Derby & Derbyshire Safer Communities

Domestic Homicide Review

EXECUTIVE SUMMARY

Report into the death of June and Peter
In September 2023

Report produced by Chris Ward
Foundry Risk Consultancy

August 2024

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1. The Review Process

1.1 This summary outlines the process undertaken by the Derbyshire Safer Communities Board Domestic Homicide Review panel in reviewing the deaths of June and Peter who were resident in the area.

1.2 The following pseudonyms have been used in this review to protect their identities and those of their family members.

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

1.3 There were no criminal proceedings in this matter as this was a homicide and suicide case. The panel were not able to find a history of domestic abuse between June and Peter prior to the tragic circumstances.

1.4 The process began following discussions with the Home Office between 6th of October 2023 and the 10th of October 2023. When a decision to hold a domestic homicide review was agreed, all agencies that potentially had contact with June and Peter prior to the point of their deaths were contacted to confirm whether they had any involvement with them.

1.5 Five of the fifteen agencies, that were contacted, confirmed they had engagement with June and Peter, and they were asked to secure their files.

2. Contributors to the Review

2.1 Individual Management Reviews and Chronologies were requested from the following agencies, all of whom were invited to form the panel.

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)

2.2 Each of the chronologies and IMR's were prepared by an author who was independent of the matter. They had no direct line management responsibilities or involvement with these individuals prior to this review being called.

3. The Review Panel Members

3.1 The review panel consisted of:

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

3.2 Each panel member confirmed their independence from any previous involvement with any of the parties in this review.

4. Author of the Review

Independent Chair and Overview Report Author – Chris Ward

4.1 In November 2023, Chris Ward was appointed the chair and author of this DHR. Chris is a former Thames Valley Police Officer, having retired in 2020, 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.

4.2 As The Assistant Chief Constable for Local Policing, he had oversight of strategic partnerships and safeguarding processes.

4.3 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.

4.4 Chris has no connection with the Derbyshire Community Safety Board.

5. Terms of Reference

5.1 The full Terms of Reference are included in Appendix 1. The chair of the Derbyshire Safer Communities Board has commissioned this review, following notification of the death of June and Peter in the county by the East Midlands Special Operations Unit. The review aims to identify the learning from their deaths and for action to be taken in response to that learning, with a view to prevent similar circumstances occurring again in the future and ensuring that individuals and families are supported.

5.2 *Key Lines of Enquiry:* The Review Panel considered both the 'generic issues' as set out in the statutory guidance and identified and considered the following 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 effects of Sertraline?

5.3 At the first meeting, the Review Panel shared brief information obtained from a 'Summary of engagement' exercise about agency contact with the individuals involved. At an early stage it was clear that June and Peter had limited engagement with any agencies. A review period of two years was set, with the caveat that agencies would review relevant material outside of the agreed period.

6. Summary of the Chronology

June

6.1 June had limited contact with statutory services, most of these were related to her health issues. During the review period June attended Chesterfield Royal Hospital in relation to on-going issues with her nose bleeding and a knee injury. Six of these visits were to the Emergency Department, during 2022. June did not disclose any issues relating to domestic abuse during these visits. Routine questions were not asked by health care professionals, this is discussed later in the report and recommendations.

6.2 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 that indicate any issues in relation to domestic abuse within the notes.

6.3 June also used the services of East Midlands Ambulance Service on three occasions during the relevant review period. These related to her blood pressure and muscular condition. No disclosures or safeguarding concerns were raised by the attending crews.

6.4 Several days before her death, June made contact with The Community Mental Health Team. This call was managed by a Community Psychiatric Nurse. June told the nurse that she was concerned that Peter's mental health was deteriorating.

6.5 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. The nurse arranged for a follow up call to be made to Peter, two days later. Sadly, the events relating to this review took place before that appointment.

6.6 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.

Peter

6.7 Peter also had limited contact with agencies during the review period. Several days before his death, his sister, Rachel, contacted the Mental Health Helpline. Peter was present on the telephone call. Rachel explained her concerns that Peter's mental health was deteriorating, and he was anxious. Advice was given and they were asked to contact Peter's GP

6.8 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.

6.9 The next contact was via a referral from Peter's GP. 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. 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. An appointment was made for further clinical assessment of Peter.

7 Key issues arising from the Review

7.1 Domestic Abuse

7.1.1 June and Peter died as a result of penetrating trauma injuries. The police investigation concluded that Peter had killed June and then himself.

7.1.2 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.

7.1.3 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.

7.1.4 In considering predictability, one theory, the eight stages contained with the Intimate Partner Femicide Timeline[1] 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.

7.1.5 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.[2]

7.1.6 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.

7.1.7 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.

[1]Intimate Partner Femicide Timeline - Research Repository (glos.ac.uk) [2]Schlesinger 2002, Adams 2007, Monckton-Smith 2012

7.2 Responding to Crisis

7.2.1 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.

7.2.2 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.

7.2.3 During the call to the Community Mental Health Team, 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 were significant concerns about June's risk of domestic abuse by Peter.

7.2.4 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.

7.3 General

7.3.1 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.

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

7.3.4 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.

7.3.5 This policy was created following statutory guidance and reflects a research project and subsequent report entitled "A Cry for Health" published by SafeLives, in 2019.[3] This report describes the benefits of health care professionals in hospital settings, using professional curiosity and asking patients routine questions relating to domestic abuse.

7.3.6 In addition to that report, SafeLives also commissioned research and a report in 2015, entitled "Getting it Right First Time"[4] 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.

7.3.7 In 2016 SafeLives conducted research and produced a spotlight report entitled "Safe Later Lives"[5] 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.

7.3.8 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.

7.3.9 In addition to her protected characteristic of age, June was female. As highlighted in

Section 7.3 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. The panel noted 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 to fulfill a recommendation discussed in section 10 of this report.

7.3.10 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.

[3] A Cry for Health - SafeLives

[4] Getting it right the first time - SafeLives

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

7.4 Equality and Diversity

7.4.1 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.

7.4.2 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.

7.4.3 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.[6]

7.4.4 The second is that of age. There have been several reports describing the systematic invisibility of the elderly in relation to Domestic Abuse.[6] 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.

7.4.5 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.

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

7.5 Link Between Domestic Abuse and Mental Health

7.5.1.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' [7]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.

7.5.2 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.

7.5.3 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.

7.5.4 The panel were able to consider the escalation in concern about Peter's mental health from the call made by Rachel and Peter, the referral call made two days later and the subsequent call made by June to the Community Mental Health Team.

7.5.5 The panel were provided with a document used by the Community Mental Health Team 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.*

7.5.6 The first call 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.

7.5.7 During the call with Peter, following the GP referral, Peter again denied suicidal ideation and it appeared that he felt better, albeit was struggling to sleep. The Community Psychiatric Nurse (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.

7.5.8 During the call to the Community Mental Health Team, 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 two nights previously, 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.

7.5.9 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.

7.5.10 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.

[7]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)

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

7.6.1 Following a consultation with Peter, 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.

7.6.2 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, that has information on prescribing and pharmacology.[9]

7.6.3 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.

7.6.4 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.

7.6.5 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.

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

10 Suicidal Thinking and Behaviour During Treatment With Sertraline in Late-Life Depression - The American Journal of Geriatric Psychiatry (ajgponline.org)

8. Conclusions

8.1 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.

8.2 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.

8.3. 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.

8.4 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.

9. Lessons to be Learned

9.1 All agencies

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.

9.2 Chesterfield Royal Hospital Foundation Trust

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.

9.3 Derbyshire Health Care Foundation Trust

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.

9.4 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 program funded by The Home Office, through The Elm Foundation that enhances staff awareness and training opportunities. Training Courses | The Elm Foundation

10. Recommendations

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 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 One

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 have 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.