insular and communicated less. She describes this as improving over time and that Peter decided to give up driving in the months prior to his death, as he was struggling and not enjoying driving.

6.15 In the week preceding June and Peter's deaths, Sally describes a significant deterioration in Peter's mental health. Sally had spoken to June, who had stated that Peter was restless and was struggling to sleep. He had been prescribed medication and that the GP had arranged an appointment for the following Monday, with the Mental Health Team. Sadly, the events in this review took place a day before that appointment. Sally explained her shock and disbelief at what her father did and how out of character it was for him.

6.16 At the conclusion of the interview the chair discussed the fact this review would result in a report being prepared and that it may be subsequently published. Sally was invited to take further part in the review and offered the opportunity to see a final draft and provide feedback. Sally's response was that she was very happy to have met the chair and provide the details described above, but that she did not wish to have any further involvement with the review process.

7. Contributors to the Review

7.1 The following agencies were contacted and confirmed engagement with June and Peter.

Agency Name	Known to the agency	Chronology	IMR
Derbyshire Constabulary	Yes	Yes	No
East Midlands Ambulance service	Yes	Yes	Yes (Short Report)
Royal Primary Care	Yes	Yes	Yes
Derbyshire Healthcare Foundation Trust (Mental Health Services)	Yes	Yes	Yes
Chesterfield Royal Hospital Foundation Trust	Yes	Yes	Yes (Short Report)

7.2 During the initial scoping process several other agencies were contacted but confirmed they were not involved with either party.

- Derbyshire Fire and Rescue Service

- GLOW (Derbyshire's IDVA service provider)
- Probation service
- Derbyshire Adult Social Care
- Derbyshire Children's Services
- Victim Support Service
- SV2
- University Hospitals of Derby and Burton
- Derbyshire Recovery Partnership
- The Elm Foundation (Service Provider of Derbyshire Domestic Abuse Helpline and the local provider of Derbyshire Domestic Abuse Support Services

8 Review Panel Members

8.1 The Review Panel was populated by the following agency representatives. As per the statutory guidance, the chair, and the review panel are named, including their respective roles and the agencies which they represent. Agencies who provided information to the review are also identified.

Name	Role/Job Title	Agency
Chris Ward	Review Chair	Foundry Risk Management Ltd.
Paul Bullock	Detective Inspector	East Midlands Special Operations Unit
Alison Boyce	Domestic Abuse Manager	Derbyshire County Council
Gillian Quayle	Health Improvement Practitioner - Public Health	Derbyshire County Council
Michelle Grant	Designated Nurse Safeguarding Adults	NHS Derby and Derbyshire ICB
Faye Green	Community Safety Manager	North-East Derbyshire District Council
Jane Walker	Manager	Rykneld Housing
Julia Ashbrook	Senior Community Safety Officer	Derbyshire County Council

Lauren Earle	Contracts Manager – Domestic Abuse and Community Support	Derbyshire WISH
Rachel Morris	Chief Executive Officer	SV2
Gina Rodgers	Manager	Derbyshire Community Health Services NHS FT
Nikki Roome	Assistant Director Safeguarding Adults	Derbyshire Healthcare Foundation Trust
Charlotte Salt	Safeguarding Adults Lead	East Midlands Ambulance Service
Sara Hinch	Named Nurse for Safeguarding Children & Families	Chesterfield Royal Hospital Safeguarding
Tom Brown	Service Manager	Derbyshire County Council Safeguarding Adults Quality Assurance & Development Team
Sharon Dove	Named Nurse for Safeguarding Adults	Derbyshire Community Healthcare Services
Kim Saunders	Deputy Head of Derby City and Derbyshire PDU	Probation Service
Helen Weston	Manager	Derbyshire Carers Association

8.2 Independence and expertise. Agency representatives were of an appropriate level of expertise and were independent of this case.

8.3 The panel initially met on the 6th October 2023, prior to the appointment of the chair. Subsequent full panel meetings took place on 25th of February 2024, the 23rd of May 2024, and the 28th August 2024. On-going reports were reviewed at the latter meetings with the panel members providing feedback. In between panel meetings, the chair held a number of meetings with individual panel members.

8.4 The chair of the review wishes to thank everyone who contributed their time, patience, and cooperation throughout this review.

9 Author of the Overview Report

9.1 Chris Ward was appointed by the Derbyshire Safer Communities Board as independent chair and author of this Domestic Homicide Review panel. Chris is a former Thames Valley Police Officer, having retired in 2010, and has over 30 years of

detective experience in the field of Domestic Abuse, Public Protection and Safeguarding. His experience includes Head of The Major Crime and Homicide Unit and Head of Crime governing Specialist Operations Teams and Child Protection Units.

9.2 As the Assistant Chief Constable for Local Policing he had oversight of strategic partnerships and safeguarding processes.

9.3 Since retirement Chris has established his own consultancy business, coaching and training in a range of risk management environments focusing upon child and adult safeguarding within the public sector.

9.4 Chris has completed Home Office approved training and has achieved The Level 3 Home Office accredited AAFDA training, in chairing DHRs.

9.5 Chris has no connection with the Derbyshire Safer Communities Board.

10 Parallel Reviews

10.1 Inquest: The inquest into the death of June and Peter was opened shortly after their deaths and was concluded in February 2025. The conclusion of the Inquest was that June had been unlawfully killed and that Peter had died by suicide.

10.2 Criminal Investigation: Following a police investigation it was confirmed that no other parties were sought for the death of June or Peter The matter was therefore referred to the Coroner.

11 Equality and Diversity

11.1 The review panel considered all the protected characteristics under the Equality Act 2018 i.e.

- Age
- Disability
- Gender Assignment,
- Marriage and Civil Partnership.
- Pregnancy and Maternity
- Race
- Religion and Belief
- Sex
- Sexual Orientation.

11.2 The panel reflected upon each of these characteristics in evaluating the quality of the various services provided to both June and Peter, and whether there were any barriers to them accessing these services. Additionally, the review has considered the wider perspective of whether agency service delivery was impacted by any of these characteristics.

11.3 There were two areas of protected characteristics requiring consideration. The first is the sex of June. She was female, and Peter was male. An analysis of DHRs reveals gendered victimisation across both intimate partner and familial homicides with

females representing the majority of victims and males representing the majority of perpetrators.[1]

11.4 The second is that of age. There have been several reports describing the systematic invisibility of the elderly in relation to Domestic Abuse.[2] The chair also notes that the British Crime Survey, in relation to Domestic abuse, had until 2017 only included those aged 16 to 59, but now includes those aged 60 to 74.

11.5 On considering the Equalities Act, it is incumbent on this review to consider the duty on public authorities to:

- remove or reduce disadvantages suffered by people because of a protected characteristic.
- meet the needs of people with protected characteristics.
- encourage people with protected characteristics to participate in public life and other activities.

11.6 These issues are discussed later in this report.

1. HO-Domestic-Homicide-Review-Analysis-161206.pdf

2. Safe Later Lives | Older people & domestic abuse - SafeLives

12 Dissemination

12.1 Once finalised by the Review Panel the Executive Summary and Overview Report were presented to the Derby and Derbyshire Domestic and Sexual Abuse Partnership Board for approval. Upon approval, they were sent to the Home Office for Quality Assurance.

12.2 The recommendations will be owned by the Derbyshire Safer Communities Board, who will be responsible for disseminating learning through local professional networks as well as managing progress of the Action Plan, which is created at the conclusion of this review and in response to the recommendations that have been made.

12.3 The following individuals and agencies have been identified as recipients of both reports

Agency
All panel members
Derbyshire Safer Communities Board
Derbyshire Safeguarding Adult Board
Derbyshire Police & Crime Commissioner
Derby and Derbyshire Domestic and Sexual Abuse Partnership Board

13 Background Information (The Facts)

13.1 As mentioned previously June and Peter lived in Derbyshire. They had been together for over 52 years. June has no siblings, or other surviving relatives. Peter has six siblings, three brothers and three sisters. The couple lived in a small neighbourhood and were well known. Sally lives a short distance away.

Events leading to the initiation of this review

13.2 Some eight days prior to the deaths of June and Peter, it was clear that Peter's mental health was deteriorating suddenly and significantly. There had been a deterioration following a family holiday in 2023. Peter was described as quiet and not engaging.

13.3 At this time Rachel, a sister of Peter, was concerned enough about him to contact Derbyshire Mental Health Helpline. She stated that Peter had been having thoughts of suicide. She was advised to contact Peter's GP, which she did.

13.4 Two days later, Peter and June attended an appointment at their GP surgery. Peter explained his low mood and anxiousness. An urgent referral was made to Derbyshire Community Mental Health Team, as well as an appointment with the surgery mental health nurse for the following week.

13.5 Two days later a telephone consultation took place between the Community Psychiatric Nurse and Peter. He denied any suicidal ideation or self-harming thoughts. He was placed on the appointment list for referral for psychiatric assessment.

13.6 Later that same day, June confided in her Daughter, Sally, that Peter had grabbed hold of her and said, "I could kill you"

13.7 The following day June contacted the Mental Health Helpline again. She explained that Peter was confused and described him threatening to strangle her two days prior. June said that she was not scared of Peter but is worried about the deterioration in his mental health. The call taker raised the urgency of the situation to Amber and an appointment was arranged with a psychiatrist.

13.8 Over the next two days, both June and Peter were seen by Sally and Peter's brother, Simon. Both noticed that Peter was quiet and not as engaging as usual.

13.9 On the next day attempts were made to contact both June and Peter on their home landline without success. Rachel and her brother, Simon attended June and Peter's address. They sadly discovered the bodies of June and Peter within the flat and alerted the Police.

14 Combined Narrative Chronology

14.1 The following section summarises contact between June and Peter with agencies. To assist the reader, the table below summarises the names of the organisations and their role in this case. The paragraphs within the narrative chronology are prefaced with the lead agency to identify the primary source of information.

14.2 There was very little contact with agencies both during the review period and some years before it.

Organisation	Role	Pre-Face
Derbyshire Constabulary	Police	Police
East Midlands Ambulance Service	Ambulance Service NHS	EMAS
GP Services	Primary Care Provider	GP
Derbyshire Healthcare Foundation Trust	Mental Health Services	DHCFT
Chesterfield Royal Hospital NHS Foundation Trust	Acute Hospital Care	CRHFT

14.3 Matters occurring prior to the review period.

14.3.1 The chair has examined medical records, which predate the time parameters of this review. There is no material which relates to or is relevant to the circumstances of this review. There are no other relevant agency contacts prior to the time parameters of the review.

14.4 May 2022

14.4.1 EMAS - On the **24th May 2022,** June called 111 as she had a significant nosebleed. June stated this was a result of a long-term cough she had and it was aggravating the symptoms. The NHS 111 operator contacted EMAS who treated June and conveyed her to Chesterfield Royal Hospital.

14.4.2 CRHFT- On the **24th May 2022** June was conveyed to the Emergency Department of the hospital with a nosebleed, she arrived by ambulance. She gave a history of having nose bleeds for the last 10 years and these were spontaneous in presentation. She was admitted for 8 hours to ensure bleeding had stopped. June was then discharged home with referral to outpatients. No routine domestic abuse enquiry had taken place in relation to domestic abuse as is recommended by local and national guidelines.

14.5 August 2022

14.5.1 EMAS- On the **8th August 2022**, June called 111 as she felt her knee crack as she got up. It was causing significant pain and EMAS attended and conveyed her to Chesterfield Royal Hospital.

14.5.2 CRHFT- On the **8th August 2022**, June arrived at Chesterfield Royal Hospital having been conveyed there by ambulance with knee pain. She gave a history of having got up off the toilet and felt her knee crack, being unable to weight bear since. Staff enquired in relation to social circumstances, June stated she lived with her husband and was mobile and independent. An X-ray was carried out and no fracture identified. June was discharged home with pain relief, crutches, and splint. No routine enquiry

had taken place in relation to domestic abuse as is recommended by local and national guidelines.

14.6 July 2023

14.6.1 GP- On the **7th July 2023**, Peter was referred for a colonoscopy, having suffered stomach cramps and bowel issues. He was diagnosed with diverticulitis.

14.7 September 2023

14.7.1 DHCFT- On the **2nd September 2023** Peter's sister, Rachel called the Mental Health Support Line. She briefly explained that she was looking for advice, as Peter had been feeling anxious. Peter confirmed he was happy for his sister to talk to the call taker. They were advised to speak to the GP and were offered support from the helpline to look at resources to help with his anxiety. The call was cut off. An attempt was made to call them back, which was expected practice.

14.7.2 DHCFT- Shortly afterwards, another call was made to Mental Health Support Line, details were taken and Peter was spoken to. He said he was feeling very anxious, and his mood was very low, he expressed physical concerns around his weight loss and reported he had thoughts around 'not being here'.

Peter described feeling more anxious about his physical health. His sister explained he had had some physical health investigations and there was no concern around the results. Peter was advised to call his GP and talk to him about how he was feeling, and the GP could look at the right pathway to get help. The Mental Health Support Line informed Peter they could support with signposting, and they were open 24 hours 7 days a week if he needed to call.

Peter mentioned he had had an operation in 1984 but confirmed he had not been struggling since this time. The call again broke off and attempts were made to call back but there was no reply.

14.7.3 GP- On the **4th September 2023** an experienced General Practitioner consulted with Peter. The record notes that June was also present at this consultation. It is documented that Peter expressed that he was anxious and "can't cope" and was suffering from insomnia and felt his memory was impaired.

The memory impairment would appear to be corroborated by June. The GP asked the standard risk assessment profile questions and the record notes "family is a protective factor" – this statement is recorded in response to questions about suicidality. It indicates that there are no thoughts of, or plans or actions of suicide are not enacted due the patient's insight into the impact of those actions on their family.

The record notes a memory assessment has been completed with a six-item cognitive impairment score of 8/28 (indicating a probable issue with memory impairment). The GP commenced Peter on sertraline (a standard and commonly used antidepressant in the SSRI class) 50mg once daily. The GP also referred Peter urgently to the Community Mental Health Team and booked a follow up appointment for the 11th September 2023 with one of the in-house Specialist Mental Health Practitioners and completed a routine referral to memory assessment clinic.

14.7.4 DHCFT- On the **6th September 2023** The Adult Community Mental Health Team (CMHT) received a referral from Peter's GP. The referral had been posted rather than emailed which is usual practice. The GP recorded that Peter had low mood and anxiety and said he had commenced Sertraline 50mg.

14.7.5 DHCFT- On the **7th September 2023**, the CMHT received a telephone call from June. She reported that Peter had changed since yesterday saying "He doesn't know where he belongs, he is in two worlds". June described on Tuesday night **(5th September 2023)** having felt scared due to Peter saying he would strangle her and then himself.

The duty nurse called June within 20 minutes. June reported she was not at home yesterday when Peter received a call from a nurse and described him being very low in mood, saying he was "half the man". She reported he had daily fluctuating thoughts of ending his life although denied any active plans. June reported on **Tuesday 5th September 2023** during the night Peter was voicing thoughts of wanting to strangle her, there was no rationale for this, and he was not aggressive.

June noticed increased confusion, she said, "He knows he is at home but that his house is not where it should be" She reported poor sleep, reduced diet, and fluids. June reported that Peter had an appointment at the GP practice with a Mental Health Nurse on **Monday 11th September 2023.** A duty call was scheduled by the CMHT for **Tuesday 12th September 2023**, June was encouraged to call again if concerned or 999 if needed. The case was triaged to Amber waiting list which reflected the change in his behaviour.

14.7.6 Police- **September 2023**, the bodies of June and Peter were discovered in their home by Peter's brother, Simon and his sister, Rachel.

15. Overview

This section summarises what information was known to each agency, and the professionals involved, about June and Peter. The overview from each agency is drawn from the IMR documents, details provided from various panel meetings and single agency meetings between the chair and the panel representative.

15.1 Derbyshire Healthcare Foundation Trust (Mental Health Services).

15.1.1 During the preparation of the IMR the independent author has researched and analysed internal documents including local and national policy databases as well as investigation logs, telephone recordings, intelligence records and other internal documents and consulted with subject matter experts.

15.1.2 Derbyshire Healthcare Foundation Trust supply mental health services across Derbyshire. This includes the provision of a Mental Health Helpline which is accessible 24 hours a day, staffed by mental health practitioners. This service offers help, support and referral options for those suffering with mental illness. This includes the services of the Older Adult Community Mental Health Team.

15.1.3 It should be noted that all these contacts occurred within a very short period of time, in fact within eight days of the deaths of June and Peter. There was a total of four contacts between Peter, June and Rachel into the Mental Health Services Team.

15.1.4 Two of these contacts were on the 2nd September 2023, when Rachel contacted the Mental Health Helpline, stating that she was concerned about a decline in Peter's mental health and concern about his anxiety, it was noted that Peter was also present with Rachel and agreed to her discussing his health. Advice was given to contact the GP as well as reassurance regarding the helpline's availability. This call cut off.

15.1.5 A further call came into the helpline a few minutes later. On this occasion Peter spoke with the call taker. He described feeling anxious about his health and weight loss. He described a car accident he had several years before. He also described feelings of "Not being here". Advice was again given to Peter to speak to his GP.

15.1.6 The next contact was via a referral from Peter's GP on the 6th September 2023. This referral came into The Adult Community Mental Health Team. On receipt of the referral, Peter was called the same day by a Community Psychiatric Nurse (CPN). Peter stated his wife was not at home. He described feeling unwell since a recent holiday. He appeared calm and denied any suicidal ideation, when questioned.

15.1.7 The CPN discussed the support available if he felt anymore unwell, and explained the next steps, which was for a clinical assessment. The CPN also explained the waiting policy, which is a Red, Amber and Green (RAG) system. This is discussed further in Section 16. On this occasion, the grading was explained to Peter as Green.

15.1.8 The last contact with the Mental Health Team was received from June on the 7th September 2023, when she made a call to the Community Mental Health Team. This was managed by a CPN. June described Peter as being confused. She stated that he had discussed how he could strangle her, two nights previously. June said he was not aggressive and that he was not eating or sleeping well.

15.1.9 Safety advice was given to June. A follow up call from The Mental Health Team was scheduled for the 12th September 2023. It was also noted that Peter had an appointment with his GP Mental Health Nurse on the 11th September 2023.

15.1.10 As a result of this call, The CPN raised the RAG status of the case to Amber. This indicates that there is an escalation in symptoms and a more urgent appointment is required.

15.2 Derbyshire Integrated Care Board GP Services.

15.2.1 June and Peter had been registered with a local GP. Neither June or Peter were frequent users of the GP services.

15.2.2 June had a total of fifteen GP interactions within the review time period. Eleven of these, were within the last twelve months. June had suffered from hypertension and muscular conditions. At the time of her death, June was prescribed a number of medications for these conditions. There are no records which indicate any issues in relation to domestic abuse within the notes.

15.2.3 Peter's notes record only nine interactions with the GP in the review timeframe. Peter had previously had a mild skin condition, a hernia repair and a shoulder injury. Prior to the last weeks of his life, there was no recorded history of suicidal ideation, depression or any other indicators of domestic abuse.

15.2.4 Peter had a consultation in July 2023 when he had suffered weight loss and abdominal pain. Peter was referred for a colonoscopy. This resulted in a diagnosis of diverticular disease, a common bowel issue, which he was supplied medication for.

15.2.5 The final contact with Peter and his GP was on the 3rd September 2023. Peter and June were present during the consultation. Peter described low mood, anxiety and memory issues. He denied suicidal ideation. He was referred to the memory clinic and was prescribed Sertraline (50mg). It was noted by the GP that Peter's family were a protective factor and he felt supported.

15.3 Chesterfield Royal Hospital Foundation Trust- Chesterfield Royal Hospital

15.3.1 Chesterfield Royal Hospital provides a range of care services, including day-care, outpatient surgery and urgent treatment facility as well as an emergency department.

15.3.2 June and Peter were users of the hospital services. In the review time period, June used hospital services on thirteen occasions in 2022 and Peter used the services on two occasions, in 2022 and then once in 2023.

15.3.3 June had a condition that gave her pain in her knee. She attended the emergency department for this condition on the 8th August 2022 and subsequently on the 3rd December 2022. Routine treatment was provided during these visits. No issues were noted in relation to domestic abuse; however, it is also noted that standard domestic abuse questions were not raised with June during these attendances.

15.3.4 Six visits were made by June in 2022, in relation to on-going issues with her nose bleeding. These occurred on the 24th and 27th May 2022, followed by visits on the 20th, 22nd and 23rd September 2022. She also attended the hospital on the 25th October 2022 in relation to this condition. These were a combination of out-patient and emergency department visits. No issues were raised by June in relation to domestic abuse, and again, during the emergency department attendances, no routine questions regarding domestic abuse were asked by staff.

15.3.5 June also attended two arranged out-patient appointments on the 8th and 10th of December 2022. These were in relation to routine heart monitoring and blood tests.

15.3.6. Both Peter's attendances at the hospital were in relation to his stomach condition. These appointments were on the 21st and 29th of July 2023. One was a colonoscopy

examination and the other a routine examination related to the same condition. There is no record of concerns in relation to Peter's mental health on the patient notes.

15.4 East Midlands Ambulance Service NHS Trust

15.4.1. East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 care and telephone clinical assessment services for a population of 4.9 million people. They provide emergency and urgent services covering approximately 6,452 square miles across six counties of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire, and Rutland.

15.4.2 During the review period, EMAS had four recorded interactions. Three of these related to June and the fourth related to both June and Peter and relate to the incident that is subject to this DHR.

15.4.3 On the 24th May 2022 at 03.57 hours, NHS 111 requested an ambulance response via the automated gateway to June's address. This was as a result of a call from June. A crew arrived on scene and recorded that June had a cough for several weeks and was coughing a lot which caused bleeding from her left nostril. On arrival of the crew, June was sat learning over a bucket, alert and conscious, looking well. June stated that she had no headache or trauma. She had lost over 300mls of blood. June explained that she suffered from high blood pressure and she was taken to Chesterfield Royal Hospital for treatment. No safeguarding concerns were noted by the EMAS crew.

15.4.4 On the 8th August 2022 EMAS received a 999 call from June at her address at 11.28 hours. June explained that she had stood up and felt a crack in her knee, lower leg swelling and pain. As a result of this call EMAS did not attend, advice and sign posting to treatments was given.

15.4.5 Several minutes later an additional call was received from a Health Care Professional, due to the same concern relating to June. An ambulance attended, and June explained she had heard her left knee crack and since then had been struggling to mobilise or weight bear on her left leg. The crew noted that June had no obvious swelling but was experiencing pain. Analgesia (Paracetamol) was administered, and she was conveyed to Chesterfield Royal Hospital. No safeguarding concerns were noted by the EMAS crew.

15.4.6 The fourth incident relates to the events within this DHR. EMAS were alerted by Derbyshire Police that both June and Peter had suffered serious injuries at their home address. An ambulance attended and given the unequivocal signs of death; resuscitation was not attempted.

15.4.7 The crew noted that Simon and Rachel were present, who explained that Peter had been suffering from mental health issues and was under-going treatment.

16. Analysis

The Terms of Reference identifies key lines of enquiry which include:

- Responding to crisis.

- Link between Domestic Abuse and mental health
- What advice was given about worsening symptoms of mental health and the effects of Sertraline

The facts leading to the deaths of June and Peter have been documented in the combined chronology and overview sections of this report. This section examines how and why events happened, what information was shared, the decisions that were made and what actions were taken, or not. In considering these points, it is accepted that none are mutually exclusive, but that incidents and issues identified under each of these headings could be used as opportunities to improve as well as recognising good practice.

16.1 Hindsight Bias

16.1.1 *As the report author, I have attempted to view this case, and its circumstances, as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against. There is a further danger of 'outcome bias's and evaluating the quality of a decision when its outcome is already known. However, I have made every effort to avoid such an approach wherever possible.*

16.2 Domestic Abuse

16.2.1 June and Peter died as a result of penetrating trauma injuries.

16.2.2 In order to try and understand why this tragic event took place, the review panel considered events from a number of perspectives. These included whether; the events were part of a controlling, coercive pattern of behaviour that represents homicide as part of a predictable process involving domestic abuse; whether the events were spontaneous in that they occurred in response to a trigger event or if there was an 'emotional journey to homicide' that developed over time.

16.2.3 The panel were not able to determine that there was a history of domestic abuse to this single act. This is based on the information gathered by Derbyshire Police, as well as that provided by agencies and family. None of this information provides any evidence indicating that June was the victim of domestic abuse perpetrated by Peter. The information from his family suggests that Peter was a devoted husband who doted on his lifetime partner.

16.2.4 In considering predictability, one theory, the eight stages contained with the Intimate Partner Femicide Timeline[3] was subject to discourse. It seems that there are features that may fit this theory, such as Stage 4: Trigger warning signs; threat of deterioration of physical and mental health; Stage 5: Escalation warning signs; Stage 6: Mental health deterioration irreversible; Stage 8: Homicide. These factors seem apparent during the relevant period of the relationship, as opposed to being conclusive as to the predictability of events.

16.2.5 The review panel considered whether the events were spontaneous in that they occurred in response to a trigger event. That is not to say that the spontaneity requires that the decision to murder is followed by the actual act very swiftly, rather the decision is made spontaneously in response to the trigger event. There is substantive research available that intimate partner femicide is rarely spontaneous and the '[He] just snapped' explanation which suggests an immediate proximal provocation is not supported. [4]

16.2.6 One theory put forward is that there is an 'emotional journey to homicide' that develops over time. In Peter's case, it is possible that he may have perceived his world as 'falling apart' over time, as well as feeling increasingly desperate at his health issues. After all Schlesinger describes 'catathymic homicides' as occurring when: there is a change in thinking whereby the offender comes to believe that [he] can resolve [his] inner conflict by committing an act of extreme violence against someone to whom [he] feels emotionally bonded.

16.2.7 The analysis of agency contact that follows shows how Peter was struggling to cope, and so there may have been a change in his thinking at a point in time. Moreover, the panel learned that they had just celebrated their Wedding Anniversary, Peter was concerned about his health and he had given up driving. Each one of these events in themselves could be considered 'emotional' and so collectively, it is arguable there was significant emotional strain on Peter.

(LO1) Learning Consideration/Opportunity: It is important that professionals are able to understand in similar circumstances those likely to be at risk and actions that agencies can take to reduce the likelihood of future murder/suicides.

Recommendation 1: The Home Office to consider further research into murder/suicide of cases of a similar profile, to develop an understanding and identify actions to mitigate the risk.

[3] Intimate Partner Femicide Timeline - Research Repository

[4] Intimate Partner Femicide: Using Foucauldian Analysis to Track an Eight Stage Progression to Homicide - Jane Monckton Smith, 2020

16.3 Responding to crisis

16.3.1 Following on from the previous section, the panel has considered the issue of how agencies responded to the crisis which was developing in the family home of June and Peter. It has considered how frontline practitioners reacted to initial reports and what subsequent activity took place.

What is clear from the information provided to this review is that in a short time before their deaths, family members were very concerned about Peter's mental health and the effects this was having on June. Peter's mental health was clearly rapidly in decline.

16.3.2 During the call to the Mental Health Helpline on the 7th September 2023, June stated that Peter had told her, two nights previously, how he could strangle her. June explained that he was not aggressive. She also explained her concerns that Peter was

not eating or sleeping well. Safety advice was given and a follow up call was scheduled for some days later. At this stage, there was a significant concern regarding June's risk of domestic abuse by Peter.

16.3.3 The panel were satisfied that frontline practitioners were caring and professional when dealing with calls and reports from Rachel, June and Peter. They were able to make referrals to support teams and sought to reassure and calm situations presented to them.

16.4 General

16.4.1 In relation to June's attendance at Chesterfield Royal Hospital on a number of occasions in 2023, the panel examined the relevant IMR report and subsequent analysis within it.

16.4.2 The Domestic Abuse Policy of the Chesterfield Royal Hospital Foundation Trust (CRHFT) was examined by the panel and was analysed within the IMR provided.

16.4.3 The policy states that enquiry by professionals should take place, where there are signs or suspicions of domestic abuse in any patient. Within the Emergency Department (ED), routine enquiry should take place in every case with any patient over the age of sixteen years.

16.4.4 This policy was created following statutory guidance. The policy reflects a research project and subsequent report entitled "A Cry for Health" published by SafeLives, in 2019.[5] This report describes the benefits of health care professionals in hospital settings, using professional curiosity and asking patients routine questions relating to domestic abuse.

16.4.5 In addition to that report, SafeLives also commissioned research and a report in 2015, entitled "Getting it Right First Time"[6] This research identified that 23% of victims of domestic abuse at high risk of harm, attended an ED, as well as 10% of medium risk victims.

16.4.6 In 2016 SafeLives conducted research and produced a spotlight report entitled "Safe Later Lives"[7] This report highlighted that people over the age of 65 years, were far less likely to report or understand the implications of domestic abuse. They were described as "Hidden victims" The report made recommendations for agencies to improve their understanding and policies in relation to this age profile and domestic abuse.

16.4.7 June was over the age of 65 years when she attended the ED at Chesterfield Royal Hospital on six occasions between May and December 2022. Analysis of these attendances highlighted that no routine questions were asked of June in relation to domestic abuse.

16.4.8 In addition to her protected characteristic of age, June was female. As highlighted in Section 11 of this review, statistically females are far more likely to be victims of domestic abuse. Given these factors and the policy of CRHFT, these were missed opportunities to explore the possibility of domestic abuse within June's life. Whilst there is no evidence within the review of June being a victim of domestic abuse, there will be missed opportunities in the future if these questions are not routinely asked.

16.4.9 The panel discussed this issue, after presentation of the IMR. It is clear that the policy has not been fully implemented and there is more work to be done by CRHFT to make this happen. The panel noted that that a Domestic Abuse Practitioner role had been created, following a review of the previous responsibilities of this role. This is a positive step to help embed the cultural change that is required in the following recommendation.

(LO2) Learning Consideration/Opportunity: It is important that professionals are able to understand the significance of asking routine questions of patients relating to domestic abuse in hospital settings.

Recommendation 2: Chesterfield Royal Hospital Foundation Trust to fully analyse the impact of their Domestic Abuse Policy and present an action plan to ensure compliance within the ED.

[5] A-Cry-for-Health-full-report.pdf

[6] Getting it right the first time - SafeLives

[7] Safe-Later-Lives-Older-people-and-domestic-abuse-Spotlight.pdf

16.4.10 Analysis and review was conducted in relation to the involvement of June and Peter's GP during the relevant time period. It is clear that Peter was seen, in the presence of June, in a face-to-face consultation with a very experienced GP. Appropriate referrals were made and exploration of Peter's potential for suicidal ideation made.

16.4.11 The panel noted the on-going and pro-active approach of the surgery to train staff frequently in domestic abuse awareness and risk management. The panel were also aware of how affected team members have been from this sad event. The good practice below was highlighted during panel meetings.

***Good practice**. Following this incident, staff at the surgery were briefed and spoken to individually to assess and monitor the effects of trauma that might be apparent. This trauma informed approach to dealing with the events is ongoing. It was also noted that the GP surgery have enrolled on The Elm Foundation Training Programme, which highlights on-going staff training in relation to domestic abuse.*

16.4.12 The panel were presented with a short report by EMAS. This report examined the four interactions with June during the review period. On each of these occasions, the comprehensive safeguarding policy was followed by crews. There was no indication during the interactions that there were issues of domestic abuse. The panel noted the professional working relationship between EMAS and other medical partner agencies within the review. EMAS have a well-established and embedded domestic abuse policy that includes on-going training for crews in domestic abuse.

16.5 Link Between Domestic Abuse and Mental Health

16.5.1 The panel have carefully considered the link between domestic abuse and mental health. In an article from Canada entitled 'Domestic Homicide and Homicide-Suicide: The Older Offender' [8]examined data over a 15-year period in Canada. At the time of the offence, most of the perpetrators had a mental illness, usually depressive disorder, but few had received psychiatric help. The impact of mental illness on domestic homicide-suicide is indicated, underscoring the importance of identifying existing psychopathology.

16.5.2. What is clear from the information provided to this review is that Peter's mental health deteriorated rapidly over a matter of days. Both June and wider family members were pro-active in seeking help for Peter.

16.5.3 Several calls were made to the Mental Health Support Line, by June and Rachel, outlining their concerns regarding Peter's deteriorating mental health. These calls were recorded and as part of the review were examined independently. The panel were reassured that the calls were dealt with professionally, sympathetically and appropriate advice was given.

16.5.4 The panel were able to consider the escalation in concern about Peter's mental health from the call made by Rachel and Peter on the 2nd September 2023, the referral call made to Peter on the 6th September 2023 and the subsequent call made by June to the Community Mantal Health Team on the 7th September 2023.

16.5.5 The panel were provided with a document used by CMHT to determine the urgency of care or intervention required as a result of information obtained during calls and referrals. In effect it is a method of triaging patients based on risk. It has a RAG status, Red, Amber and Green dependant on the available information. This is:-

Red *– Person is in crisis. CMHT will discuss or refer to Dementia Rapid Response Team (DRRT) or In Reach Home Treatment Team (IRHTT). If the referral is triaged as needing to be seen within a few days - a CMHT duty visit is booked to see the person.*
Amber *- Significant risks identified but not in crisis. Person to be allocated to a CPN as soon as possible and assessed within 2 weeks.*
Green *- Some risks identified but being managed by family / carers etc (and not appropriate for Memory Assessment Service / Outpatient Appointment). They get placed on the green waiting list. Once allocated, they are assessed within 4 weeks.*

16.5.6 The first call on the 2nd September 2023, from Rachel outlined general concerns and Peter was spoken to. He did not show signs of suicidal ideation and the analysis of this call was that it was appropriate, given the available information.

16.5.7 During the call on the 6th September with Peter, following the GP referral, Peter again denied suicidal ideation and it appeared that he felt better, albeit was struggling to sleep. The CPN correctly graded the matter as Green, as per the policy. On this occasion, June was not present on the call with Peter, so no further contextual information was available to the CPN.

16.5.8 During the call on the 7th September 2023, June outlined significant concerns about Peter and his escalating issues. These included Peter being very low in mood, "half the man". She reported he had daily fluctuating thoughts of ending his life although denied any active plans. June reported on Tuesday 5th September during the night Peter was voicing thoughts of wanting to strangle her, June noticed increased confusion, she said, "He knows he is at home but that his house is not where it should be" She reported poor sleep, reduced diet, and fluids.

16.5.9 This information was graded as Amber by the CPN. This call has been reviewed as part of the IMR, and the relevant CPN interviewed. The chair is keen to stress, there is no criticism of the CPN who dealt with this call.

16.5.10 The CPN reflected that prior to speaking to June she had considered that a referral to the Crisis In-reach Team may have been an option to manage any risk, however on speaking to June she did not have concern about the risk of harm to himself or to others. The CPN described feeling reassured that since the disclosure of harm, a few days had passed, and it was not expressed again. Peter was not displaying any agitated behaviour on questioning. The professionals involved were clear that at the time of the phone contact they did not perceive concern about harm to June from her Husband or self-harm towards himself.

(LO3) Learning Consideration/Opportunity: Derbyshire Health Care Foundation Trust need to be assured that staff have a clear understanding about the signs of domestic abuse and help staff access further training if required. This case has highlighted the importance of considering potential signs and indicators even when no disclosure has been made, and there is no obvious use of violence.

Recommendation 3: Derbyshire Health Care Foundation Trust review the RAG risk document in relation to disclosures of violence, regardless of their historic nature. Managers to be confident that staff are aware of trigger factors for domestic abuse. Work around this has started. The Safeguarding Team have met with external NHS 360 auditors and have a staff survey focussed on domestic abuse.

[8]Source: Bourget, Dominique & Gagné, Pierre & Whitehurst, Laurie. (2010). Domestic Homicide and Homicide-Suicide: The Older Offender. The journal of the American Academy of Psychiatry (Accessed August 2024 via researchgate.net)

16.6 What advice was given about worsening symptoms of mental health and the side effects of sertraline?

16.6.1 Following the consultation with Peter on the 3rd September 2023, the GP prescribed him with sertraline (50mg). Sertraline is available in tablet form it was first made available in the UK in 1991. It is widely used across the world and is one of the most widely used selective serotonin reuptake inhibitors (SSRI). It is most commonly prescribed to treat depressive illness and anxiety.

16.6.2 The panel were greatly assisted by both the GP IMR document and subsequent clarification from a pharmacist in relation to this key line of enquiry. The British National Formulary (BNF), is a medical and pharmaceutical publication, which has information on prescribing and pharmacology.[9]

16.6.3 Sertraline is contained within this publication, and reference is made to possible side-effects for a patient. These include the possibility of increased anxiety and depression in the first two weeks of prescription. These affects relate to a small number of patients. These warnings and a guide to the patient are included within the medicines prescribed.

16.6.4 Further information on the effects of Sertraline on elderly patients was provided by *Suicidal Thinking and Behaviour During Treatment With Sertraline in Late-Life Depression - The American Journal of Geriatric Psychiatry*[10.] This research document concluded that suicide risk in those over sixty years of age, taking sertraline is no greater than placebo. It also notes that greater effects are present in those below twenty-five years of age.

16.6.5 Given there are guidance and instructional notes included within the medication, it is not routine for patients to be given a warning as to potential side effects. In this case it was noted by the GP that Peter was severely depressed. It was necessary for the medication to be prescribed and taken as soon as possible.

16.6.6 There is an additional risk that highlighting medication side-effects could prevent a person from taking them and therefore increasing the risk. Given this information, and following careful consideration, the panel do not feel it necessary or appropriate to make any recommendations in relation to this key line of enquiry.

[9] Sertraline | Drugs | BNF | NICE

[10] Suicidal Thinking and Behavior During Treatment With Sertraline in Late-Life Depression - The American Journal of Geriatric Psychiatry

17. Conclusions

17.1 This is a particularly sad case. It is clear that June and Peter were a devoted couple and were loving parents and had a wide circle of friends and family.

17.2 It is not the role of a Domestic Homicide Review to apportion blame or find fault. The content of the report simply reflects the findings of panel agencies and seeks to identify opportunities for learning and the recognition of good practice.

17.3 The deterioration in Peter's mental health was rapid and significant. It is not suggested that the tragic events were either predictable or preventable but reminds professionals of the potential for such events to occur.

17.4 There are themes within the review, each of these have been explored, with these learning points and recommendations the review panel has sought to try and understand what happened and recognise the issues that June and Peter faced in the days before their deaths that might help to explain why the events occurred. The Panel would like to extend their deepest sympathy to all those affected by June and Peter's death.

18. Learning Points

Learning Point 1: It is important that professionals are able to understand in similar circumstances those likely to be at risk and actions that agencies can take to reduce the likelihood of future murder/suicides.

Learning Point 2: It is important that professionals are able to understand the significance of asking routine questions of patients relating to domestic abuse in hospital settings.

Learning Point 3: Derbyshire Health Care Foundation Trust need to be assured that staff have a clear understanding about the signs of domestic abuse and help staff

access further training if required. This case has highlighted the importance of considering potential signs and indicators even when no disclosure has been made, and there is no obvious use of violence.

Good Practice was identified in relation to the trauma informed approach taken by the GP surgery. It was also noted that the GP surgery have a pro-active approach to staff awareness of domestic abuse. This includes a programme funded by The Home Office, through The Elm Foundation that enhances staff awareness and training opportunities. Training Courses | The Elm Foundation

19. Recommendations

Single Agency

Chesterfield Royal Hospital NHS Foundation Trust

Following the conclusion of the review Chesterfield Royal Hospital NHS Foundation Trust have preprepared an action plan which is considered a proportionate response to ensure the recommendations and learning are captured and undertaken. See Appendix 2

Derbyshire Health Care Foundation Trust (Mental Health Services)

Following the conclusion of the review Derbyshire Health Care Foundation Trust have preprepared an action plan which is considered a proportionate response to ensure the recommendations and learning are captured and undertaken. See Appendix 3

Recommendations from this review.

Recommendation 1: The Home Office to consider further research into murder/suicide of cases of a similar profile, to develop an understanding and identify actions to mitigate the risk.

Recommendation 2: Chesterfield Royal Community Hospital Foundation Trust to fully analyse the impact of their Domestic Abuse Policy and present an action plan to ensure compliance within the Emergency Department.

Recommendation 3: Derbyshire Health Care Foundation Trust review the RAG risk document in relation to disclosures of violence, regardless of their historic nature. Managers to be confident that staff are aware of trigger factors for domestic abuse.

Appendix 1

Terms of Reference

V2 Feb 2024

Terms of Reference

Domestic Homicide Review

1 Commissioner of the Domestic Homicide Review

1.1 The chair of The Derbyshire Safer Communities Board has commissioned this review, following notification of the deaths of June and Peter.

1.2 All other responsibility relating to the review, namely any changes to these Terms of Reference and the preparation, agreement, and implementation of an Action Plan to take forward the local recommendations in the overview report will be the collective responsibility of the Review Panel.

1.3 The resources required for completing this review will be secured by the independent chair commissioned by Derbyshire Safer Communities Board.

2 Aims of Domestic Homicide Review Process

2.1 Establish what lessons are to be learned from the deaths of June and Peter regarding the way in which local professionals and organisations work individually and together to safeguard people in similar circumstances to those of June and Peter.

2.2 Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

2.3 To produce a report which:

- summarises concisely the relevant chronology of events including:
- the actions of all the involved agencies.
- the observations (and any actions) of relatives, friends, and workplace colleagues relevant to the review.
- analyses and comments on the appropriateness of actions taken.
- makes recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced.

2.4 Apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate.

3 Timescale

3.1 Aim to complete a final overview report by July 2024 acknowledging that drafting the report will be dependent, to some extent, on the completion of individual management reviews to the standard and timescale required by the independent chair.

4 Scope of the review

4.1 To review events up to the deaths of June and Peter. This is to include any information known about their previous relationships where domestic abuse is understood to have occurred.

4.2 Events should be reviewed by all agencies for 2 years preceding the death. However, if any agencies have any information prior to that they feel is relevant, then this should also be included in any chronology/IMR.

4.3 To seek to fully involve the family, friends, and wider community within the review process.

4.4 Consider how (and if knowledge of) all forms of domestic abuse (including the non-physical types) are understood by the local community at large – including family, friends, and statutory and voluntary organisations. This is to also ensure that the dynamics of coercive control are also fully explored.

4.5 Consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community – including family and friends, and how to maximise opportunities to intervene and signpost to support.

4.6 Determine if there were any barriers faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.

4.7 Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DHR. In particular what were the effects of the Covid-19 pandemic on relevant organisations? Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.

4.8 Review relevant research and previous domestic homicide reviews to help ensure that the Review and Overview Report is able to maximise opportunities for learning to help avoid similar deaths occurring in future.

5 Key Lines of Enquiry

5.1 The following themes have been prepared by the chair and discussed with the panel. Their purpose is to focus the review upon areas of learning and opportunities to improve service. They have been reviewed and discussed at various stages of this review.

• Responding to crisis

• Mental health and links to domestic abuse

• What advice was given about worsening symptoms of mental health and the side effects of sertraline.

6 Role of the Independent Chair

• Convene and chair a review panel meeting at the outset.

• Liaise with the family/friends of the deceased or appoint an appropriate representative to do so. (Consider Home Office leaflet for family members, plus statutory guidance (section 6))

• Determine brief of, co-ordinate and request IMR's.

• Review IMR's – ensuring that reviews incorporate suggested the outline from the statutory Home Office guidance (where possible).

• Convene and chair a review panel meeting to review IMR responses.

• Write report (including action plan) or appoint an independent overview report author and agree contents with the Review Panel

• Present report to the Community Safety Partnership

7 Domestic Homicide Review Panel

7.1 Membership of the panel will comprise:

Name	Organisation
Chris Ward (Chair)	Foundry Risk Management
Alison Boyce	Community Safety, Derbyshire County Council
Christine Flinton	Community Safety, Derbyshire County Council
Sharon Ingram (Admin)	Community Safety, Derbyshire County Council
Charlotte Salt	East Midlands Ambulance Service
Darren Pope	Derbyshire Constabulary
Emma Barnes-Marriott (FLO)	Derbyshire Constabulary
Faye Green	North-East Derbyshire District Council
Gillian Quayle	Public Health, Derbyshire County Council
Helen Weston	Derbyshire Carers
Jayne Walker	Rykneld Homes
Jennifer Calverley	The Elm Foundation
Michelle Grant	Derby & Derbyshire Integrated Care Board
Nikki Roome	Derbyshire Healthcare Foundation Trust
Paul Bullock (SIO)	Derbyshire Constabulary
Rachel Morris	SV2
Tom Brown	Adult Care, Derbyshire County Council
Zoe Rodger-Fox	Chesterfield Royal Hospital

7.2 Each Review Panel member to have completed the DHR e-learning training as available on the Home Office website before joining the panel. (online at: https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning)

8 Liaison with Media

8.1 Derbyshire Safer Communities Board will handle any media interest in this case.

8.2 All agencies involved can confirm a review is in progress, but no information to be divulged beyond that.

8.3 Confidentiality

All panel members are bound by the agreed confidentiality agreement.

Appendix 2

Chesterfield Royal Hospital NHS Foundation Trust

Action	Activity
1. Domestic abuse policies to be reviewed.	To establish if policies are compliant with national guidance and recommendations.
2. To review routine questioning of patients within the ED, to ensure the current policy is working and fully embedded as normal practice.	Quarterly audits to be carried out to ensure compliance. Where it is identified compliance has not taken place a management review will take place.
3. Develop the role of the newly appointed Domestic Abuse Practitioner.	Review their job description and task them with ensuring routine enquiry is made within the ED.
4. Enhance safeguarding training	Establish that front line staff are receiving updated training and best practice through the Domestic Abuse Practitioner.

Appendix 3

Derbyshire Health Care Foundation Trust (Mental Health Services)

Action	Activity
1. Ensure teams are aware of the signs and risks of domestic abuse.	Audit team to carry out an NHS 360 staff audit to gauge knowledge and understanding.
2. To develop training tools to ensure front line staff are trained in signs of domestic abuse.	Using the results of the audit to identify gaps in training and understanding. Produce and deliver appropriate training as a result of this.
3. To review and re assess the RAG risk review for mental health triage.	Ensure that the grading systems reflects both the signs of developing mental illness and its association to domestic abuse.

Appendix 4

Glossary of Terms

Glossary of Terms	
Domestic Homicide Review	DHR
Derbyshire Safer Communities Board	DCSP
Derbyshire Community Healthcare Services	DCHS
Individual Management Reviews	IMR
Derbyshire Health Care Foundation Trust	DHFT
Terms of Reference	TOR
Advocacy After Fatal Domestic Abuse	AAFDA
General Practitioner	GP
East Midlands Ambulance Service	EMAS
Community Psychiatric Nurse	CPN
Red, Amber Green (Status)	RAG

Appendix 5

Review Authors sources of research

HO-Domestic-Homicide-Review-Analysis-161206.pdf (publishing.service.gov.uk)

Safe Later Lives | Older people & domestic abuse – Safe Lives

Intimate Partner Femicide Timeline - Research Repository (glos.ac.uk)

Schlesinger 2002, Adams 2007, Monckton-Smith 2012

A Cry for Health – Safe Lives

Getting it right the first time – Safe Lives

Safe-Later-Lives-Older-people-and-domestic-abuse-Spotlight.pdf (safelives.org.uk)

Bourget, Dominique & Gagné, Pierre & Whitehurst, Laurie. (2010). Domestic Homicide and Homicide-Suicide: The Older Offender.

The journal of the American Academy of Psychiatry (Accessed August 2024 via researchgate.net)

https://bnf.nice.org.uk/drugs/sertraline/#side-effects

Suicidal Thinking and Behaviour During Treatment With Sertraline in Late-Life Depression

- The American Journal of Geriatric Psychiatry (ajgponline.org)