



## **OVERVIEW REPORT**

### **DOMESTIC HOMICIDE REVIEW**

in respect of

**A**

**Born 1969**

**Sue Lane  
October 2014**

# 1 Introduction

## 1.1 Context of the Domestic Homicide Review

1.1.1 Domestic Homicide Reviews were introduced by the Domestic Violence, Crime and Victims Act (2004), section 9.

1.1.2 A duty on a relevant Community Safety Partnership to undertake Domestic Homicide Reviews, along with associated procedural requirements, was implemented by the *'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews'* in April 2011<sup>1</sup>. This defined a Domestic Homicide Review<sup>2</sup> (DHR) as:

a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship; or
- a member of the same household as himself

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

1.1.3 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- 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;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.1.4 DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and criminal courts. They are also not specifically part of any disciplinary enquiry or process; or part of the process for managing operational responses to the safeguarding or other needs of

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<sup>1</sup> [www.homeoffice.gov.uk](http://www.homeoffice.gov.uk). The statutory guidance was revised in August 2013.

<sup>2</sup> Domestic Violence, Crime and Victims Act (2004) section 9 (1).

individuals. These are the responsibility of agencies working within existing policies and procedural frameworks.

## 1.2 Circumstances of the review

1.2.1 A was found dead as a result of stab wounds in January 2012 at the home he shared with his partner B. She too was found dead on the premises. The alarm was raised by the family of B who had called round as they could not get an answer to telephone calls. Police enquiries rapidly established that A had been killed and that B had committed suicide and that no other person was involved.

1.2.2 The location of these events is a small community within Staffordshire Moorlands District. The individuals involved were born and brought up in the area and their families live close by and continue to do so. The events deeply shocked and surprised the families, the community and the professionals who knew the couple.

## 1.3 Terms of reference

1.3.1 A DHR Scoping Panel met on 6 February 2012 to consider the circumstances leading to the death of A. The Panel was unanimous that the criteria for commissioning a DHR had been met. This recommendation was endorsed by the Chair of the Moorlands Community Safety Partnership (CSP) who was present at the meeting and the decision was recorded. Full terms of reference for this DHR are attached at Appendix A.

1.3.2 The DHR considered the period from 5 October 2007, when B seriously harmed herself (the last occasion on which she did so before her death), up to and including the date of A's and B's deaths in January 2012. The focus of the DHR was maintained on the following family members:

Name	A	B
Relationship	Subject of DHR	Partner
Date of Birth	Aged 42	Aged 46
Date of Death	January 2012	January 2012
Ethnicity	White British	White British

1.3.3 Key issues addressed by the DHR, in the context of the general areas for consideration listed at Appendix 1 of the Statutory Guidance, are outlined below.

- Were any risks posed by B to her partner identified by any agency and appropriately understood/shared/acted upon?

- Were any concerns for his personal safety expressed by A or recognised, appropriately risk assessed and responded to?
- Should B have been identified as a risk to herself and others in the period under review?
- Provision of mental health services to B.
- The significance of both A and B acting as carers for each other with their very different health problems.
- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration.
- Was the homicide of A predictable and/or preventable?

1.3.4 It has not been necessary to amend the terms of reference in the course of the review.

## 1.4 Contributors

1.4.1 Individual Management Reviews (IMRs) were provided by the following agencies which had contact with A and/or B during the period under review:

- University Hospital North Staffordshire NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- Staffordshire NHS Trust Cluster of PCTs
- Staffordshire Police
- Staffordshire Moorlands District Council

A summary report was provided by West Midlands and Staffordshire Probation Trust regarding their involvement with B prior to the review period.

1.4.2 All agencies submitted chronologies and IMRs as requested. The Panel is satisfied that these are comprehensive reports and that they make appropriate recommendations for their agencies where necessary. No other agencies have been identified as having had involvement with A or B as a result of the IMRs.

## 1.5 DHR Panel members

Agency	Job Title
Independent Chair	Independent Chair

<b>Agency</b>	<b>Job Title</b>
NHS Staffordshire Commissioning Support Services	Designated Nurse Child Protection
NHS Staffordshire Commissioning Support Services	Lead Nurse Adult Safeguarding (North Staffordshire)
North Staffordshire Combined Healthcare NHS Trust	Team Leader Criminal Justice Mental Health Team
Staffordshire County Council - Adult Safeguarding	County Commissioner Adult Safeguarding
Staffordshire County Council - Community Safety	Principal Community Safety Officer
Staffordshire County Council - Community Safety	County Commissioner for Safer Communities
Staffordshire Moorlands District Council	Community Safety Manager
Staffordshire Police	Detective Inspector
Staffordshire Police	Crime and Policy Review Manager, Major Investigations Department (MID)
University Hospital Of North Staffordshire NHS Trust	Adult Safeguarding Nurse

1.5.1 Arch (North Staffs), a charity which provides domestic abuse support services in the Staffordshire Moorlands District, was invited to join the DHR Panel. They were unable to attend the first Panel meeting and, as there was no indication of domestic abuse or violence ever being a feature of the relationship between A and B prior to their deaths, did not consider that their participation would add value to the subsequent meetings. It has subsequently become the practice in Staffordshire to invite the Domestic Abuse Support Services provider for the district or borough in question to fully participate in the Review Panel, regardless of whether they have had any contact with the subjects of the DHR or if domestic violence was known to have occurred.

1.5.2 The DHR Panel Chair and report author is Susan Lane. She has undertaken similar enquiries and training commissions for safeguarding boards and is not employed by any of the agencies or associated bodies. She is an experienced and registered social worker and has previously held senior positions within children's social care and the Probation Service. She currently works part-time as an associate lecturer for the social work degree with the Open University. Following the Scoping Panel meeting it was agreed that this review did not require a separate report author.

- 1.5.3 The DHR Panel met on three occasions and had the full support of the District Council and the participating agencies. The conclusion of the process was originally agreed as 6 August 2012. It was delayed until the completion of the Inquest which was held at the end of September 2012. The report was then confirmed by agencies and the families of both victim and offender were given opportunity to read the final draft before it was submitted to the CSP.
- 1.5.4 The Moorlands Community Safety Partnership approved the report for submission to the Home Office on 8 February 2013.
- 1.5.5 Following receipt of a letter from the Home Office dated 25 July 2013 the Panel met for the third time and the report was revised to provide more detail and analysis.

## **1.6 Parallel processes**

- 1.6.1 No formal processes in respect of these events have been triggered other than notification to HM Coroner.
- 1.6.2 HM Coroner recorded a verdict of Unlawful Killing with regard to A and Suicide in relation to B in September 2012.

## **2 Family engagement**

- 2.1.1 The Panel Chair met with the families of both the victim and the perpetrator in June 2012 to explain the process and to listen to any concerns or observations they might have. It was agreed that the draft report would be available to them shortly after the inquest. A further meeting was arranged in November 2012 when the families had the opportunity to read a final draft of the report.
- 2.1.2 At the initial meetings both families expressed their bewilderment with the events and their difficulty explaining what had happened or why.
- 2.1.3 A had lived with B for over 15 years. They were both born and brought up in the immediate area close to their shared home and were in frequent contact with their families and friends who had known them all their lives. Together they brought up B's daughter from a previous relationship who now has her own home and a young daughter. A's health meant that he was unable to work consistently and B's health problems also prevented her from working. The couple had been dependent on benefits for some time. They lived in privately rented accommodation where they had been settled for some years.
- 2.1.4 A is described by his family as a sociable, friendly person who made friends easily in any circumstances. He had substantial and persistent health problems from early childhood which placed restrictions on him throughout

his life and required regular medical review until his death. He had not been expected to survive childhood and his parents had spent a great deal of time caring for him and supporting him. Despite the difficulties, he trained as a car mechanic and worked when he could. He lived with them until he moved to live with B. He had a good sense of humour and enjoyed time with friends and family.

- 2.1.5 A's parents indicated that there had been a few occasions when A had returned home briefly in the early stages of the relationship with B because of conflict. He had not done so in recent years and they considered he was happy in the relationship with B. A's family informed the chair of Panel that early in the relationship B had caused a difficulty at the GP practice where A was registered and was barred from the premises.
- 2.1.6 At the initial meeting in June 2012, A's family had shared observations about the difficulties they had experienced in bringing all their family together because B refused to associate with their other son's partner. They confirmed this experience when reading the draft report. B's family were aware that she and A did not attend family gatherings with his family but were surprised by this account and the implied criticism of their daughter.
- 2.1.7 B's family had lived with concerns for B's well-being for some years. They were aware that she suffered from depression and that there had been points in the past where she had harmed herself. They considered A caring and supportive of her as she was of him.
- 2.1.8 B had started to experience episodes of depression around 1997 and there had been occasions when she had self-harmed. The most serious incident known to the family had occurred in October 2007. B's mother believes that B's condition was not taken seriously enough in 2007 by mental health services. B's mother explained that she had felt she needed to supervise her daughter on a daily basis following her discharge from hospital in October until Christmas 2007 when she began to be more herself. She recalled an occasion at a weekend when she had taken her daughter to a local clinic because she was so worried about her during this period. She considered her daughter required in-patient treatment at this time and remains disappointed it was never considered. She considers that following B's recovery, she was well maintained on medication until the summer of 2011 when B began reporting feeling unwell.
- 2.1.9 Around the summer of 2011 the medication appeared to 'stop working'. B was reluctant to seek further help as she did not believe there was anything to be gained. She was persuaded by her mother to attend a private consultation in the belief that this may offer different advice. B's mother was very disappointed by the lack of a treatment that could fully meet her daughter's needs and believes it should have been possible to find one. B's family acknowledged that she was reluctant to cooperate with social and psychological treatments but saw this as an indication of the limits of the treatments available and B's determination to manage her condition

herself. Her family were always watchful and concerned for her well-being. Her mother could not suggest any treatment that B would have accessed willingly other than medication. They did not have any specific complaint about the treatment other than that it had not helped B sufficiently.

- 2.1.10 B's mother was routinely in daily contact with her daughter either by phone or face to face. She knew that B was depressed over the Christmas holiday period in late 2011 and that B had not wanted to visit family or join in social gatherings. A was at home with her, was open with B's family about any concerns, and they believed B was safe in his company.
- 2.1.11 Neither family had any fears or suspicions prior to the deaths that there was any risk of harm to A from B. Both families knew of previous incidents of self-harm by B but did not consider it possible that she would ever act to harm herself in a way that might also place him at risk. They had believed she would have wanted to avoid such a possibility.
- 2.1.12 Neither family had any concerns about the possibility of domestic violence in the relationship between A and B, and had never had any experiences which could have indicated that such incidents had occurred. Neither B nor A had ever disclosed fears of violence or other types of abuse in the relationship to their families.
- 2.1.13 Both families confirmed their belief that if A had had serious concerns about B or for himself in the days immediately before his death, he would have contacted them for help.
- 2.1.14 When they had opportunity to view the draft report in November 2012 the families of B and A confirmed that the account of the facts is consistent with their experiences. Until the deaths these two families were in close contact with each other.

### **3 The facts known to agencies**

- 3.1.1 The deaths were discovered because B's family had rung her as usual and been unable to get a response to either landline or mobiles. When they arrived at the house they were unable to get a response either and became suspicious because the car was on the drive. They contacted the police to gain entry and were advised not to attempt to do so themselves. Despite this advice, B's brother forced entry before the arrival of the police and discovered A's body at the foot of the stairs.
- 3.1.2 Forensic enquiries established that A had suffered multiple stab wounds and appeared to have attempted to escape the attack before he died from his injuries. He appeared to have been taken by surprise when getting ready for bed.

- 3.1.3 The body of B was found by police in the upstairs bathroom. She had died from self-inflicted wounds to her throat and neck. There was no evidence that she had been subject to any assault by A.
- 3.1.4 Police enquiries established that had B lived, there was sufficient evidence for her have been charged with Murder. No suicide note or other material that can explain these deaths has been discovered.
- 3.1.5 A detailed chronology of professional contacts has been collated which is the basis for this account. The chronology formally starts in October 2007 and reviews the period from then until the death of A in terms of records relating to him and B. Where agencies had significant information that predated the terms of reference, this history was also included in both the chronology and this review and its relevance for subsequent events noted.

## **3.2 Agency contacts from 1997 – 2007**

- 3.2.1 A was well known to health agencies. He had had serious health problems from early childhood requiring regular review and substantial periods of in-patient treatment. During 2005 he required regular dialysis and had a successful kidney transplant in 2006. He had access to health care professionals on a regular and frequent basis throughout the time he lived with B.
- 3.2.2 B had a history of mental health problems which first appear to have started in late 1997. In December that year she took an overdose resulting in a brief A and E admission and she received follow-up services at home. By March 1998 she had been discharged from the community services as she had not kept appointments or declined the services offered. She continued to receive medication from her GP. Difficulties in her relationship with A were considered an element of her condition at that time and relationship counselling was one of the services she declined. There is a further episode in 1998 and she was again advised to consider relationship counselling which she declined. In 2000 she requested early payment of her NHS pension due to ill-health. She had worked as a support worker in a mental health setting and was experiencing both depression and pain following minor surgery.
- 3.2.3 A further episode of depression occurred in late 2003 when she again took an overdose and was treated in A and E and assessed by mental health services. She was offered in-patient treatment on this occasion which she declined. She was referred to community psychiatric services. She did not attend appointments given and was discharged to the GP who continued to see her as previously.
- 3.2.4 Between 2002 and 2006 B had contacts with the police relating to disputes with neighbours and with parents and children associated with B's daughter. These events involved accusations and counter accusations of verbal abuse by the children and the adults and angry encounters in public places or at the homes of the various individuals involved. In none of the

incidents is there any record of physical violence by B and at no point was she subject to arrest or formal charges.

- 3.2.5 In April 2004 and again in July 2004 B was arrested for shoplifting. She gave different false details on these occasions and was cautioned in the false names. She was arrested for a further shoplifting offence in September 2004 and the previous deception was identified. B was charged with perverting the course of justice in addition to the shoplifting offences and received a community sentence in November 2004. As part of the sentencing process a psychiatric report was requested which explained her health history. The Probation Service considers that the risk assessment completed at the time was appropriate to the offences and met relevant standards. She was assessed as being at low risk of serious harm and low risk of re-offending. The supervising officer provided supervision which met national standards and was relevant to B's circumstances.
- 3.2.6 B informed her probation service supervisor in a self-assessment that she suffered from depression and worried about things, although stressing that this was not connected with her offending. The supervision did not involve any liaison with B's GP, who continued to manage the care of her mental health issues, and consent for this was not sought from B.
- 3.2.7 B was superficially compliant with her supervision but did not seek any specific assistance from the officer. She reported accurately on other matters that caused difficulty during this time, including A's hospitalisation with major surgery, the dispute with neighbours and her daughter's difficulties with school. She also reported that her mother considered that probation should offer more 'help' but when asked to identify what this might be could not be more specific. She was persistently rude towards office staff who she encountered when attending appointments despite warnings. She completed this sentence without breach and had no further encounters with the police on criminal matters from completion of the order until her death.
- 3.2.8 A complaint of noise nuisance in respect of the property in which A and B lived was made to the District Council in 2005 and the details were passed to the community safety team who offered mediation in respect of anti-social behaviour. No further complaints were received.
- 3.2.9 By late 2006 B sought help from the GP with a further episode of depression which resolved itself in early 2007 without referral to specialist services.
- 3.2.10 B also experienced minor physical health problems throughout this time which received appropriate investigation and treatment. Although investigations did not discover any significant cause for concern B appears to have been anxious about her physical health.

### **3.3 Summary of facts within Terms of Reference 2007-2012**

- 3.3.1 A was seen frequently and regularly by health care professionals throughout the period under review. He had consistent contacts with GPs and specialist services. IMRs completed in respect of both GP and local hospital services indicate no concerns about his home situation. He was last seen on 3 November 2011 for his flu vaccination at the GP practice and at the hospital on 2 December 2011 by a vascular surgeon. He was due to attend for an operation in January 2012. He was registered throughout the period under review at the GP practice where he had been registered from childhood. This is different from the practice where B was registered.
- 3.3.2 In early October 2007, having seen her GP a week earlier complaining of depression, B appeared to attempt suicide by first cutting herself across her chest and neck and then throwing herself from an upstairs window when her mother was at her home and in the garden. She sustained injuries requiring orthopaedic treatment and spent a week in hospital for the initial treatment of these injuries. She was assessed by psychiatry prior to discharge and offered follow-up treatment by mental health services at home. She was seen twice within ten days of her discharge by different professionals and determined that she did not wish to receive any therapeutic services other than medication. She did however attend out-patient appointments with her mother accompanying her later that month. When seen in mid-December, a working diagnosis of bi-polar spectrum disorder was given. At this appointment B reported feeling better. Her GP made referrals for relaxation and anxiety management therapy but B did not attend.
- 3.3.3 By early January 2008 B reported continuing improvement and indicated her intention of attending Yoga classes instead of the anxiety management service. She attended her GP and out-patient appointments through 2008 and maintained her medication, remaining well.
- 3.3.4 B did not attend out-patient appointments in 2009, continuing her medication through the GP and remaining well. By January 2010 she decided she no longer wished to be seen by mental health services. This was supported by the services and she was discharged.
- 3.3.5 Throughout 2010 B reported physical health concerns which were investigated and resulted in re-assurance that there were no problems. She continued to be prescribed medication to stabilise her mood. Her contacts with health professionals became less frequent until the summer of 2011 when she attended the GP feeling tearful and low. She refused referral back to the mental health services but with her mother's support accepted referral to a private consultation where she was seen once and advice was made available to her GP in respect of her continuing treatment. There was no suggestion at this point that she required in-patient treatment or was not competent to make this decision. She was last seen by a GP on 10 October 2011 when she was described as 'elated'. A

request for a change to her medication from liquid to tablet formulation is recorded in December 2011 and was the last contact with the practice.

- 3.3.6 An inquest into both deaths took place. The inquest determined that B had killed A before taking her own life.

### **3.4 Diversity issues**

- 3.4.1 Both A and B were white British and had English as their first language. Neither had any communication difficulties.

- 3.4.2 A suffered from physical ill health for most of his life, which affected his ability to work consistently but did not prevent him from undertaking normal domestic and social activities. His health condition certainly would not have acted as a barrier to him seeking assistance or accessing services from any agency.

- 3.4.3 B suffered from depression from 1997 onwards and had a history of self-harming. This was such as to prevent her from working although, as with A, it did not prevent her from undertaking normal domestic and social activities. B's mental health condition would not have prevented her seeking assistance or accessing services from any agency although there is evidence that she was selective in which services she was prepared to engage with. These choices particularly reflected her view that her depression had a biological rather than psychological or social aetiology.

- 3.4.4 No other diversity issues were relevant to the lives of A or B.

## **4 Analysis**

- 4.1.1 The Panel considered a range of possibilities in seeking to understand and identify any lessons to be learned from these events and these were reflected in the terms of reference. Research reviewed by the police indicates that this is a highly unusual event where a female perpetrator kills a male partner and then commits suicide. Any incidents of murder or suicide will be unique, but it is often possible to get some idea of the reasons for events and the motivation of perpetrators. The Panel wanted to know if there were signs of previous violence by either party in respect of each other or any other person and whether risk assessment processes had been considered and action taken when necessary in relation to any mental health conditions in either partner. The Panel wanted to identify opportunities when either partner may have been able to seek advice about relationship problems and whether professionals had responded appropriately at such times.

- 4.1.2 The Panel was provided with details of the police enquiries in respect of the deaths and was satisfied that these were thorough and ruled out any possibility of an accidental event or a suicide method that inadvertently resulted in both partners' deaths. B had said of previous suicide attempts

that they were impulsive actions, with little forward planning. She left no traces of forward planning, no suicide note and no indicators of her motivation to attack A on this occasion.

- 4.1.3 The Panel reviewed the chronology to identify opportunities for disclosure of domestic violence or any observations of unexplained injuries. Neither A nor B reported any violence or other form of abuse within their relationship at any time, nor were any indications of injuries or suspicious behaviour observed by either professionals or family members. A had regular checks and reviews with health professionals who he trusted. There were ample opportunities to seek advice, for disclosure of problems or for observations to be made independently by professionals. There is no evidence of missed opportunities to explore difficult circumstances or information indicative of difficulties being ignored. It therefore follows that procedures for responding to domestic abuse were never triggered or tested by these circumstances.
- 4.1.4 The Panel reviewed the events that occurred prior to the full review period to identify whether there were any suggestions at that time of violent behaviour by either partner.
- 4.1.5 The incidents described during 2004-2006 provide evidence that B could be verbally abusive and deceitful, but on no occasion was any violence or threat of violence recorded or observed. The police confirmed that incidents of this kind are unexceptional and there was no reason to consider B's actions any differently from those of other individuals involved in similar situations.
- 4.1.6 The Panel concluded that there were no grounds at this time to assess B as presenting any risk of violence to others either within the family or the wider community. The CSP is satisfied that multi-agency arrangements are in place for those who commit serious offences but such arrangements need to focus on situations where risks can be identified. At a lower level the mediation service provided by the District Council was effective in resolving the dispute over noise between B and A and their neighbour. As none of the incidents resulted in arrest or charge, they had no implications for B's community sentence, although it would have been good practice for the supervisor to confirm the information on this provided by B with the District Council.
- 4.1.7 B's superficial cooperation with her supervision whilst sharing only limited information about herself was consistent with her approach to other services.
- 4.1.8 The Panel reviewed a summary report from the Staffordshire and West Midlands Probation Trust (SWMPT)<sup>3</sup> in respect of B's community

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<sup>3</sup> From 1 June 2014 the responsibilities formerly undertaken by the Staffordshire and West Midlands Probation Trust were split between two new organisations; the National Probation Service, responsible for high risk offenders, and the Staffordshire and West Midlands Community

supervision between 2004 and 2006. There was a missed opportunity for multi-agency working at this time as the supervisor, although aware that B suffered from depression, did not seek consent to liaise with her GP. During the supervision period B sought appropriate medical support which appeared to be successful in managing her condition. It did not seem to the Panel that, if consent had been provided, such liaison would have made any significant difference to the perceived risks, the probation supervision regime or the treatment provided by the GP.

- 4.1.9 Such information sharing might however have implications for other supervision cases and potentially alert supervisors where problems might occur. In this respect the probation service, prior to commencement of this review, had introduced Multi Agency Criminal Justice Mental Health Teams to ensure joint working and close liaison in sharing information for diversion from prosecution, sentencing, risk assessments and support to Probation staff with a wide range of interventions. SWMPT and NHS agencies confirmed that these arrangements ensure that liaison with the GP (and any other health agencies involved with a particular client) would now occur. Further development of provision for offenders with mental health issues is a key priority within the Staffordshire Police and Crime Commissioner's strategic plan for 2013-18.
- 4.1.10 Overall, having considered professional involvement with A and B prior to October 2007, the Panel took the view that any differences in the way that agencies worked on a single or multi-agency basis would not have produced significantly different information than that which was actually available to those professionals in contact with A and B from then on. In view of the substantial developments in services since 2007 the Panel was also satisfied that the involvement of A and B with agencies prior to then does not indicate the need for any further measures to improve services.
- 4.1.11 The Panel considered that a key opportunity to assess risks occurred at the time of B's attempted suicide in 2007. The risk assessment at this time was thorough, consistent with NHS Trust standards, and considered the risk B presented to herself and others. She received treatment and support intended to mitigate the risk to herself and assessments concluded there were no risks to others. The North Staffordshire Combined Health Trust IMR notes that professionals were thorough and persistent when services were refused. The GP was informed promptly of B's refusal, and assurances were given that she could access services should she change her mind. At no point was she considered to need an assessment of her competence to make this decision and at no time was she considered to need in-patient treatment either on a voluntary basis or as a detained patient. There is no record of her ever suffering major psychotic symptoms which might have justified more intrusive treatment or restrictions of liberty. Mental health services were not aware of the intensive support offered by

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Rehabilitation Company, responsible for medium and low risk offenders. Policies and service specifications of the Trust are being carried across at local and national level to the two new bodies.

her mother at this time. They had no involvement at the time of the referral to a private doctor in July 2011 by the GP at B's request.

- 4.1.12 The IMRs from health agencies conclude that B received appropriate services, that there was prompt exchange of information between health agencies and that every effort was made to support her in her concerns about both her physical and mental health. Although B did not wish to engage in psychological therapies, there is no suggestion that she was reluctant to take her medication or non-compliant with her treatment in that respect. The PCT IMR noted that in 2011 B saw different doctors within the GP practice and considered whether this may have had a negative impact on her treatment through lack of continuity concluding that it did not. There is good evidence of persistent efforts to respond to her concerns, to follow the consultant's advice following the private consultation, and to ensure appropriate treatment. The PCT IMR does however make two recommendations to set high standards of practice. While there is no suggestion that these additional measures would have made any difference to these events they may make a difference to others by ensuring effective management of complex health conditions.
- 4.1.13 The Panel considered whether A or B's mother should have had more opportunity for consultation with professionals about B's treatment and support. Her mother frequently accompanied her to appointments but there is no record that professionals had planned contacts with either her or A at any other time. Where patients are receiving treatment on an informal basis their consent to involving family members is always necessary. Had B accessed psychological or relationship counselling, it would have been very likely that A would have been more engaged. However as these approaches were refused, her preference for being accompanied by her mother at appointments was accepted.
- 4.1.14 Neither B nor her mother made mental health services aware of the intensive support provided during October/November 2007. Had this been made known, it is possible that B's mother may have qualified for a carer's assessment and support for this short period.
- 4.1.15 It is normal practice in the NHS Trust to offer carers an assessment when a formal Care Programme Approach<sup>4</sup> (CPA) is required. Carer's assessments are intended for those who provide substantial and regular care, where the cared for person may be in need of services and engagement of the CPA therefore seems a reasonable level at which these criteria are likely to be met. Under current guidance, the Trust considers that B did not qualify for this approach. The Panel concurred with this view but noted that this did not obviate a carer or the person cared for requesting an assessment if they consider it appropriate. The Panel think this, which is consistent with national guidance, an appropriate strategy.

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<sup>4</sup> The Care Programme Approach (CPA) is a person centred approach used to inform partnership working in mental health. This partnership should always, as a minimum, include the service user, any carers and the CPA Care Coordinator. It should also include working relationships with health and/or social care professionals and other relevant organisations.

- 4.1.16 The panel did not consider that either B or A met the criteria for such assessment in respect of each other at any point. Neither was so disabled by their ill-health that they required support with personal care, and both were capable of normal domestic activities. In caring for each other, the responsibilities were little different from any couple. There is no evidence that either was distressed by the other's health care needs, or in need of counselling in respect of the pressures. B in particular rejected any suggestion that her ill-health was a reaction to circumstances and consistently stressed her belief in the biological nature of her condition in discussions and assessments.
- 4.1.17 The Panel has considered whether a more intrusive approach by health service professionals could have been successful in changing B's approach to her condition and enabled her to make use of psychological therapies as well as medication, possibly increasing her well-being and reducing the risks of these events occurring. The Panel was not confident that such an approach was likely to have a positive outcome. Professionals worked hard to maintain a constructive working relationship where it was needed and there was a serious risk that B would withdraw from any treatment if pressed on this issue. The judgement of health professionals to maintain open communication with B was sound in the view of the Panel.
- 4.1.18 The family believe that B's mental state deteriorated over the Christmas period of 2011. There is no professional corroboration of this as she was seen for last time by a GP on 19 October 2011. The Panel considered whether A might have sought medical assistance if it had not been a holiday period. It is unlikely he would have done so without discussing any concerns with B's mother and he gave no indication to her that there was any need to do so. The Panel has concluded that the Christmas holidays were not a factor in accessing services.
- 4.1.19 The Panel considered whether there is evidence that either B or A were involved in other potentially dangerous behaviours associated with violent incidents such as excessive alcohol consumption or illicit drug abuse that was not known to professionals. No such evidence came to light from this review process or police enquiries.
- 4.1.20 The Panel looked for missed opportunities to intervene in ways that could have changed events. Although there was a point in 2005 when liaison between the probation service and B's GP might have offered an opportunity to have more impact, the Panel concluded that it would not have done so and in any event it is quite uncertain that any impact at the time would have carried through to 2012. In the more recent period studied in detail, the Panel concluded that that appropriate and proportionate services were offered whenever requested or needed and there were no opportunities for multi-agency consultation or intervention. There was no legal basis for more intrusive interventions and, more importantly, no events to warn of the eventual outcome.

- 4.1.21 There were no warning signs at any time in respect of any risk to A. While previous self-harm incidents had occurred in respect of B there were no immediate warning signs that she was contemplating suicide known either to professionals or her family.
- 4.1.22 On this basis the Panel concluded that neither death was either predictable or preventable.
- 4.1.23 Notwithstanding this conclusion the Panel was pleased to be informed of the Staffordshire Suicide Prevention Plan 2013-2016 which is included within a Mental Health and Wellbeing Strategy owned by County Health and Well-being Board. The document sets out key risk factors and at risk populations together with strategies for providing more effective services on a multi-agency basis; it sets out areas for service improvement and where work is already in hand.

## **5 Agency management reviews**

### **5.1 North Staffordshire Combined Healthcare NHS Trust**

- 5.1.1 This Trust provided services to B between 2007 and 2010. The IMR author commends the thoroughness of the assessment undertaken in October 2007 and concludes:

“B was subject to full mental health and risk assessments at this time (2007) which made clinically sound judgements concerning her level of need and risk. B’s risk of harm to herself was well documented and interventions were put in place to safeguard that risk. At no time was a risk of harm to others identified and there appears to be no information or indication from any source that she presented a risk of violence at that time.”

“B decided that she no longer wished to be seen by mental health services in January 2010. The decision to discharge her from mental health services appears to have been sound and there was no other information available to the team at that time to have attempted to more assertively engage with B.”

- 5.1.2 The IMR made no recommendations. The Panel accepted these conclusions and has discovered no further material information that might challenge them.

### **5.2 NHS Staffordshire Cluster of Primary Care Trusts**

- 5.2.1 The IMR considered whether the fact that B saw several different GPs at her various appointments in the six months before her death may have had an impact on the quality of practice and concluded:

“In terms of effective practice the GPs providing care to B took every opportunity to support her mental health and physical health needs in the records reviewed, appropriate referrals in a timely fashion were instigated at every opportunity”.

5.2.2 However to mitigate the risks that are present when different professionals see patients with complex problems, the IMR made two recommendations to the practice to reduce the risks when multiple practitioners are involved in the treatment of an individual:

- Locally general practices have maintained a register of those patients with mental health conditions since 2005. The register could be further utilised to inform multi-disciplinary practice meetings and include overarching case review of these complex patients in order to assist robust risk assessment; and
- Consideration should be given to the immediate extended family (registered at the same general practice) as those entered on to the register during case discussion.

5.2.3 Both recommendations have been implemented and the details are in the Action Plan (Appendix B).

### **5.3 University Hospital North Staffordshire NHS Trust**

5.3.1 Both B and A attended clinics on an out-patient basis for physical health matters. A also had periods of in-patient treatment and had an admission planned for January 2012. Detailed chronologies in respect of both were provided. There were no disclosures, signs or indications of any domestic violence or abuse; and no injuries in respect of either which could have been caused by undisclosed violence. When B was admitted for treatment of injuries following an incident of serious self-harm in October 2007 she was referred to the mental health services promptly and appropriately. There are no concerns about the treatment of either and therefore no recommendations.

### **5.4 Staffordshire Moorlands District Council**

5.4.1 In 2005 enforcement action was initiated by the Council in respect of noise nuisance by B and A's household. The matter was resolved through mediation and no further matters of a similar nature have been brought to the attention of the Council.

5.4.2 B and A were housing benefit claimants and were reviewed annually in respect of this. No information of any significance emerged in these contacts. In 2008 they failed to pay council tax and appeared jointly in court as a result. No information emerged from this contact that could have alerted this or other agencies to any personal difficulties. There are no recommendations.

## **5.5 Staffordshire and West Midlands Probation Trust**

- 5.5.1 SWMPT provided a summary report of the period of community supervision prior to the period under review. It confirmed that B was assessed as low risk of serious harm and reoffending and completed the sentence without breach.
- 5.5.2 The Panel was pleased to receive details of changes in service standards since 2006 improved organisational arrangements highlighted earlier in the report. The Panel accepted that no recommendations were required.

## **5.6 Staffordshire Police**

- 5.6.1 The last police contact (prior to the discovery of the bodies of A and B) was in 2007 and predated the period under review. A full chronology of contacts was however provided. No information emerged in the course of the enquiries into the deaths that suggested any missed opportunities to involve the police service. None of the contacts prior to 2007 involved reports of violence or domestic abuse.
- 5.6.2 Details of the police enquiries into the deaths were shared with the Panel. The Panel was satisfied that every effort was made to discover the reasons for these deaths, or warning signs of difficulty, and that none was identified.

## **6 Conclusions**

- 6.1.1 The Panel has concluded that the death of A was not predictable and accordingly not directly preventable. No professionals or family members had any information regarding, or other indication of, violence by B in the past; or that this might occur in the future. Although B's potential for suicide was known there were no indications to professionals or family in the weeks immediately before the deaths that suggested she was contemplating suicide. It was more than two months before her death that she last had contact with her GP, when she was noted to be elated not depressed, and she had no other professional contacts in the intervening period. There were no grounds for any professional to be involved at this time on any other basis.
- 6.1.2 The Panel also concluded that the decisions and actions of professionals during the period reviewed were appropriate and that there were no reasonable opportunities to intervene or provide services differently which might have led to the deaths being indirectly prevented.
- 6.1.3 Two recommendations (see 5.2.2 above and Appendix B) intended to set high practice standards for the management of those with complex health conditions in a primary care setting were made by the NHS Staffordshire Cluster of Primary Care Trusts<sup>5</sup>. There is no suggestion that these

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<sup>5</sup> Responsibility for commissioning of primary care services now rests with NHS England.

additional safeguards would have made any difference to the events under review but the Panel recognised that they may make a positive difference to others with complex health needs. The Panel is therefore pleased to endorse these recommendations and to note that they have now been implemented.

- 6.1.4 In order to ensure that this good practice is disseminated as widely as possible the Panel recommends that NHS England promotes the use of such arrangements within primary care settings nationally. Staffordshire Moorlands Community Safety Partnership will share the findings of this review with the NHS England Shropshire and Staffordshire Local Area Team and request they take this recommendation forward in conjunction with their dissemination of the review, once published.
- 6.1.5 There are no other significant issues emerging from this review which require recommendations from the Panel.

Susan Lane  
Chair of Panel and Report Author

## References

National Institute for Health and Clinical Excellence, Depression, 2009;  
(<http://guidance.nice.org.uk/CG90/QuickRefGuide/pdf/English> accessed 24/9/2012)

## Appendix A

### **DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE**

#### **1 Introduction**

1.1 The Terms of Reference for this Domestic Homicide Review (DHR) have been drafted in accordance with the Staffordshire and Stoke Multi-agency Guidance for the Conduct of Domestic Homicide Reviews (October 2011), hereafter referred to as “the Guidance”.

1.2 The relevant Community Safety Partnership (CSP) should always conduct a DHR when the death (including death by suspected suicide) meets the following criterion under the Domestic Violence, Crime and Victims Act (2004, section 9 (3)), which states that a domestic homicide review is:

a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- **a person to whom he was related or with whom he was or had been in an intimate personal relationship; or**
- **a member of the same household as himself**

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

1.3 An ‘intimate personal relationship’ includes relationships between adults who are, or have been, intimate partners or family members, regardless of gender or sexuality.

1.4 A member of the same household is defined in section 5(4) of the Domestic Violence, Crime and Victims Act [2004] as:

- **a person is to be regarded as a “member” of a particular household, even if he does not live in that household, if he visits it so often and for such periods of time that it is reasonable to regard him as a member of it;**
- **where a victim (V) lived in different households at different times, “the same household as V” refers to the household in which V was living at the time of the act that caused V’s death.**

- 1.5 The Guidance lays out that the purpose of undertaking a DHR is to:
- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
  - **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;
  - **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and
  - **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

## 2 Background

- 2.1 The victim, A, is a 42 year old male, who lived with his female partner, B, aged 46. She had a child from a previous relationship whom B and A brought up together and who is now an adult. She has a child of her own and is not a member of the household. Both B and A have lived in the area all their lives and have parents and siblings living nearby.
- 2.2 In January 2012 B's mother was concerned that she had not been able to get in touch with either her daughter or A, and she had therefore visited the address. She saw that both cars were parked there but she could get no answer from the door which was locked. Therefore, she contacted the police.
- 2.3 In the meantime, B's brother forced the door of the property and saw a body lying on the staircase. When the police arrived at the property they found the body of A on the stairs and the body of B in the bathroom.
- 2.4 There was no third party involvement and the police are treating the incident as a murder/suicide on the basis that B stabbed A and then took her own life.

## 3 Grounds for commissioning a DHR

- 3.1 A DHR Scoping Panel met on 6 February 2012 to consider the circumstances leading to A's death. The Panel was unanimous in the view that the following criteria for commissioning a DHR had been met:

<b>CRITERIA</b>	
There is a death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse or neglect.	<b>X</b>
The victim has sustained a potentially life-threatening injury or serious and permanent impairment of their physical and/or mental health, and development through physical abuse; emotional abuse; sexual abuse; or neglect*.	
The alleged perpetrator was related to the victim and was in, or has previously been in, an intimate personal relationship with the victim.	<b>X</b>
The alleged perpetrator is a member of the same household as the victim.	<b>X</b>
The case gives rise to concerns about the way in which practitioners or agencies have individually or collectively worked together to safeguard and promote the welfare of the victim and their family. This includes inter-agency and/or inter-disciplinary working*.	

*\* These criteria are applicable to alternative review processes where the criteria for a statutory DHR are not met.*

3.2 This recommendation was endorsed by the Chair of the Staffordshire Moorlands Community Safety Partnership who was present at the meeting and the recommendation was recorded in the minutes.

#### **4 Scope of the DHR**

4.1 The DHR should consider the period that commences from 5 October 2007 up to and including the events of January 2012. The focus of the DHR should be maintained on the following family members:

<b>Name</b>	<b>A</b>	<b>B</b>
<b>Relationship</b>	Subject of DHR	Partner
<b>Date of Birth</b>	Aged 42	Aged 46
<b>Date of Death</b>	January 2012	January 2012
<b>Ethnicity</b>	White British	White British
<b>Address of Victim</b>	Moorlands District, Staffordshire	

4.2 A review of agency files should be completed (both paper and electronic records); and a detailed chronology of events that fall within the scope of the DHR should be produced. **NB:** The Commissioner for Safer Communities will produce a single merged chronology.

4.3 An Overview Report will be prepared in accordance with the Guidance.

## **5 Individual Management Reviews (IMR)**

5.1 Key issues to be addressed within this DHR are outlined below as agreed by the Scoping Panel. These issues should be considered in the context of the general areas for consideration listed in the Guidance.

- Were any risks posed by B to her partner identified by any agency and appropriately understood/shared/acted upon?
- Were any concerns for his personal safety expressed by A or recognised, appropriately risk assessed and responded to?
- Should B have been identified as a risk to herself and others in the period under review?
- Provision of mental health services to B.
- The significance of both A and B acting as carers for each other with their very different health problems.
- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration.
- Was the homicide of A predictable and/or preventable?

5.2 Individual Management Reviews are required from the following agencies:

- Staffordshire Police
- NHS Staffordshire Commissioning Support Services
- University Hospital of North Staffordshire NHS Trust
- North Staffs Combined Healthcare NHS Trust
- Staffordshire Moorlands District Council

5.3 Where an agency has had involvement with the victim and B the IMR should consider:

- the circumstances and needs of each individual;
- the need to summarise the chronology relating to frequent contacts concerning routine matters concerning the management of chronic health matters for A to ensure any significant matters are properly identified;
- the relationship that existed between the family members where known;

- the relationships with members of their immediate and extended family, which may have impacted upon them; and
  - maximising learning from the circumstances leading up to the homicide.
- 5.4 In the event an agency identifies another organisation that had involvement with either A or B during the scope of the review, this should be notified immediately to the County Commissioner for Safer Communities to facilitate the prompt commissioning of an IMR.
- 5.5 Integrated Health Chronology and Overview Report: The Designated Safeguarding professional will review and evaluate the practice of all involved health professionals (including GPs and providers commissioned in the area), in accordance with the Guidance.
- 5.6 Third Party information: Information held in relation to members of the victim's immediate family should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.
- 5.7 Staff Interviews: All staff who have had direct involvement with A and B within the scope of this review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Senior Investigating Officer. This is to ensure primacy of evidence for any parallel proceedings. Participating agencies are asked to provide the names of staff who should be interviewed to the County Commissioner for Safer Communities who will facilitate this process. Interviews with staff should be conducted in accordance with the Guidance. It is not expected that this will create any significant delays.
- 5.8 Equally, where staff are the subject of other parallel investigations (Disciplinary, SUI, etc) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the DHR Panel Chair, supported by the County Commissioner for Safer Communities.

## **6 Summary reports and other matters**

- 6.1 Where an agency has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them or involvement with their extended family (outside of the scope of this DHR), a Summary Report should be prepared.
- 6.2 A Summary Report is required from the following agency:
- Staffordshire and West Midlands Probation Trust

- 6.3 The Summary Report should commence from the point at which the agency first became involved with B, until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.
- 6.4 The purpose of the Summary Report is to provide the Independent Overview Author with relevant information which places each subject and the events prior to the incident that resulted in A's death into context
- 6.5 The Summary Report should identify and discuss any significant life events.
- 6.6 The IMR or Summary Reports will not form a part of the submission to the Home Office at the conclusion of this process; they must be authorised by the agency Commissioning Manager. Agencies will want to use these reports to brief staff on the conclusions.
- 6.7 In the event that an agency identifies another organisation that had involvement with the victim or his family, outside of the scope of this review, this should be notified immediately to the County Commissioner for Safer Communities to facilitate the prompt commissioning of a Summary Report.
- 6.8 Staffordshire County Council (Adults Services) is not required to provide any additional information. It is noted that their involvement with A was restricted to the provision of a Disabled Parking permit. A letter confirming the date of issue within the period of the Terms of Reference is sufficient.
- 6.9 IMR authors and Summary Report authors should have no line management responsibility for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

## **7 Parallel investigations**

- 7.1 During the course of the DHR, each agency should give consideration to whether they should initiate an Internal Review and/or take disciplinary action (in respect of individual employees), in the event that policies and procedures have not been complied with. This information should be included in the agency's IMR.
- 7.2 The IMR need only identify that consideration has been given to disciplinary issues and, if identified, that these have been acted upon accordingly. IMRs should not include details which would breach the confidentiality of staff.
- 7.3 The County Commissioner for Safer Communities should be notified by the Commissioning Manager in writing where parallel investigations of practice etc are initiated during the course of the review.

- 7.4 The Senior Investigating Officer (SIO) for A will attend all DHR Panel meetings, during the course of the review.
- 7.5 The SIO will act in the capacity of a Professional Advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service, during the course of the DHR.
- 7.6 All communication with the SIO and County Commissioner for Safer Communities, between meetings, will be in writing to maintain a clear audit trail and accuracy of information shared.

## **8 Independent Chair and Overview Author**

- 8.1 The Panel Chair (and report author) is independent of Staffordshire Moorlands Community Safety Partnership, Staffordshire Safeguarding Children Board and Staffordshire Vulnerable Adults Safeguarding Board, and is not an employee of any of the agencies involved in this review.

## **9 DHR Panel**

- 9.1 The DHR Panel will comprise senior representatives of the following organisations:
- Arch (North Staffs) Ltd
  - Staffordshire Moorlands District Council
  - Staffordshire Police
  - University Hospital of North Staffordshire NHS Trust
  - North Staffordshire Combined Healthcare NHS Trust
  - Staffordshire County Council Adult Safeguarding representative (independent member)

## **10 Legal and/or expert advice**

- 10.1 The County Commissioner for Safer Communities, in consultation with the DHR Panel Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.
- 10.2 However, the IMR authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.
- 10.3 The report author should include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and other reviews conducted locally and nationally.

## **11 Family engagement**

- 11.1 The DHR Panel will consider and keep under review arrangements for involving A's and B's families and social network in the review process in accordance with the Guidance. Any such engagement will be arranged in consultation with the SIO.
- 11.2 The DHR Panel will ensure that at the conclusion of the DHR the victim's family will be informed of the findings of the review, prior to submission of the Overview Report to the Home Office. The DHR Panel will also give consideration to the support needs of family members in connection with publication of the Overview Report.

## **12 Media issues**

- 12.1 The death of this couple has attracted local media interest. The Police Press Office will coordinate all requests for information/comment from the media in respect of this case. Press enquiries to partner agencies should be referred to the Police Press Office for comment.

## **13 When should the DHR start, and by what date should it be completed?**

- 13.1 The DHR commenced with effect from the date of the decision of the Chair of the Community Safety Partnership: **6 February 2012 and should be completed and submitted to the Community Safety Partnership by 6 August 2012.**

## Appendix B

### OVERVIEW REPORT RECOMMENDATIONS ACTION PLAN FOR A

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
<p>Locally general practices have maintained a register of those patients with mental health conditions since 2005. The register could be further utilised to inform multi-disciplinary practice meetings and include overarching case review of these complex patients in order to assist robust risk assessment.</p>	<p>Local.</p>	<p>Communication to general practices reiterating the importance of the register, its maintenance and utilisation to inform case discussion and risk assessment.</p>	<p>NHS England Shropshire and Staffordshire Local Area Team and Clinical Commission Groups (formerly NHS Staffordshire Cluster Of Primary Care Trusts).</p>	<p>Communication with NHS England Local Area Team regards communication to General Practices.</p> <p>Communication via CCG newsletter to GPs.</p>	<p>November 2013.</p>	<p>Communication to general practices undertaken to reiterate that the register is maintained and up to date and is utilised to inform multi disciplinary case discussion and risk assessments.</p> <p>Local action completed communication via GP newsletter September 2013.</p>

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
<p>Consideration should be given to the immediate extended family (registered at the same general practice) as those entered on to the register during case discussion.</p>	<p>Local.</p>	<p>Communication to general practices reiterating the importance of the register and its utilisation to inform case discussion and risk assessment. This could include where appropriate the immediate extended family registered at the same practice.</p>	<p>NHS England Shropshire and Staffordshire Local Area Team and Clinical Commission Groups (formerly NHS Staffordshire Cluster Of Primary Care Trusts).</p>	<p>Communication with NHS England Local Area Team regards communication to General Practices.</p> <p>Communication via CCG newsletter to GPs.</p>	<p>November 2013.</p>	<p>Communication to general practices undertaken to reiterate that the register is maintained and up to date and is utilised to inform multi-disciplinary case discussion and risk assessments.</p> <p>Local action completed communication via GP newsletter September 2013.</p>
<p>In order to ensure that this good practice is disseminated as widely as possible the Panel recommends that NHS England promotes the use of such arrangements within primary care settings</p>	<p>National/ Regional/ Local.</p>	<p>Staffordshire Moorlands Community Safety Partnership will share the findings of this review with the NHS England Shropshire and Staffordshire Local Area Team and request they</p>	<p>Staffordshire Moorlands Community Safety Partnership (CSP).</p>	<p>Staffordshire Moorlands CSP to share findings with NHS England once Home Office permission to publish the review is received.</p>	<p>Within one month of permission being granted to publish the review.</p>	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key Milestones achieved in enacting recommendation	Target Date	Date of completion and Outcome
nationally.		take this recommendation forward in conjunction with their dissemination of the review, once published.				