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Safer Cornwall

Domestic Homicide Review Overview Report

DHR4

Independent Chair and Author

Steve Appleton,
Managing Director - Contact Consulting (Oxford) Ltd

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Foreword

As part of the review, the chair met with Adult C the step-son of Adult A. Throughout the process the panel sought to ensure that the family's voices were heard and that through them, Adult C and his brothers were at the centre of our thinking. With this in mind, it was agreed that Adult C would have the opportunity to provide a written statement about his parents as a foreword to the Overview Report. This statement is set out here in full including areas where Adult C disagrees with the panel on specific aspects of the reports findings and the DHR process as a whole. The content has not been edited but the initials relating to the victim and perpetrator have been replaced with Adult A and Adult B.

The report uses Adult A and Adult B to denote the victim and perpetrator in this case. The decision to adopt this approach was taken after discussion with family members and their advocate. It was taken to maintain confidentiality but also to be more personal to him rather than using random initials or other forms of anonymisation.

A statement from Adult C

I would like to inform the reader that my comments concerning the Domestic Homicide Review (DHR) are limited as at present I am yet to receive a copy of the chronology and intended action plan that is to follow its publication. I feel this DHR began with such enthusiasm and understanding and am forever grateful for the initial panel meetings for providing me with the hope that some good may come of what has been a traumatic experience for myself and my two younger brothers. It was touching to meet people with the ears to hear and eyes to see. However, due to the changing of the Chair person, which could not be helped, I feel that not just the attention paid to my input but the very nature of this DHR have taken a turn in the wrong direction.

My parent's relationship was loving yet dysfunctional and for the best part of my life so was my relationship with them. However, it would be biased of myself not to be grateful and appreciative of the love and provisions they had made for myself with the means and shortcomings they had been given. No one predicted such a horrific event could ever take place between two people whom were not ever known by their immediate family or friends to have been physically aggressive towards each other. It appears that the nature and dynamics of my parent's relationship has been polluted due to the language and terminology associated with the high risk behaviour demonstrated by my step father in his last months and weeks and its domestic setting. I would like to share an extract that I feel encompasses the relationship of my parents as best as I saw it. This new recognition of the foundations for dysfunctional and controlling relationships to be formed upon, if researched and explored, may provide much needed public information and awareness on how to avoid entering into

relationships based on shared hurt, trauma and pain that may put detrimental to both partners.

This extract describes the dynamics of relationships based on an intimate connection of shared trauma:

1. We will be there to support each other through any difficult memories associated with this wound.
2. That support will include reorganizing any part of our social life, or even work life, around the needs of our wounded partner.
3. If required, we will carry our wounded partner's responsibilities as a way of showing how sincere we are in our support.
4. We will always encourage our partner to process his/her wounds with us and to take as much time as necessary for recovery.
5. We will accept with minimal friction, all weakness and shortcomings rooted in wounds, sincere acceptance is crucial to healing.

"…In short, a bond based upon wounded intimacy is an implicit guarantee that weakened partners will always need each other and that we will forever have open passage to each other's interior. In terms of communication, such bonds represent an entirely new dimension of love, one that is orientated towards therapeutic support and the nurturing of mutual commitments to healing. In terms of power, partners have never had such easy access to each other's vulnerabilities or so much open acceptance for using wounds in order to control our close relationships." (C. Myss PHD, Seven stages of power and healing, 1997)

I have never been able to pinpoint just what pain my parents shared. I know my step father felt very resentful about his own childhood as did my mother, for reasons I do not know. They both came from broken/reconstituted homes and felt abandoned and let down by their families. Again, I cannot comment as to the origin of such beliefs and attitudes; however musings about the "Txxx Family Twig" were regular in our home. Despite my encouragement to address their wounds of the past, my parents appeared content in wearing these wounds, perhaps as damage is often considered as approving justification for dysfunctional behaviour in contemporary social settings.

Myself and my two younger brothers were just as baffled as the police as to why and how my step father's condition has escalated so dramatically as to have brought about such an unpredicted and ferocious attack on my mother and himself. The police however removed the soul crushing weight of such confusion and unknowing with the revelation that my step father had been taking a pharmaceutical with the following side effects attributed to it:

"…intensifies depression and suicidal feelings in the early stages of treatment. These people may have an increased risk of self-harm or suicide in the early stages of taking Zispin Sol Tab."

The police were unable to locate this name on either the acute or deleted medication for my step father and told us that they believed he may have been self-prescribing. As I was informed that a mitigating factor of this incident had been a "self-shaken" chemical cocktail within the mind of a man with a long history of mental health concerns, it was with this understanding I agreed to assist in this DHR.

I am grateful that this DHR has been successful in recognising potential areas for improvement concerning risk, training and the management of domestic abuse victims and mental health patients and believe credit is due to the agencies whom have already implemented such changes prior to the publication of this DHR.

However, it can be suggested that the DHR has been restricted in its findings due to its limited scope and isolated focus upon Adult A's engagement with services and institutions in the past two years only. This scope was initially addressed by myself and my advocate and was met with agreement by the initial panel members however it appears to have been to no avail. I would also argue that the DHR may have lost its independent standing when it replaced the University affiliated Mrs Jane Monckton-Smith with Social Services and NHS affiliated Mr Appleton as the Chair and author of the DHR. The independency of the review is vital as it was the standpoint of the family that the NHS had failed to adequately safeguard Adult A and Adult B during Adult B's medical intervention. This DHR has consequently failed to address the monitoring of risk and patient safeguarding concerning the pharmaceutical intervention for Adult B.

"There does not seem to be any particular motive for this murder other than the fact that Adult B could have been suffering from some form of mental health issue that may have been formally diagnosed." Det. Con. B

As the DHR was unable to look into self-medication due to this lack of evidence I began to look into 'Zispin Sol Tab' myself and was quite taken to find that it is merely one of many brand names for a drug called Mirtazapine which was prescribed to Adult B by his local GP and was present in the toxicology of Adult B. One can only deduce that the investigating officers confused Adult B's reference to the brand name and the GP's records of the drug name as two different antidepressants. Furthermore the dictated and unsigned reports within the inquest from the local GP regarding Adult B and Adult A do not indicate any consultation between the GP and Adult B's Outlook SouthWest counsellor prior to the prescription of 'Zispin Sol Tab' or address the potential side effects or safeguarding measures.

Despite this information being shared with the Chair, the Chair appears to perceive it wise to spend money on trying to dispute the very inquest he is said to be reviewing. I would like to inform the reader now that it is our intention as the remaining family members to appeal the current findings of the Inquest which we can only but hope will give rise to a more comprehensive DHR.

As mentioned above, Adult B openly stated he had a phobia of what response he may receive from mental health authorities and from what he had shared with us this was due to his experiences of his parents' interactions with and subsequent chemical dependency on such agencies. **I would like this DHR to recommend a nationwide campaign to address the public conceptions and beliefs about mental health authorities and what it really means to be mentally healthy or unhealthy.** This would require a shift from relying on the pacifying effect of pharmaceuticals as the first line of response to individuals approaching their psychological ill health. Therefore, I would call upon such agencies to ensure that the services provided are designed to address the 'root cause' of an individual's concern and take appropriate measures to resolve the underlying cause with an individualised approach placing the patient in the driving seat. **I would like to see a further DHR recommendation that mental health services commit to such an approach.** I find it most perplexing that we are a nation whom put emphasis on teaching children to tie their shoes but fail to teach them how to look after their self-esteem, psychological or emotional wellbeing. I would therefore argue that the introduction of solutions-based and applicable psychological and emotional wellbeing education for young people would have far reaching benefits to all those whom are empowered early to facilitate their own wellbeing – **this would be my third additional recommendation for this DHR.**

It was through my own research that I have come to see that this view is already wide spread and is on its way to becoming public demand. The ideologies that I shared during panel meetings, despite not making an appearance in this DHR in an official capacity, are shared by many others who are working incredibly hard in their specialised fields to make a less dangerous system of health and psychological care less dangerous. Professor Peter Gøtzsche, co-founder of The Cochrane Collaboration, says that "doctors treat patients much too loosely" and many would be better off with talking therapies or exercise. For those who care to see the true lessons to be learnt from this tragic loss of two lives I would suggest further reading into the works of Dr David Healy, Dr Julian Whitaker and Dr joseph Mercola who all have engaged in research concerning the unnecessary deaths of individuals who are prescribed antidepressants. A recent documentary called "Bad Pharma" has also given great insight into to disproportion levels of power and foul doings of large pharmaceutical companies and gives hope to making a better reality for everyone.

I would like close with a dedication of gratitude to Mrs Lesley Welch whom was appointed as my advocate by AAFDA for the duration of this DHR. I would like to express my sincerest thanks to Lesley for her time, assistance and exquisite demonstration of compassionate understanding throughout the process of this DHR. I would also like to express thanks for the support and strength Lesley has given me in what has been dubious yet insightful undertaking. It has been a pleasure to have been introduced to Lesley and have worked alongside her.

A response from the Panel to Adult C's statement

The independent Chair and panel wanted to provide Adult C with the opportunity to write a personal statement for inclusion in the Overview Report. It was agreed by the panel that the statement should be included in its entirety. It has not been edited or amended.

However the panel wishes to add the caveat that publishing the statement in full does not mean the Panel is in agreement with some elements of the statement.

Adult C has had a copy of the final draft of the Overview Report, including the chronology and action plan.

In response to the suggested recommendations made by Adult C, the panel agreed that these fell outside the terms of reference and scope of this DHR. In addition the three areas covered by Adult C's suggested recommendations are already part of national government policy and practice.

1. A nationwide campaign of mental health awareness, anti-stigma and anti-discrimination, Time to Change already exists.

2. Mental health services are adopting the individualised approach described. These are part of plans set out in No Health without Mental Health and more recently in the Five Year Forward View for Mental Health.

3. Future in Mind sets out the aspirations for the improvement of the mental health and wellbeing of children and young people. The work suggested in Adult C's statement is already underway and being led by Cornwall Council and NHS Kernow.

Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the death of Adult A in October 2013. The DHR was commissioned by Cornwall Council on behalf of Safer Cornwall (Cornwall's Community Safety Partnership).

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13 April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be 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'*

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

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future, to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

A DHR was recommended and commissioned by Cornwall Council on behalf of Safer Cornwall in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

A panel met for the first time in December 2014 following the appointment of an independent Chair and author, Dr. Jane Monckton Smith. Dr. Monckton Smith is a specialist in domestic homicide and works for the University of Gloucestershire. She does not work for any of the agencies which had contact with Adult A or Adult B and she is independent of any agency that had involvement with the case.

That meeting also agreed the Terms of Reference and it was agreed with NHS England that the DHR would also serve as a Mental Health Homicide Review.

In April 2015, Steve Appleton, Managing Director of Contact Consulting (Oxford) Ltd was appointed by NHS England South to provide additional mental health expertise and to assist the Chair in writing the Overview Report.

In October 2015, Dr. Monckton Smith withdrew as the Independent Chair and Steve Appleton took over the Chairing of the DHR and authoring of the overview report. Dr. Monckton Smith provided the review panel with a draft report of key findings which the panel has drawn upon in finalising this Overview Report.

Panel Membership

The DHR panel comprised a range of people representing local agencies, all of whom brought relevant expertise and knowledge, not only in terms of domestic abuse but also in relation to mental health and broader public services. The individuals involved represented the following agencies:

- Cornwall Council
- NHS England
- NHS Kernow Clinical Commissioning Group
- Devon and Cornwall Police
- Cornwall Partnership NHS Foundation Trust

Voluntary Sector and National Probation Service have membership but have been unable to attend meetings.

Chair and Overview Report Author – Steve Appleton

Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve has had no previous involvement with the subjects of the review or the case, nor does he have any connection to the agencies that had contact with Adult A or Adult B. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written DHRs for a number of local authority Community Safety Partnerships.

1.4 Subjects of the review

Adult A
White British Female
Date of Birth December 1962
Date of Death October 2013
Adult A was the wife of Adult B and the victim in this case

Adult B
White British Male
Date of Birth December 1964
Date of Death October 2013
Deceased was the husband of Adult A and the perpetrator in this case

1.5 Time Period

The DHR has focused on the two year period prior to the homicide, however where information about contact between agencies and Adult A or Adult B prior to that has been available this has been reviewed to provide any relevant context or information that might assist the DHR process. The chronology appended to this report contains information that commences in 1994.

1.6 Terms of reference

The DHR's specific terms of reference, as agreed by the panel were:

Purpose of the panel:

- To establish the facts about events leading up to and following the death of Adult A in October 2013.

- To examine the roles of the organisations involved in her case, the extent to which she had involvement with those agencies, and the appropriateness of single agency and partnership responses to her case.

- To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard her wellbeing.

- To identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result.

- To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

The scope of the panel review:

- To establish which agencies had contact with the family (chronology requests were sent to the following agencies: Anti-Social Behaviour Team, DAAT, Devon and Cornwall Housing Ltd., GPs, Outlook South West, Cornwall Partnership NHS Foundation Trust, Police, School, Domestic Abuse Sexual Violence Providers, National Probation Service and Community Rehabilitation Company and Social Care (Adults and Children's Services).

- To produce a chronology of events and actions in relation to the case of the victim, from (a year before her marriage to Adult B in 1987) to October 2013 seeking information from:

- Organisations which had contact with her or the perpetrator: Outlook South West; GP services; NHS England; Devon and Cornwall Police; Thames

Valley Police; Children's Services; relevant schools; Child and Adolescent Mental Health Services (CAMHS); Cornwall Partnership NHS Foundation Trust (CFT); School Nurse; Education Welfare

- To review current roles, responsibilities, policies and practices in relation to victims, perpetrators and families of domestic abuse – to build up a picture of what should have happened.

- To review this against what actually happened to draw out the strengths and weaknesses.

- To review national best practice in respect of protecting victims and their families from domestic abuse.

- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

The review will also specifically consider:

- An assessment of whether family, friends, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

- A review of any barriers experienced by the family, friends, colleagues in reporting any abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wanted to.

- A review of any previous concerning behaviour or history of abusive behaviour from the perpetrator and whether this was known to any agencies.

- An evaluation of any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services in Cornwall.

- Whether family, friends, colleagues, employers, wanted to participate in the review. If so, ascertain if they were aware of any abusive behaviour by the perpetrator prior to Adult A's death.

- Whether any organisational policy, training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

- Whether the work undertaken by the services in this case are consistent with their own: professional standards, compliant with their own protocols, guidelines, policies and procedures.

- In addition this review will also include an inquiry into the care and treatment of Mental Health by Cornwall Partnership NHS Trust: Purpose of the inquiry:

- To identify whether there were any gaps or deficiencies in the care and treatment that Adult B received, which could have been predicted or prevented the incident in October 2013 from happening. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

- The outcome of this investigation will be managed through corporate governance structures in NHS England, the Safer Cornwall Partnership, NHS Kernow and the provider's formal Board sub-committee.

- Terms of Reference for the mental health inquiry:

- Review the engagement, assessment, treatment and care that Adult B received from Outlook South West from his first referral in June 2012 up to the time of the incident in October 2013.

- Review if Outlook South West fully assessed and appreciated Adult B's depression and provided appropriate support, care and treatment options which met national standards.

- Review the care planning and risk assessment, policy and procedures and compliance with national standards and best practice.

- Review the communication between agencies and services, before and after the incident.

- Review Outlook South West's internal investigation report and scrutinise its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference.
- If all key issues and lessons have been identified and shared.

- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt.
- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt

- Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further investigation and comment.

- To fully assess and review why Outlook South West did not engage with the victim and perpetrator's families before and after the incident, in accordance with best practice and national standards.

Outputs for the reviews:

- A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

- Meetings with the victim and perpetrator families to seek their involvement in influencing the terms of reference.

- At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the investigation.

- A concise and easy to follow presentation for families.

- A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

- We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should

produce a short report for NHS England, families and the commissioners and this will be made public.

- We will require monthly updates and where required, these to be shared with families.

1.7 Individual Management Reviews (IMRs)

IMRs were requested from a range of agencies that had been in contact with or providing services to both Adult A and Adult B. The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Adult A and Adult B.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with Adult A and Adult B as well as summary reports, scoping information and interviews with Adult C, the eldest son of Adult A and step-son of Adult B.

The IMRs have been signed off by a responsible officer in each organisation. Although there are some elements of the IMRs that the panel challenged in terms of factual accuracy and a number of the conclusions that were drawn, the panel was content to approve them following discussion with IMR authors and the input of further independent expertise to review those areas where panel members had concerns about the conclusions drawn. Where differences of opinion remain, these are highlighted in the report.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The DHR Panel has received and considered the following Individual Management Review Reports (IMR):

- NHS England (Primary Care)
- Cornwall Partnership NHS Foundation Trust
- Outlook South West
- Education Welfare

The DHR panel also had access to the Coroner's report and post mortem examination notes.

In addition to the IMRs, the Chair of the panel, with the support of NHS England (South) commissioned two reports, one from a General Practitioner and one from a Pharmacist. These reports were commissioned to provide expert advice and opinion in relation to the prescription of medication to Adult B. The commissioning of the reports followed queries about the effects of that medication and the follow-up provided from Adult C, one of the children of Adult A.

1.8 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

"*The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation*."[1]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

The nine protected characteristics in the Equality Act were considered by the panel and none was found to have direct relevance to the review.

1.9 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Overview Report and action plan are accepted by the Community Safety Partnership.

1.10 Involvement with the family

The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed its work and that their views are reflected in this Overview Report. The engagement with Adult C has taken place through email, telephone contact and face-to-face meetings, facilitated by his advocate.

Adult C's views were gathered through a face-to-face meeting with the Chair and he has been kept informed of progress with the DHR.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

Section Two

Domestic Homicide Review Panel Report

2.1 Summary background

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Adult A and Adult B. The report examines agency responses to and support given to Adult A and Adult B prior to the incident on in October 2013. The report necessarily provides particular focus on the facts relating to the interactions and interventions of services with Adult B. This should not be viewed in any way as a diminution of the victim, Adult A, who the report has striven to represent appropriately and clearly throughout.

The summary of this case is drawn mainly from testimony of family members, friends and colleagues of Adult A and Adult B after their deaths as there was little formal contact with agencies. There were some key consistencies across testimony which have been merged to form this summary of events.

It was agreed that Adult A and Adult B gave the appearance of being in a happy marriage where both were devoted to each other and their children. Adult A was a loving mother to her sons and the panel has noted the commitment she showed to them throughout her life. However, it was equally consistent that Adult B was described as paranoid, depressed, angry, unpredictable and fixated on the idea that Adult A was going to leave him and significant disclosure was made by Adult B and Adult A indicating this.

Before moving to Cornwall, Adult A and Adult B had lived in Berkshire. The family was composed of Adult A and Adult B, and three sons, and a daughter. During this period it appears that arguments arose between Adult A and her daughter.

The arguments caused Adult A's daughter to move out of the family home and into a hostel. She was 16 years old at the time. It is reported that the hostel she went to was for people fleeing violence. There is a recorded incident of violence between Adult A's daughter and Adult B, though the circumstances are unclear.

The rest of the family moved to Cornwall apparently in part because of the arguments, and in part because Adult B felt the family would have a better life in Cornwall. Adult A's daughter stayed in Berkshire and all contact between her and the rest of the family appeared to end. Efforts by the DHR panel to make contact with Adult A's daughter have not been successful.

At this time Adult A was described as a patient and devoted wife to Adult B. Adult B was described as paranoid and fixated on Adult A leaving him by everyone. His colleagues also described him as competitive and unpredictable.

Adult A seemed to have minimal social contact outside of the family, and her time was often spent with Adult B. It was reported by her son that Adult A was not a particularly social person and that although she did have friends, her child caring responsibilities meant she had little time for socialising.

When Adult A was not with Adult B it is reported that she maintained significant electronic contact via texts and calls, because Adult B found this reassuring.

When Adult A changed her job she became busier and was unable to maintain the level of texting and calls to Adult B. She also bought herself new clothes commensurate with her new position as a legal secretary.

Adult B found it difficult to accept less contact and became more paranoid and fixated on the idea that Adult A was going to leave him, including disclosing these fears to his colleagues.

He was also sharing his concern that there would be an estrangement, confiding in colleagues, his sons and health professionals. He was constantly questioning Adult A about her movements and intentions. He appeared to be convinced she was having an affair.

Two days before death Adult A sought help from GP regarding feeling unwell, finding intimate sexual relations painful. During this consultation Adult A made a disclosure about tension at home due to husband's paranoia and anxiety and stating that Adult B was wanting sex everyday as proof that she loved him.

Adult B also articulated the idea to colleagues that he would kill Adult A, himself and his youngest son should she ever leave him by driving them over a cliff in his car.

He also said that life would not be worth living without his family.

In the weeks before the murder of Adult A, Adult B told of plans for them to renew their wedding vows to celebrate their 25th wedding anniversary, and a foreign holiday was planned. Adult B's mood was described as 'up and down' at this time, but more down than up.

There are family reports of increasing surveillance of Adult A by Adult B, increasing demands for text and phone contact when they were apart, and increasing paranoia and obsession about her leaving, and suspicions about her having an affair.

Adult B also expressed fears to his family that he was suffering from hereditary mental illness. He reported that his mother was put in a mental health hospital and was detained under the Mental Health Act, and that his father was extremely violent and abusive. It was said by family that he painted a picture of a dreadful childhood.

On the evening before the murder Adult B was very concerned about his fixation on Adult A leaving him and he left work early having arranged to make up the time the next day. According to testimony Adult B spent the whole evening and half the night questioning Adult A about her movements, her phone and his suspicions that she was having an affair.

One of the sons was kept awake by this exchange, though Adult A was apparently not arguing with Adult B, but trying to manage, reassure and placate him. The son became annoyed by what was happening. He described increasing annoyance with the behaviour of Adult B and how it was affecting his mother, and the family.

The following morning when the son was leaving the house for school he did not immediately wave goodbye to Adult B. When he turned to wave, Adult B was gone and the son had missed his chance to wave. The son worried about this all day, very concerned that there would be repercussions of his forgetting to wave in time. He was worried that Adult B would become paranoid and take things out on his mother.

Some time that morning Adult B murdered Adult A. She died as a result of wounds inflicted by blunt force trauma. Adult B then killed himself.

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Adult A and Adult B, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel has been mindful of the guidance relating to the application of hindsight in DHRs and has attempted to reduce it where possible. This is in accordance with the Pemberton Homicide Review conducted in 2008: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[3]

The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[4]

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

[3] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

[4] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.

2.2.1 NHS England (Primary Care)

NHS England commissioned an independent author to produce the IMR relating to primary care involvement. The author had previous experience of conducting reviews of serious incidents in the NHS and producing similar reports for DHRs. In conducting this IMR, the author had access to all GP notes and associated information held by GPs. The GPs who had contact felt they had nothing further to add to the information they had previously provided and therefore declined to be interviewed for the IMR.

Analysis and lessons learned

The IMR finds that the clinical practice of the care offered to both Adult A and Adult B was in line with expected clinical practice.

The IMR finds that the GP practice did have safeguarding policies in place and that the records indicate that practitioners who saw Adult A did undertake risk assessments. The IMR also finds that care interventions were timely and were escalated appropriately when changes in risk level were observed or identified. It is clear from the IMR that at times those risks were of a nature that was near to or only just over the threshold for escalation and that when help was offered it was not taken up.

There is no evidence from the IMR that there was any indication that Adult A felt under threat from Adult B. They had attended GP consultations together and again there is no evidence to indicate that there was any concern expressed to the GPs that Adult A felt threatened or at risk. There is no evidence that questions were asked about why Adult B and Adult A attended GP appointments together and whether this might have been indicative of controlling behaviour, particularly given the concerns presented by Adult B.

On the occasions when practitioners felt that Adult B might pose a risk to himself, there is evidence that they responded appropriately, updated risk assessments and communicated concerns in a timely way. The IMR states clearly that all professionals who had contact with Adult B and Adult A were appropriately professionally trained and had expertise in identifying risk factors and potential indicators of abuse. The IMR found that when the level of risk escalated or concerns were noted other members within the practice were included in care as appropriate. There is no evidence that concerns were escalated or referred to other agencies.

The IMR demonstrates that information sharing was of a standard and appropriateness that would be expected within primary care medical practice. What is less clear is the extent to which information was shared with other agencies or services. The IMR finds that there is no evidence of written referrals to other

agencies. There are also gaps in the information available to those practitioners within the practice about Adult B's early life.

The absence of notes predating 2002 made it difficult for them to establish the impact of any adverse childhood events (either known or unknown) might have had on Adult B. Written evidence indicated direct conversations between relevant medical professionals, but not across agencies.

The IMR finds that the presenting symptoms enabled prioritisation of responses, in line with good clinical practice. However, it notes that whilst it is clear that conversations occurred between individual professionals, it is not clear if the number of practitioners who saw the couple at different individual times jointly discussed Adult A and Adult B's cases. If they had this could have enabled other options to be considered, even though there is evidence of two consultations where both Adult B and Adult A attended together.

It is not clear whether Adult A was either signposted to domestic abuse support services, or whether she felt the need to access them. This represents a particular and important gap in the information available to the DHR, but more notably, to the fact that there was information available which Adult A was unaware of and thus did not have the opportunity to access. The IMR author did not have the opportunity to interview the GPs as this was declined. This limited the IMR.

The IMR suggests that whole family support may have been helpful but could not find any evidence to indicate whether the practice directed Adult A or Adult B towards any such support, or if they had sought to access it independently.

The IMR finds there is no evidence that the impact of Adult A and Adult B's issues on the long-term care and development of the children was considered, or whether any supportive care was arranged for them.

The IMR states that there was an emerging picture of Adult B becoming more agitated and mistrusting of Adult A. However it suggests that the primary concern of professionals was that Adult B may have been a risk to himself. There is no written indication in the two months prior to the incident that suggests Adult B's risk heightened sufficiently to necessitate onward referral to mental health services.

The IMR finds that the issues that Adult A and Adult B presented with clinically should have highlighted the need for additional vigilance in terms of the whole family, particularly as there were young children in the household. In such situations this should trigger the requirement for a multi-agency approach, which may have occurred but was not evident in the notes. It is possible that a multi-professional /agency review of the whole family may have identified additional pieces of the jigsaw which were unknown to the clinicians in the GP practice at the time and

which could have potentially indicated other stresses/issues. In turn this may have heightened concerns and therefore provoked different interventions. Information regarding Adult B's childhood (being fostered as a child) and the history of parental mental illness may have been relevant in this context. Adult B's parental mental illness is noted by Outlook South West and GP contact and raised a number of times by Adult B as being significant but this was not explored by either service.

There are gaps in respect of multi-agency procedures identified by the IMR. There is no written evidence that indicates multi-agency or team level discussion about this case despite an identified level of risk to Adult B from self-harming. There is also no evidence of a GP or practice discussion about this, or whether the impact of referrals/interventions with other practitioners i.e. a counsellor was considered or followed up by the GPs.

There was a potential missed opportunity in terms of discussion with health visitors, school nurses, teachers and social care services to consider whether the children should be subject to safeguarding or just required additional support/vigilance from professionals working with them.

The IMR finds that the lessons to be learnt from this case indicate the need to ensure all staff within general practice are required to access regular multi-agency safeguarding training (particularly in relation to domestic abuse issues) and advice from a skilled safeguarding lead if required. Alongside this it suggests the need for the development of a more consistent approach to other agency engagement particularly where children are involved as well as ensuring regular audit of individual risk assessment processes within medical practices and establishing a process of team discussions where a large variety of GPs/practice staff are seeing individual patients who present a concern or an identified risk.

The recommendations made in the IMR are set out in Section Five of this Overview Report.

2.2.2 Cornwall Partnership NHS Foundation Trust (CFT)

Cornwall Partnership NHS Foundation Trust (CFT) provides community health services to children and young people and mental health and learning disability services to people of all ages across the county. The CFT IMR was produced by the named nurse for child protection for CFT who has experience of conducting reviews and investigations of serious incidents.

Neither Adult A nor Adult B received any services or interventions from CFT. However CFT did provide service and interventions to the couple's youngest son. In the IMR he is referred to as Child C, a nomenclature used in this Overview Report to maintain anonymity.

Analysis and lessons learned

Child C was seen by his GP in September 2009 with sleep problems and symptoms of anxiety. These issues appear to have commenced following an episode during a school trip where he was pushed over and hit his face. The GP made a prompt referral to CFT's children, young people and family service, now known as Child and Adolescent Mental Health Services (CAMHS). It is important to state that under the current system Child C would not have been offered an assessment or any service as he did not have a diagnosed mental health condition.

The IMR shows that Child C was offered an assessment by the service and although the exact date is not contained in the records, this assessment took place, probably in October 2009. Both Adult A and Adult B attended the assessment with Child C. The notes indicate that Child C did not have a peer group with which he socialised, but that he had a close relationship with both Adult A and Adult B.

By January 2010 there had been an improvement in Child C's sleep pattern and he was discharged from the service. By November 2010 Child C was again having sleep difficulties and the GP requested support from CFT. The service wrote to Child C's parents making the offer for them to make contact. The practice of inviting contact is common and is intended to provide an indication of willingness to engage. By mid-December 2010 the family had not responded and the service wrote to the GP to advise that the case was therefore being closed.

Although the family did not respond to CFT they did contact the School Nurse in March 2011 about Child C's sleep problems. The school nurse did liaise with the primary care mental health team and they agreed to a joint visit with the school nurse.

An assessment did take place and it was suggested that Child C learn how to manage his sleep himself, using techniques he had learnt and used during the previous intervention in 2009/10. The plan involved the school nurse making contact with Child C's school to see if there were ways in which his anxieties about his school work could be managed and suggest a collaborative approach.

The IMR notes that currently such arrangements would be managed with the Common Assessment Framework (CAF), Children in Need (ChiN) arena or a Team Around the Child (TAC). In 2010 a pre-CAF form was available but had not been completed. That form had a section asking whether the parent/carer has ever experienced domestic violence. The rationale provided for non-completion was that 'the observed interactions and relationships during the home visits did not illicit the need to compete a risk assessment form as there were no risk indicators identified.'

In May 2011 a joint visit took place between the school nurse, primary mental health worker, with both Adult A and Adult B and Child C at their home. Improvements were discussed and Child C was especially excited about an upcoming school trip.

Of particular note, the IMR states that at this meeting, Adult B was keen to discuss his own stress and anxieties, but that there was no exploration of the nature of these issues, their underlying cause or how he was managing them.

By November 2011 Child C had improved significantly, had by now moved to his new high school and was enjoying it. This was the last contact by CFT and Child C was discharged by CFT services (and by the school nurse) on 19th November 2011.

It is clear from the IMR that neither Adult A nor Adult B were the subject of any direct service or intervention from CFT. All interactions they had with CFT were related to the support offered to Child C which resulted in an improvement in the child's sleep difficulties. Although there was a disclosure about stresses and anxieties being experienced by Adult B to CFT staff during one of the sessions with CFT staff, this was not explored and there is no detail relating to the nature of the stresses of anxieties he expressed and what the underlying cause of his sleeplessness was.

During their interactions with Child C, CFT staff did not identify any issues relating to domestic abuse or violence within the family. There is no evidence that this was a subject that was ever raised with Child C or that it was explored as a potential causal factor in his problems at the time. It does not appear that there were any indicators present at the time that would have led those staff to pursue that line of enquiry.

Adult A did not raise any issues relating to domestic abuse with CFT staff during their conversations with her. There was no record of any history of domestic abuse for CFT staff to refer to or to prompt them to explore this.

In many cases, those involved in domestic abuse learn (often quickly) to become expert at keeping it hidden, thus indicators often do not appear and must be proactively sought out by professionals.

Information sharing between professionals working within CFT with other agencies was appropriate and collaborative working is evident throughout their interactions with Child C and Adult A and Adult B.

There are gaps in record keeping at the time of the interventions with Child C. As risks were perceived to be low, the judgment made at the time was not to complete a written risk assessment and not to complete a pre-CAF. This was not good practice.

There were risk assessments in Child C's records but these were not completed in the school nursing notes or in the primary mental health care worker's records. As Child C did not have a diagnosed mental health problem the primary mental health worker did not complete a risk assessment. The IMR suggests that supervisory oversight of the case would have revealed any potential risks. Although practice has changed since the time of these interventions, the lack of a risk assessment indicates a gap in practice at the time. It is a gap in practice that the IMR indicates has since been addressed by new processes and procedures.

The interventions provided to Child C by CFT were appropriate and effective and brought about a resolution to his difficulties at that time. However there were gaps in recording and incomplete assessment and domestic abuse was not considered as a possible cause of the anxiety experienced by Child C.

The mental health worker did not ask any questions about routine enquiry as this was not in place at this time. Although there were no obvious indictors from the child's presentation this would have been an opportunity to ask the child when alone with the worker and may have elicited more information. The IMR indicates that this will become a mandatory enquiry once all staff have been appropriately trained and the CFT electronic patient record system has been updated to enable an appropriate field on domestic abuse to be included.

The CFT IMR does not make any recommendations.

2.2.3 Outlook South West (OSW)

Outlook South West (OSW) is a Primary Care Mental Health Service and is part of the national Improving Access to Psychological Therapies (IAPT) programme. The service works with people who are experiencing common mental health problems. These problems include depression and anxiety disorders such as phobias, generalised anxiety, post-traumatic stress disorder, social anxiety and obsessive compulsive disorder.

One of OSW's lead partners, and a co-founder of the agency wrote the IMR. He is a Chartered Clinical Psychologist.

Analysis and lessons learned

Adult B was first referred to OSW on 5 May 2011 by his GP. The referral centred on Adult B's apparent poor self-esteem at the time and the fact the he was concerned that he was not liked at work. The referral also noted that Adult B got angry at home (that his wife noticed this) and that he had been verbally aggressive and drinking to excess.

Although this referral was responded to on the same day as it was received by telephone and letter, with a further letter sent three weeks later on 26 May, Adult B did not respond and Adult B was discharged from the service on 31 May 2011. It would have been usual practice for a letter to be sent to the GP notifying them of the discharge and the reasons for it but the IMR finds no record of any such letter being sent. This identified gap in practice has already been resolved through improvement within OSW to record keeping and central administration.

The second contact between Adult B and OSW started just over a year later on 25 June 2012 when Adult B referred himself to the service by telephone. OSW accepted Adult B into the service and an appointment was made. The referral information collected indicates that Adult B referred himself due to anxiety, stress, paranoia, frustration at work. He stated he was not taking any medication and had no suicidal thoughts.

On 19 July 2012 Adult B had a face-to-face assessment appointment with OSW at the GP surgery. During that assessment Adult B answered questions about his mood and a Patient Health Questionnaire (PHQ9) was completed. He was also assessed for suicide risk and self-harm risk. During the assessment Adult B disclosed that for about 18 months there had been rumours of redundancy at work and although he was one of the longest serving members of staff, he had received less training etc. and felt he was more at risk than his colleagues. Although a source of stress Adult B did not indicate this was having any negative impact at home.

Adult B did not disclose any concerns relating to his relationship with Adult A at the assessment.

On 9 August 2012 Adult B had his first treatment session with OSW at the GP practice. He commenced what is described as Low Intensity guided self-help.[5] A further appointment was held on 20 September 2012 following Adult B being on holiday. The IMR reports that at this time Adult B was trying to put things at work into perspective, had enjoyed holiday and was more relaxed. It was agreed to review him in a month.

On 18 October 2012 Adult B completed a third treatment session. Adult B articulated his concerns about work, specifically job security and that he was unable to let go of his worries but was trying to focus on the positives in life. The clinical record records 'no risk' at this time.

On 8 November 2012 Adult B had a fourth treatment session. He was feeling much better, there was an overall improvement and it was agreed that he could now be discharged from the service. There was then no contact between Adult B and OSW for seven months.

On 17 June 2013 Adult B again referred himself to OSW by telephone. During that call Adult B related his concern that he may have hereditary mental health issues. He was assessed by telephone on 18 June 2013 and added to the waiting list for low intensity cognitive behavioural therapy (CBT). During the assessment Adult B disclosed that he felt 'paranoid that my wife is seeing/wanting other men'. He said that Adult A had started a new job and he was suspicious of her. Adult B stated that he wanted these thoughts to cease, he was not sleeping and had lost weight. He said that he did not believe his wife's assurances but that she 'forgives him'. Adult B confirmed he had thoughts of suicide but would definitely not do anything. There is no evidence that OSW took any further action to confirm these assurances.

OSW updated Adult B's GP on the same day as the assessment and informed of the proposed treatment plan.

On 2 July 2013 OSW sought phone contact with Adult B but was unsuccessful, this was followed up on 3rd July 2013 again unsuccessfully. A message was left on Adult B's voicemail asking him to call.

On 4 July 2013 Adult B attended his first treatment session. He again restated his worries in particular about his wife. Some of these concerns seemed to stem from

[5] Low intensity Cognitive Behavioural Therapy treatment, which requires engagement from patients

the fact that a friend from their time living in Berkshire had requested Adult A's mobile phone number and she had been texting him. Adult B believed Adult A to be having an extra-marital affair.

The OSW worker had a supervision session on 10 July and reflected on the first treatment session with Adult B. It was agreed that although the focus was different to the previous intervention in 2011, the presentation and effect was similar and as such a similar treatment process should be used.

On 18 July 2013 Adult B attended a second session when it was suggested that high intensity CBT should be used. The OSW worker encouraged Adult B to explore other explanations for the behaviour of Adult A's that he was concerned about. Adult B said he had been open with Adult A about his anxieties and asked her to go to RELATE with him, she had refused and told him the problems were with him. He asked her to stop texting their friend and Adult B told the OSW worker he did not believe Adult A and was checking her phone.

The OSW conducted another suicide risk assessment and Adult B said he would never do anything as he loved his wife and children. The OSW reported that after both the first two sessions, Adult B had seemed calmer and more rational. In a following case review on 27 July it was agreed to consider stepping up to high intensity CBT with Adult B.

On 1 August 2013 Adult B attended session three of treatment where he again stated his worries about his marriage and that he was looking for evidence of Adult A having an affair. It was during this session that Adult B discussed the fact that Adult A had assured Adult B that she was not having an affair and that she had suggested they renew their wedding vows in 2014 as it would be their 25th wedding anniversary. The OSW worker again checked out risk factors and also provided Adult B with phone numbers of Samaritans and out of hours services. The OSW worker felt that Adult B was not improving and would need to step up intensity. There was a waiting time of ten weeks for the higher intensity intervention. As Adult B was about to go on holiday it was agreed to book an appointment with him for his return.

An appointment on 22 August 2013 was cancelled as Adult B was returning from holiday. On 29 August 2013 Adult B contacted the OSW worker by phone and left a voicemail requesting that the worker contact him. The worker was on annual leave at this time.

An appointment was created for Adult B for 5 September 2013 but it is not clear how this was communicated to him. Adult B did attend the appointment on 5 September 2013. During that session the OSW signposted Adult B to RELATE but he declined to seek support from them.

On 11 September the OSW worker took Adult B's case to clinical supervision. She felt that Adult B had entrenched thinking, had refused community mental health team service, had not taken responsibility for his part in the therapeutic relationship and had unreasonable expectations of the therapist.

On 11 September 2013 it was agreed to offer Adult B either telephone CBT, wait for face-to-face CBT (high intensity) and a discussion about referral to secondary care mental health services. During a telephone call with Adult B on 19 September 2013, the OSW worker described Adult B agreeing to being stepped up to high intensity CBT and a telephone appointment was made for 15 October 2013. During this contact Adult B again stated that he was convinced Adult A was having an affair, he had been "*spying*" on her and that he was able to reflect that his behaviour was irrational on some level. He again guaranteed safety when asked by the OSW about risk.

This was the last contact between OSW and Adult B.

OSW had no contact with Adult A and as such were not in possession of any information from her about the nature of her relationship with Adult B. They also had no information about the family dynamic or any history about the relationships or other issues within the family.

Adult B did not disclose any thoughts of anger or violence towards Adult A during his interactions with OSW. Nor was any information about such concerns communicated to OSW by the GP, indeed, the GP's did not enquire about this. Consequently they were not prompted to ask any direct questions about this. Their focus was on considering the risks he may have posed to himself. The lack of direct enquiry about domestic abuse and thoughts of harm to others in the context of his concerns about his relationship with Adult A represent a missed opportunity to gather relevant information and to build a more accurate picture of what was happening. It is not possible to state whether such enquiry would have elicited truthful information, or indeed if Adult B did harbour thoughts of violence towards Adult A but nevertheless the fact that questions were not asked represents a missed opportunity.

Some of the terminology used within the IMR is not concordant with that which might usually be expected. In particular the panel remains unclear of the validity of the term 'guarantees their safety'. This is not a term that those on the panel with mental health training and expertise were familiar with. It appears to have resulted in OSW being reassured, but without evidence of a fuller, more robust assessment of likely risk. Again this raises a question about opportunities missed. Indeed, the IMR states that there were no concerns about risk, a position that reflects the responses Adult B had provided. Whether these should or could have been

challenged by OSW staff is perhaps a matter of professional judgment, but it does appear that Adult B's assurances were accepted at face value.

OSW did have a suite of relevant and up to date polices and procedures in place relating to safeguarding. However it did not have a policy on domestic abuse which resulted in an over reliance on safeguarding as a process, which tends to focus on adults at risk/vulnerable adults and/or children as means to identify domestic abuse, rather than utilizing a specific policy for identification.

OSW did not have a designated lead for domestic violence/abuse at the time of the incident although steps have been taken since the incident to deal with this deficit in expertise. The IMR states that even if such a lead person had been in post at the time that the worker involved with Adult B would have been unlikely to seek advice as there were no indicators of domestic violence or abuse present in their interactions with him. Again this reflects the lack of direct enquiry about domestic violence in OSW's contact with Adult B. It should be noted that staff had limited knowledge of domestic abuse and did not recognise the significance of this presentation.

OSW did not seek any information from Adult A, nor did they make contact with any other agencies, family members of friends. This was due to the restrictions of confidentiality. The IMR also indicates that although the OSW worker could have sought consent to discuss issues with Adult A, this would not have been appropriate given the content of the clinical sessions. Adult B requested that no messages were to be left on the home telephone provided in the contact details. This was taken to imply that there was no consent to disclose information to other members of the family.

Adult B did disclose his concerns about hereditary mental illness and talked about the mental health of his parents. This appears to have been a recurring issue for him. Both OSW and the GP note that he raised this but did not seek to explore this in any detail. It seemed to the DHR panel that this history of familial mental ill health was of significance to Adult B and may have had an impact on his thinking and his concerns. The OSW IMR notes the disclosures and that they may have had an impact on Adult B, it also recognises there may have been information about this history that he did not disclose. Again, it is not clear if further probing of these issues would have revealed any particular information that would have helped or hindered his treatment by OSW. However, the fact it was not explored further appears to be a gap in the history taking process.

The IMR makes clear that the information provided to OSW by Adult B and his GP gave no indication of a history of domestic abuse or violence. Indeed, the impression given was of a happy and strong couple. The IMR suggests that there were limited opportunities to have foreseen the incident. In particular it points to the

fact that Adult B had previously responded well to treatment, albeit for a different set of concerns.

His second set of contacts for treatment were focused primarily on his concerns about Adult A and his relationship with her. The main focus was on the risks he might pose to himself and not to others. The OSW made an assumption that Adult B's concerns about Adult A and infidelity were transient and potentially resolvable by therapy and relationship discussion. On the basis of what was known at the time, and taking into account Adult B's earlier self-referral to OSW and his improvement following intervention, the lack of knowledge about domestic abuse and high risk factors, coupled with the lack of direct enquiry already highlighted, this appears to have been a reasonable assumption.

The IMR takes up the matter of morbid jealousy and whether or not this would have in fact have been a part of Adult B's presentation to OSW.

Morbid jealousy describes a range of irrational thoughts and emotions, together with associated unacceptable or extreme behaviour, in which the dominant theme is a preoccupation with a partner's sexual unfaithfulness based on unfounded evidence. Domestic violence is a common result of jealousy, normal or morbid. [6]

Morbid jealousy is a symptom rather than a diagnosis. It may take the form of a delusion, an obsession or an overvalued idea, or combinations of these. The nature of its form, and other features evident from the history and mental state examination, should reveal the underlying diagnosis or diagnoses and allow appropriate management. [7]

The IMR concludes that the recognition of morbid jealousy as part of Adult B's presentation could have led to a different treatment approach. It appears that the OSW staff involved did not have a sufficient knowledge of this, which may have been due to lack of training and the small number of such cases presenting in primary care settings. In addition it appears that OSW staff did not have knowledge that morbid jealousy is associated with high risk of harm/death. It is important to note that the assessment of morbid jealousy has not, to date, been covered in OSW's in-house or in nationally NHS commissioned university therapist training courses, a situation which does not appear to be confined to the local area but may be an issue nationally. Since the incident OSW have taken action to provide guidance and training to all staff on identifying morbid jealousy.

OSW undertook their own internal review of the incident and developed an action plan in response to its findings. The action plan relating to that review was part of the IMR submission.

[6] Aspects of morbid jealousy Kingham, M and Gordon, Harvey Advances in Psychiatric Treatment 2004
[7] ibid

The other recommendations arising from the IMR can be found in Section Five.

2.2.4 Education Welfare

The Cornwall Council Education Welfare Service provides support and help to pupils, parents (or carers) and schools who may be having problems with attendance and wider issues of pupil welfare. Child C had received support from CFT in relation to his sleep difficulties and anxieties arising from issues relating to a school trip. Given these contacts an IMR was requested from Education Welfare to establish what contact if any there had been with Child C, Adult A and Adult B and whether any information was available that might assist the DHR panel.

The Principal Education Welfare Officer for Cornwall Council produced the IMR.

Analysis and lessons learned

Child C attended St. Ives School. The school had two designated child protection officers, both of whom had received regular training and updates in relation to child protection which included issues relating to domestic violence and abuse.

The school reported that Child C had not raised any concerns about issues at home and that there were no behavioural or attendance issues. Progress, behaviour and attendance in school were in line with or above national averages. There were no indications that the home life of Child C was a concern.

The school had no concerns for the welfare of Adult A, who they report had a good relationship with the school. They reported good communication, attendance at parents' evenings was regular and the feeling of the deputy head of the school was that Adult A always did her best for Child C (and his brother who had also attended the school.) The school held no information about Adult B and Adult A was the primary contact. During review of the IMR, the DHR panel enquired as to whether this was usual and it was stated that as long as a school has contact with one parent this would not necessarily be a matter of concern.

As the school held no concerns about Child C's welfare, or that of Adult A it did not raise any issues or make any referrals to other agencies.

The IMR notes that the school had safeguarding policies in place and had trained and experienced workers in relation to child protection who had knowledge of domestic violence and abuse issues.

The panel did discuss the IMR with the author during a panel meeting. During that discussion the issue of Child C's referral and contact with CFT was covered. In particular the links between the school nurse and the school were covered.

The author was not aware of that contact and restated that the IMR focused on Child C's time at secondary school. The IMR author stated that the information about such contact would only be shared with the school with the permission of parents and/or the child concerned.

The focus of the IMR was on Child C and although it describes the limited contact with Adult A there was nothing within it that directly related to the incident itself or the lead up to it.

The IMR made no recommendations.

2.3 Views of the family

In conducting this review the panel has sought the views of family members in order to inform its understanding of the incident and the events that led up to it. Dr Monckton Smith met with Adult C during her period as chair and gathered helpful information. The report author, after taking over as chair also met with Adult C and his advocate. The report author also had access to the information gathered by Dr. Monckton Smith.

This section summarises the discussions with Adult C by the author during the DHR.

2.3.1 Summary of meeting with CT

Adult C stated that one month prior to the incident the family were on holiday, and that there were discussions about how happy Adult A and Adult B were at home and that they were thinking about renewing their vows. One week before the incident Adult C stated that he was talking with Adult A and they were laughing and joking that Adult B 'will be alright and that he would get there.' Adult C raised the issue of the trigger to the incident and that in the reports there was no clear identifiable trigger.

Adult C stated that his mother loved his step-dad too much and that other relatives recognised that there were issues.

Adult C informed us that following information provided to him by the police during their investigation he believed that Adult B had been taking drugs that he had ordered from the internet and that he was doing this alongside taking the medication he was prescribed and wondered if as a result was this creating an unstable cocktail of drugs that could have been a trigger? Subsequently this proved to be untrue, Adult B was only taking prescribed medication, specifically Mitrazapine.

Adult C spoke about his sister who left home at the age of 15 years of age but that this was through normal teenage issues, which were exacerbated by her relationship with her step-father. She lived in a hostel for underage single parents. The reason she left home was due to her relationship with her step-father. These issues were not investigated by local authorities, even though they had been made aware.

Adult C said that professionals never spoke to the children to identify any issues at home and that if they had he/they would have spoken out.

Adult C said that his brother, Child C, had issues with sleep and within school but again he (Child C) was never asked anything or if he had any issues/concerns.

Adult C said that Adult B was a really anxious man, a worrier, and that this atmosphere of constant anxiety within the house and their relationships was not healthy for the children to be in. Adult C stated that he did to talk Adult B about his (Adult B's) anxiety and gave him books to help him. Adult C spoke about the on-going taboo and stigma that still surrounds mental health. He indicated his view that if someone is injured this is accepted and people are supported but that with mental health people do not knowhow to react and the stigma continues.

Adult C advised that Child C internalised a lot of things. He never got to explore and share these feelings and get help to address them. Adult C said that the main involvement from social services was when he had taken on the care of his brother.

Adult C was asked about how things are now within the family.

Adult C spoke about his brother, Child C. He described that at the age of 13 he would never go out and he had no friends to speak of. A school trip to the beach highlighted this as whilst everyone else was playing and enjoying themselves he was just stood on the beach looking/staring at the ground with his head down and in his own world. When his parents died the school offered support, and Adult C said he 'obviously tried to help him.' Adult C reported that Child C can now see a wider world and he is bridging the gap. He now gets asked to hang out with the 'cool' kids, he goes on social outings, is in to clothes and style. Child C is now getting straight A's at school and is currently Head Boy.

Adult C went on to speak about his other brother (referred to here as Child D, though he was an adult at the time of the incident). Adult C stated that he has helped his brother and they have supported each other. Child D has now learnt to drive (which has really been confidence building), and Adult C said that 'he is now finding himself and is playing with emotional healing.'

Adult C spoke about his own journey, whereby it took him a year to deal with the house, the funeral and prioritising the support of his brothers. Adult C had a job as a Learning Support Assistant at a school which he enjoyed and was skillful at but when Child C became more social, inviting friends to his home, after his parents' death Adult C felt that could be awkward for him if he remained working at the school.

Adult C shared that he was thinking about writing to allow him to share with others what he has learnt, to offer tools and to allow some perspective on this kind of incident.

Adult C stated that all the boys have moved in together in to their parents' old house and that it was a little like the American sit-com Two and a Half Men. His advocate reminded us that this success is down to the support and involvement of Adult C and the sacrifices he has made to help them through this difficult period. Adult C

stated that Child C is sad that his parents are gone but that he has been able to adjust to his new circumstances and that he appreciates that he is now free of the mental health burden that had been present in the household.

Adult C states that he was surprised by events and did not see the incident happening.

He talked about the possibility of the pressures of everything becoming difficult for Adult A, specifically living with the constant anxiety.

Adult C recalled that in 2013 when they were all on holiday Adult B had asked Adult A if she would ever see another man. Adult C remembers laughing and stating to Adult B that Adult A would never leave him and that they discussed this further. Adult C feels Adult B needed to believe that Adult A would do these things in order to justify his thoughts and anxieties.

Adult C talked about how his brother (Child C) had a bedroom very close to the living room and that he would leave the door open to his room as he did not like it being shut, and as a result he often would hear the accusations levelled at Adult A.

Adult C did not know that Adult B had sought support for his mental ill health until after his parents' deaths, he was informed of this during the police investigation. He said that Adult B knew his own mental health was not good but did not do anything substantial about it because he was afraid he might be taken away into mental health care, by which it is presumed he believed he would be taken into hospital.

Adult C wonders if the fear of this was due to the experience of Adult B's parents and their own mental illness.

Adult C clearly states that throughout their upbringing Adult A was never physically struck by Adult B. The DHR chair did reiterate that domestic abuse is not just about the physical elements but also the emotional and psychological elements and that from what he had read and heard so far today that there seemed to be an unhealthy level of control within the house over his mother.

Adult C was keen to state that within the house Adult A was always in control and as such he did not feel she was being abused but more that they *"suffered each others foibles"*. Adult C stated that Adult B tried to get Adult A to have more friends and that he was more naive and quite like a baby needing mum to look after him.

Adult C said that his mother was very much the traditional housewife, looking after the house and everyone in it.

Adult C's advocate prompted him to speak about the fact that the employers of his parents were aware of some of the issues and that on one day in particular Adult B was sent home from work after having an outburst at work. Adult B felt that his employers were conspiring against him as he perceived that he was being continuously passed over for promotion at work.

Adult C clearly expressed that he did not want the process of the review to demonise Adult B as he was just as much a victim due to his mental health issues and that the DHR panel should know that there were a lot of good times with lots of laughter within the house.

2.4 Professional expert advice and opinion in relation to prescribed medication and follow-up

As part of the engagement with Adult C, the full draft of the Overview Report was shared with him, through his advocate. Having read the report, Adult C raised a query about Mirtazapine, which had been prescribed for Adult B by his GP. Specifically, Adult C wanted to understand whether the medication could have had any adverse effects, if those might have had any link to the incident and whether the fact that Adult B had not been followed up by his GP in the time between the prescribing and the incident was sub-standard care.

With the assistance of NHS England (South) the panel Chair commissioned two short reports. The first from Dr. Paul Turner, a GP based in Birmingham, who is a GP mental health lead within his Clinical Commissioning Group and who has particular expertise in relation to mental health and primary care. The second report was provided by Michael Marven, the Chief Pharmacist of Oxford Health NHS Foundation Trust. Michael has been a senior pharmacist with particular expertise in mental health for many years. Both experts are independent and had no prior links to or knowledge of the case under review.

The questions posed to them were as follows:

- Is Mirtazapine (Zispin) a reasonable drug to have prescribed (in light of any NICE guidance) and would it be regarded as a usual first line pharmacological treatment?

- Is Mirtazapine regarded as an effective drug in the management of anxiety and depression

- Provide your view on the impact of the drug or its side effects - whether these might have had any influence on his eventual behaviour relating to the incident.

- What follow up if any would you expect a GP to provide following prescription (given that the drug was prescribed only three weeks before the incident)

- In your judgment was the prescription proportionate and should the GP have done anything more proactive to follow up in that three week period?

A summary of their findings is set out below:

Summary of Mr. Marven's report

Mr. Marven is the Chief Pharmacist & Clinical Director for Medicines Management at Oxford Health NHS Foundation Trust. He holds the following qualifications and memberships: BPharm (Hons) DipClinPharm MRPharmS MCMHP

Mirtazapine has a product licence for major depression only. However, in the treatment of many mental illnesses it is not uncommon to use a medicine outside of their product licence ("off-label") if there is sufficient evidence for its safety and efficacy, so this in itself should not be seen as inappropriate.

When a drug treatment for anxiety is indicated, the NICE guidance for generalised anxiety disorder (GAD) (CG113, 2011) recommends offering an SSRI (usually sertraline). Mirtazapine is not currently included in NICE guidance for the management of anxiety, nor is it included in the British Association of Psychopharmacology (BAP) Guideline as a treatment option for GAD. However mirtazapine *is* included in the Maudsley Prescribing Guidelines (both currently and at the time of prescribing in this particular case) as one of the potential first line treatment options, along with the SSRIs, venlafaxine, duloxetine and pregabalin. This recommendation is based on published evidence. The Psychotropic Drug Directory (2014) also supports some evidence for the use of mirtazapine in GAD.

If sleep is a major problem and there is co-morbid depression with anxiety, it would not be unusual to see mirtazapine (which is one of the most sedating antidepressants) prescribed as a first line drug treatment. Its sedative effects will usually mean that another treatment to help with sleep will not be necessary.

Antidepressants can cause or aggravate anxiety during the initial few weeks of treatment, though they are anxiolytic in the long term. Anxiety has been reported with mirtazapine; it is listed as a common adverse effect (i.e. reported in between 1 in 10 and 1 in 100 patients who take it). Agitation has been reported as an uncommon side effect (i.e. reported in between 1 in 100 and 1 in 1000 patients who take it), and aggression as a rare side effect (between 1 in 1000 and 1 in 10,000 patients who take it). All antidepressant manufacturers include standard text in their product literature highlighting the possible increase in risk of suicidal ideation/behaviour. Mirtazapine is a widely used medicine in the UK (more than 6 million prescriptions were issued in 2015) and has been available since the 1990s, so there is wide experience with it and its efficacy and side effect profile are well recognised.

NICE GAD guidelines recommend: *"Before prescribing any medication, discuss the treatment options and any concerns the person with GAD has about taking medication. Explain fully the reasons for prescribing and provide written and verbal information on: the likely benefits of different treatments; the different propensities of each drug for side effects, withdrawal syndromes and drug interactions; the risk of activation with SSRIs and SNRIs, with symptoms such as increased anxiety, agitation and problems sleeping."* The NICE GAD guideline does not include mirtazapine, however if mirtazapine had been started primarily for GAD, the same recommendations as above would apply.

The guideline also recommends "monitor[ing the] patient carefully for adverse reactions" and reviewing effectiveness and side effects every 2-4 weeks during the first 3 months of treatment. The guideline recommends seeing patients two weeks after starting medication (if not considered to be at increased risk of suicide) and then regularly thereafter, for example at intervals of two to four weeks in the first three months, and then at longer intervals if response is good. For those with an increased risk of suicide or if younger than 30 years the recommendation is to see the patient after one week and frequently thereafter until the risk is no longer considered clinically important.

Mirtazapine was prescribed on the 12th September for "sleep and anxiety". The GP letter notes on 5th September that the patient had suicidal thoughts but no intent. It is unclear if the antidepressant was also intended to help with low mood (which is noted in his history from 2011 but doesn't seem to be mentioned as a reason for prescribing the mirtazapine). If the mirtazapine was started for both indications then the prescription was indicated, but according to NICE guidelines it would have been appropriate to see the patient a week after initiation of the antidepressant in view of the presence of suicidal ideation that was present prior to the start of treatment. Guidelines also recommend reviewing effectiveness and side effects every 2-4 weeks during the initial months, so perhaps an initial follow up at 1 week and then, if not displaying suicidal ideation or behaviour, a follow up a few weeks later would have been an appropriate time-frame.

However, the patient did have a telephone consultation with a counsellor eight days after starting the mirtazapine and was not suicidal at that point, which the GP would have been made aware of and alerted to otherwise. It would be reasonable to expect that any emerging adverse effects of mirtazapine of a behavioural or psychiatric nature would have been identified in the follow up contacts with the counsellor and nurse and the GP made aware.

It is Mr. Marven's opinion that:

- In a case such as this where the presentation does not fit a specific diagnosis of depression or GAD but where the symptoms and presentation would indicate that treatment with an antidepressant would be beneficial, then mirtazapine would be a suitable option based on its pharmacology, known safety profile and the range of target symptoms.

- Any risks around increased anxiety, aggression or risk of suicide are low compared to the underlying illness and similar to other antidepressants.

- It is highly unlikely that the mirtazapine contributed significantly to this incident.

- Treatment was started appropriately, and that although arguably a follow up review of the treatment by the GP could have happened sooner after initiation, that any adverse effect on the patient's behaviour or mental state in this time frame would have manifested itself and would have been picked up in either of the two subsequent contacts with other professionals.

Summary of Dr. Turner's report

Dr. Turner is a partner in a General practice in Birmingham, where he has been practicing for the last 20 years. He qualified in Medicine in 1991 from the University of Birmingham. (GMC registration 3550577). He is also employed by Birmingham South Central Clinical Commissioning Group as Clinical lead for mental health, a position he has held for the last two years.

The antidepressants most frequently prescribed by GPs include fluoxetine, sertraline, citalopram, venlafaxine and mirtazapine. Mirtazapine (Zispin) is an atypical antidepressant with noradrenergic and specific serotonergic activity which is usually prescribed second or third line for depression i.e. after trials of one or two SSRIs (selective serotonin reuptake inhibitors). The first-line prescription of mirtazapine in General Practice is not uncommon for symptoms of depression particularly when poor sleep is a prominent presenting feature of the history. NICE (National institute for Health and Care Excellence) guidance for the management of depression (2015) is not specific about which drug should be used first except in specific circumstances.

In Dr. Turner's experience of using mirtazapine extensively since it was first marketed in 1997, it is a safe and predominately well-tolerated drug, and is one of the four most commonly prescribed antidepressants in the UK.

A meta-analysis of three studies comparing mirtazapine with SSRIs found comparable response rates which were very similar in size to that seen with the Serotonin Noradrenaline Reuptake inhibitors (SNRIs).

Side effects of Mirtazapine as listed in the British National Formulary (BNF) and Maudsley Prescribing guidelines are increased appetite, weight gain, dry mouth, postural hypotension, oedema, drowsiness, fatigue, tremor, dizziness, abnormal dreams, confusion, anxiety, insomnia, arthralgia, myalgia *less commonly* syncope, mania, hallucinations, movement disorders; *rarely* pancreatitis, aggression,; also reported hypersalivation, dysarthria, convulsions, suicidal behaviour.

NICE guidance for the management of depression (updated in December 2015) suggests that for people who are not considered to be at increased risk of suicide, the prescribing clinician would normally see them after two weeks. Thereafter, they should see them regularly, for example every 2–4 weeks in the first three months, and then at longer intervals if response is good. For people who are considered to be at increased risk of suicide or are younger than 30 years, clinicians should normally see them after one week and then frequently until the risk is no longer clinically important.

It is Dr. Turner's opinion that:

- In clinical practice, aggression and other sorts of impulsive behavioural adverse drug reactions are very uncommon with mirtazapine use, if anything the opposite (somnolence and anergia) are more likely complications. On a statistical basis, therefore, and when coupled with the pre-existence of symptoms which have subsequently been identified as Morbid Jealousy ,in his opinion it would seem highly unlikely that the subsequent violent acts were stimulated or accelerated by the use of mirtazapine.

- In clinical practice for someone considered to be at low risk of self harm, an initial review period of 2-4 weeks might be appropriate depending on how well the patient was known to the clinician and whether previous treatment courses had been successful.

- The prescription of mirtazapine to a man presenting with symptoms of anxiety and depression were neither unusual for a GP nor sub-standard in terms of quality of care.

- It is not clear to me whether a follow-up appointment had been planned by the GP who prescribed the medication, but it would not be unusual or sub-standard professional practice for a patient not to be seen within three weeks of starting a new antidepressant medication.

Section Three

Key findings

3.1 Key findings

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and other information provided the panel has identified a range of key findings:

- Adult B had limited contact with professionals from statutory agencies. These were principally confined to his GP surgery and with staff from OSW. Adult A had no direct contact with statutory agencies other than her GP. This meant that information about them, their relationship and their family life was confined to a small number of professionals.

- The impression portrayed to professionals, certainly prior to Adult B's second engagement with OSW, was of a happy, settled family and of a couple in a stable and loving relationship.

- The children in the household were not considered to be at any risk, and were not in contact with any child protection services. The principal contact with statutory agencies was in relation to Child C through his referral and support from CFT and the school nurse service. This contact ended two years before the deaths.

- Agencies involved (other than CFTs direct contact with child C) did not ask questions of Adult B or Adult A about children in the household at any time.

- Although Adult B was open with OSW staff about his anxieties and concerns in relation to his relationship with Adult A, specifically his belief that she was being unfaithful to him, the true extent of his concerns was not known or explored.

- Adult B had experienced issues with the use of alcohol and had sought advice from his GP about this. It is less clear whether alcohol was a trigger or an influencer in the incident or in his beliefs about Adult A, although blood tests showed his use of alcohol was excessive.

- Adult B was prescribed mirtazapine by his GP in the three weeks prior to the incident. Treatment was started appropriately and the prescription of mirtazapine to a man presenting with symptoms of anxiety and depression was not unusual.

- Adult B was experiencing anxiety and was concerned about his mental health. He did seek help and advice from OSW. He did engage with the service on two occasions. He appeared to make progress during his first engagement, when the focus of that intervention was on matters to do with the security or otherwise of his employment. The second period of engagement was more focused on Adult B's beliefs and anxieties about his relationship with Adult A and his belief that she was being unfaithful to him.

- In recognising Adult B's entrenched thinking the OSW practitioner discussed referral to mental health services, but this was strongly declined by Adult B therefore whether Adult B had mental health diagnoses requiring secondary mental health services is unknown. His engagement with OSW was reviewed by that service to establish the right level of therapeutic input and plans were in place to increase the intensity of therapy but there were delays in accessing this due to waiting time constraints.

- Adult B's beliefs about his wife were a central factor in his life in the period leading up to the incident and were a significant contributor to the incident.

- OSW's focus was entirely on Adult B and his anxieties. They conducted risk assessments relating to self-harm and suicide but did not adequately consider the risk Adult B might have posed to others most specifically Adult A. This is concerning given the content of anxieties and beliefs about her being unfaithful to him. There was an over reliance on Adult B's own guarantees of safety.

- Adult B exhibited a number of known risk behaviours and characteristics in relation to domestic abuse. These were not well recognised by those professionals in contact with him and as such were not responded to. In particular these related to acts of coercion and control rather than the sometimes more clear signs of physical or violent abuse. This is not to say that if they had been recognised then the incident would not have occurred, rather it identifies a gap in knowledge and expertise within those services that had contact with Adult B.

- In particular the lack of a more thorough and holistic risk assessment might have prompted professionals to seek more information from either Adult A and Adult B and might have enabled them to intervene. Although some elements were known, they were not viewed 'in the round'.

- Adult B had confided in a work colleague that he was worried that Adult A would leave him and that if that happened he would kill her or kill himself. He also stated that life would not be worth living if Adult A left him. Taken in isolation these statements may have been dismissed as simply thoughts or figures of speech. Hindsight may give them a different complexion, knowing what is now known about the incident.

- Adult B was particularly concerned that Adult A would leave him. It is widely acknowledged that a significant trigger for a domestic homicide is a fear of estrangement. This could be real or imagined, but imagined fear of estrangement, where the perpetrator is fixated on that fear, presents a particular threat of harm or homicide for the victim.

  Adult B was fixated and his fear that Adult A would leave appeared to dominate him and at times the lives of the whole family. He repeatedly told people of his fears. At times he seemed to be unable to think about anything else. This kind of obsessive fear of estrangement is very highly correlated with future serious harm.

- There was a history of control of the entire family. It was said that members of the family would be worried that Adult B would suddenly lose his temper and they behaved in ways that would avoid that and its repercussions. Social contact for Adult A was limited and Adult A did almost everything with Adult B. She had very little life outside of this. Adult A did not necessarily complain about this and never criticised Adult B, however this does not mean that these circumstances were not about Adult B's need for control. Adult A seemed to accept all of his challenging behaviours with patience.

  Adult B expected Adult A to spend all her time with him, and when she was at work she was expected to constantly text or call him. This amounted to a significant degree of control, and irrespective of whether Adult A complained or not, it is an indication of coercive control by Adult B.

- There are a number of serious high risk factors noted as present in this case, and there may have been more that are not known about. Adult A was coping with these behaviours and attempting to manage the situation herself. She may not have recognised the danger she was in. In cases like this where police are not involved there may be no other agency that has a policy of conducting risk assessment interviews where domestic abuse is identified. However there are points at which there could have been intervention, and this may be considered points where the potential for learning can be identified.

- The level and depth of knowledge about domestic violence and abuse appears to have been particularly variable and in some instances it is hard to see that it existed at all. The GP practice involved did not have a domestic abuse policy in place at the time of the incident. There were high risk factors in most contacts with Adult B and it is evident that staff working with him were not aware of those factors.

- No direct enquiry about domestic abuse was ever made and this meant that there were missed opportunities to identify risk and to intervene.

- Morbid jealousy was not considered as a factor in Adult B's presentation.

- Professionals working with Adult B appeared not to consider the wider circumstances of his life and as a consequence the nature of his family and marital relationships were not well understood or acted upon.

- The views and experiences of Adult A were not known or understood and no opportunities were provided to explore them, to establish her experiences or to support her.

- Child C presented with anxiety, sleeplessness and there was a referral to CAMHS and the School Nurse. There was a lack of recognition by professionals to see Child C's presentation in the wider context of the family setting and circumstances. Research has shown that children who are exposed to violence in the home may have difficulty learning and limited social skills, exhibit violent, risky or delinquent behaviour, or suffer from depression or severe anxiety. Children in the earliest years of life are particularly vulnerable: studies show that domestic violence is more prevalent in homes with younger children than those with older children.[8] Around 1 in 5 children have been exposed to domestic abuse.[9] Children who have experienced domestic abuse may exhibit physical symptoms that are associated with trauma and stress. For instance, they may develop eczema, experience bed-wetting, have nightmares, or suffer from sleep disturbances.[10]

  There appears to have been no detailed enquiry as to the underlying cases of the anxiety and sleeplessness. This was a missed opportunity to gather information that could have provided a more holistic insight into family life.

[8] Brown, Brett V., and Sharon Bzostek, 'Violence in the Lives of Children', Cross Currents, Issue 1, Child Trends DataBank, August 2003
[9] Radford, L. et al (2011) Child abuse and neglect in the UK today
[10] Humphreys, C, Lowe, P and Williams, S (2009) 'Sleep disruption and domestic violence: exploring the interconnections between mothers and children', Child and Family Social Work, 14, 6-14

- There have been three previous DHRs in Cornwall where the perpetrator has exhibited symptoms and risk assessed as risk to self as opposed to risk to others. This emerging theme around quality of risk assessment in the wider context of an individual and the effect this may have on understanding whether they pose a risk to others is an area of practice that should be considered for wider learning and practice development.

Section Four

Conclusions

4.1 Conclusions

This section sets out the conclusions of the DHR Panel, having analysed and considered the information contained in the IMRs within the framework of the Terms of Reference for the review. The Chair of the DHR is satisfied that the review has:

- Been conducted according to National Guidance and best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified 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.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic violence homicide and improve service responses for all vulnerable people and domestic violence victims through improved intra and inter-agency working.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and draws them together to present an overall set of conclusions, concluding with the central issues of whether the incident was predictable or preventable.

Knowledge of domestic abuse and domestic abuse

Knowledge of domestic abuse and domestic violence, both in terms of the risks and the triggers was not of a sufficient depth and quality within the services that had contact with Adult B. The indicators of domestic abuse were not recognised and thus were not acted upon.

In addition those agencies in contact with Adult B did not use routine enquiry in relation to domestic abuse as an approach in their interactions with him. This meant that information about potential risks and triggers was not gathered.

Risk assessment

Risk assessment was variable and focused primarily on Adult B's risk to himself. Risk to others and in particular to Adult A was not adequately considered and explored. This meant that those risks that can now be identified as a result of this review were not known and thus not acted upon. There are wider questions about the adequacy of the risk assessments that were undertaken and these have been addressed within the IMRs.

The lack of a holistic view

The agencies in contact with Adult B saw him in isolation from both Adult A and the rest of his family. This meant that they did not have a wider or more holistic view of his circumstances, nor the validity or otherwise of his concerns about his relationship with Adult A. Although the OSW worker understood the nature of those anxieties and placed them in the context of what might be described as a delusion state, there was no wider understanding of the effect of this upon Adult A, and what was happening in the home environment.

Understanding of morbid jealousy

This case has highlighted the challenges in identifying and responding to the possible presentation of morbid jealousy and its part in domestic homicide. The research evidence suggests that domestic violence is a common result of jealousy, normal or morbid.[11] As the OSW IMR suggests, there remains a knowledge deficit in relation to morbid jealousy that is not confined to Cornwall as a locality.

Whether Adult B did present the symptomatology of morbid jealousy is not the remit of this DHR, but the information reviewed suggests that it may have been a part of his presentation. Its accurate and formal identification would have led to a different treatment methodology.

[11] Aspects of morbid jealousy Kingham, Mu and Gordon, H. Advances in Psychiatric Treatment 2004

It is not possible to say with any certainty whether that would have had any impact on the likelihood of the incident occurring or not, it would certainly have assisted in the treatment of Adult B's anxiety about his relationship with Adult A.

Prescription of mirtazapine and GP follow-up

The matter of the appropriateness of the prescription of mirtazapine and the follow up by the GP after that prescription was the subject of additional independent expert review and advice.

The judgement of the independent experts was that the prescription of mirtazapine was not unusual. Adult B's symptoms and presentation indicated that treatment with an antidepressant would be beneficial, and as such mirtazapine represented a suitable option based on its pharmacology, known safety profile and the range of target symptoms.

Any risks around increased anxiety, aggression or risk of suicide are low compared to the underlying illness and similar to other antidepressants. On a statistical basis, therefore, and when coupled with the pre-existence of symptoms which have subsequently been identified as morbid jealousy, it would seem highly unlikely that the subsequent violent acts were stimulated or accelerated by the use of mirtazapine.

Turning to the matter of GP follow-up, if the national guidance had been strictly applied, this would suggest that follow up review of the treatment by the GP could have happened sooner after initiation of the medication. In clinical practice for someone considered to be at low risk of self-harm, an initial review period of 2-4 weeks might be appropriate, depending on how well the patient was known to the clinician and whether previous treatment courses had been successful.

Having noted that, the independent GP advice was that it would not be unusual or sub-standard professional practice for a patient not to be seen within three weeks of starting a new antidepressant medication. The judgment of the expert pharmacist is that arguably a follow up review of the treatment by the GP could have happened sooner after initiation, but that any adverse effect on the patient's behaviour or mental state in this time frame would have manifested itself and would have been picked up in either of the two subsequent contacts with other professionals.

Having considered the expert advice, the conclusions reached are that the prescribing of mirtazapine was appropriate, and that the medication itself is unlikely to have any direct effect or causal link with the subsequent violent incident.

In relation to the issue of GP follow-up, it appears that the application of the NICE guidance for Generalised Anxiety Disorder was not fully adhered to. In saying this it

is important to bear in mind that the guidance itself is not applicable to mirtazapine as part of a treatment plan for anxiety. Nevertheless, that guidance recommends seeing patients two weeks after the commencement of the medication and this did not happen.

Therefore, the DHR finds that there is no evidence to indicate that mirtazapine had any direct effect or causal link to incident. It also finds that although the follow-up did not take place within two weeks, this was not unusual and cannot conclusively be said to have had a direct effect on the eventual incident.

Predictability and preventability

The review has not identified any evidence that indicates that physical violence had been a factor in Adult B's relationship with Adult A. Indeed Adult C has stated that no such incidents took place that he was aware of.

Adult B had self-disclosed his anxieties and concerns about his relationship and these centred on his (misplaced) belief that Adult A was being unfaithful to him. He had also articulated thoughts about his life not being worth living without her and stating that he would kill her and/or himself if they were separated. The validity of these statements must be viewed in the context of his anxiety state, but even in that context this represents a real concern and escalation of risk.

The risk factors present and those identified in this review were not well recognised by the professionals in contact with Adult B. However, the risk factors and the behaviours being exhibited by Adult B in the period prior to the incident, demonstrate that it was likely that Adult A would be a victim of domestic abuse.

Coming to a view about the predictability of the homicide is a complicated process and necessarily is a nuanced judgment. The panel has come to the conclusion that the probability of physical violence directed towards Adult A was highly likely and that it could have been predicted. When considering whether or not a homicide was predictable is harder to judge, but given the risk factors and the statements made by Adult B, our conclusion is that the homicide was predictable.

Turning to the matter of preventability, neither the police or health services received any information or calls around the time of Adult A's death alerting them to the fact that there was an immediate threat. It is on this basis that the panel has concluded that no professional or agency could have prevented Adult A's death.

Section Five

Recommendations

5.1 Recommendations

This section of the Overview Report sets out the recommendations made by the DHR panel and then the recommendations made in each of the IMR reports.

5.1.1 DHR Overview Report Recommendations

Some of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs. The DHR panel therefore offers the following overarching recommendations for local action:

1. We recommend that there should be clear domestic abuse policies/policy written for all GP surgeries in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to safeguarding.

2. We recommend that a training needs analysis for GP's, mental health workers and others for example, NHS Kernow commissioned services such as psychological therapies should be conducted to identify which staff would benefit from training in recognising high risk markers for domestic abuse. Further work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.

3. We recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. In addition we recommend that pastoral care in schools have issues relating to domestic abuse as part of their work plans and processes. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within the pastoral care process. There weren't indicators of abuse regarding concerns relating to Child C. The consideration of domestic abuse in these circumstances should not be reliant on specific indicators, it should form part of routine enquiry when a child presents with anxiety issues.

4. We recommend that a programme of work be developed to raise public awareness of domestic abuse. It should include information about where members of the public can appropriately and safely share concerns or information about individuals they believe may be at risk of domestic abuse or at risk of perpetrating domestic violence.

5. We recommend that guidance relating to the identification and management of morbid jealousy by primary care workers and those working in primary care mental health services should be developed to aid those workers in supporting individuals who may be exhibiting those symptoms.

6. We recommend that assessment and risk assessment processes in health and social services be reviewed to ensure clearer guidance about the need to consider and respond not only to the needs of the presenting individual, but to spouses, partners and children within the family unit.

7. We recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can take place with local organisations. We make this recommendation in the context of there having been three previous DHRs in Cornwall where the perpetrator has exhibited symptoms and risk assessed as risk to self as opposed to risk to others. This emerging theme around quality of risk assessment in the wider context of an individual and the effect this may have on understanding whether they pose a risk to others is an area of practice that should be considered for wider learning and practice development. There may be other commonalities and it would be of benefit to the local system to know and understand these so that a co-ordinated approach to learning and development can be undertaken in response to DHRs undertaken as a whole rather than seeing each in isolation.

5.1.2 Recommendations made in the individual IMRs

NHS England – Primary Care

Single agency recommendations

- NHS England in association with the Care Quality Commission audit/confirm the completion of training by GPs and other primary care practitioners to ensure that appropriate training has been completed.
- GPs undertake an agreed formal process to identify thresholds that trigger joint multi professional assessments of particular cases.
- Paper record search to ensure that all relevant information is included on electronic record
- Consideration of how to tighten documentation regarding any referrals, outcomes or follow up.

Multi-agency recommendations

- Agree and design joint approaches and thresholds for multi-agency working when risks to individuals have been noted and include further exploration of the needs of the wider family to enhance joint family care.
- Joint training is undertaken as standard, wherever possible
- Information regarding episodes where child in care of Local Authority to be shared with General Practitioner and other health professionals.
  (Note: practice has changed since 1960.s)

National recommendations

- That the full impact of understanding and acting in a timely way where individuals display symptoms of depression, particularly where it is apparent that other family members are being identified is one of the key causal factors.
- That the learning from these domestic homicide reviews is routinely shared with children's safeguarding teams to facilitate early joint approaches where children may be involved
- That there is a requirement for relevant early history, such as fostering, to be included as an integral part of GP records.
- That consent issues pertaining to engaging and sharing information in a timely way for the purposes of contributing to this Domestic Homicide review, is clearly understood by all health partners, to minimise any unnecessary disputes or delays

It is important to note that these recommendations were made in 2013 and some have been acted upon prior to publication of the DHR.

Outlook South West recommendations

- The Service Treatment guidance should be reviewed and updated to include guidance on pathological jealousy
- It is further recommended that a) cases are referred on for specialist psychological therapy in secondary care, and b) that specific risk questions are asked. (See Action Point below)
- Staff should receive training in identifying this condition
- There is currently no assessment tool used by therapists to assess the risk of harm to others.
- It is recommended that the Clinical Governance team will co-opt a working group to develop a tool for risk screening to others
- Referring to High Intensity therapy – It has been recommended that a procedure to fast track priority patients if there is an urgent need should be developed. This is to be discussed and reviewed by the Clinical Pathway team.
- It has been recommended that guidance is to be produced for staff relating to situations where a proposal to refer to the CMHT is refused by the patient.

It is important to note that these recommendations were made in 2013 and some have been acted upon prior to publication of the DHR.

DHR4 Action Plan

No.	Recommendation	Measure	Lead	Timescale
1.	The DHR recommend that there should be clear domestic abuse policies/policy written for all GP surgeries in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to safeguarding.	Develop GP Domestic Abuse Policy and Guidance including local pathway Scope number of GP practices operating in Cornwall. Deliver domestic abuse training to each GP practice including GP Policy and local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.	NHS Kernow Safeguarding Lead and Kernow CIC	Development of GP Policy and Guidance by 31 January 2017. Scope GP numbers by 31 January 2017. Delivery of training by 31 March 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 May 2017.
2.	The DHR Panel recommend that a training needs analysis for GPs, mental health workers and others for example, NHS Kernow commissioned services such as psychological therapies should be conducted to identify	Develop workforce development programme to enable frontline staff to identify, risk assess and refer those at risk of domestic abuse in GPs, mental health and other NHS Kernow commissioned services.	NHS Kernow Safeguarding Lead and Kernow CIC	Development of workforce development training by 31 January 2017. Scope numbers by

	which staff would benefit from training in recognising high risk markers for domestic abuse. Further work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.	Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.		31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 October 2017.
3.1	The DHR Panel recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. In addition we recommend that pastoral care in schools have issues relating to domestic abuse as part of their work plans and processes. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within the pastoral care	Workforce development training to be extended to pastoral care and designated safeguarding leads within education settings. Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.	Safeguarding Standards Unit Learning and Achievement Service	Development of workforce development training by 31 January 2017. Scope numbers by 31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of

	process. There weren't indicators of abuse regarding concerns relating to Child C. The consideration of domestic abuse in these circumstances should not be reliant on specific indicators, it should form part of routine enquiry when a child presents with anxiety issues.			year performance report to DASV Strategic Group by 31 October 2017.
3.2	Create a Culture of TELL, ASK and REFER by; – Raising awareness of Domestic Abuse in the Community to encourage increased reporting to REACH – Ensuring the commissioned provider delivering LSCB Safeguarding Children Training includes a Domestic Abuse Specific module including the DASH Risk Assessment. – Including a specific Domestic Abuse DASH	A culture of TELL will be achieved through the implementation of the Communication Strategy (see Action 4). A culture of ASK will be achieved by providing all professionals with access to Domestic Abuse and DASH Risk Assessment Training – and equipping them with the knowledge to feel competent and confident to ASK, Risk Assess and REFER. A culture of REFER will be achieved by making it easier for the Public and Professionals to refer cases to REACH for Information, advice, risk evaluation and access to specialist Domestic Abuse Services.	All trained professionals will be required to include a copy of the DASH Risk Assessment when referring a client to REACH. This will provide the DASV SG with evidence of DASH completion, adherence to guidance and effectiveness of training.	Table the recommendations and actions from this Domestic Homicide Review at the DASV Strategic Group within one-month of Home Office approval to Publish. Commission a Multi-Agency Domestic Abuse Training Programme by 31 January 2017.

	module on the Safeguarding Adults Board Training – Ensuring all Designated Child Protection Officers working for the Cornwall Education Authority attend DASH training as part of enhanced Child Safeguarding Training. – Commission Domestic Abuse & DASH Training for Multi Agency Practitioners including the Voluntary Community Sector, Probation, Mental Health, Drug & Alcohol Services and the Health Sector. – Provide DASH Training to all Special Constables, First Response Officers, Supervisors (including Communication staff), Call Handlers and Sexual Offences Domestic Abuse Investigation Teams.	A measure of progress will be; – The Commissioning of a Domestic Abuse Training Program by 31 January 2017; – The number of Professionals attending DA Training; – The number of new DASH Forms accompanying referrals to REACH; – The number of Non-Police Professionals referring cases to MARAC – A year on year increase in the identification and overall reporting of Domestic Abuse		Set a time frame for individual agencies to implement actions and report back to the DASV Strategic Group.
4.	The DHR Panel recommends a	Create a Communication Strategy (2016	The DASV & SOC	Prioritise and

	programme of work be developed to raise public awareness of domestic abuse. It should include information about where members of the public can appropriately and safely share concerns or information about individuals they believe may be at risk of domestic abuse or at risk of perpetrating domestic violence. A public communication and marketing strategy should be developed to increase public confidence to report concerns by; – Educating the Public on what constitutes abuse; – Highlighting all forms of Domestic Abuse and the signs and symptoms of sustained abuse; – Educating the Public on when and how to intervene/report concerns; – Advertising a single point of	– 2018) linked Domestic Abuse HUB (REACH) by October 2016. Record annual figures from 2016 – 2018 for; – The number of Public reports, enquiries or concerns made to the HUB for a third person; – The number of self-disclosures or reports to the HUB; Compare figures against comparable data held for 2015/16 to establish progress.	Strategy Lead to liaise with the DASV Providers Group.	agree outcomes for the Communication Strategy by 31 October 2016. Write Communication Strategy by 30 November 2016. Communication Strategy endorsed by DASV Strategic Group by 31 October 2016.

	contact for all concerns.			
5.	The DHR Panel recommend that guidance relating to the identification and management of morbid jealousy by primary care workers and those working in primary care mental health services should be developed to aid those workers in supporting individuals who may be exhibiting those symptoms.	Workforce development training to be extended to morbid jealously for those operating within mental health services. Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including policy and guidance. Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.	NHS Kernow	Development of workforce development training by 31 January 2017. Scope numbers by 31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 October 2017.
6.	The DHR Panel recommend that assessment and risk assessment processes in health and social services be reviewed to ensure clearer guidance about the need to consider and respond not only to the needs of the presenting individual,	Review of risk assessments to ensure partner, family and children views are sought as part of a comprehensive history. Workforce development training include comprehensive history taking within mental health and social care services.	NHS Kernow and Cornwall Council	Review of current policies within Mental Health Services and Children Social Care Services against national standards by end

	but to spouses, partners and children within the family unit.	Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including policy and guidance. Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.		of 31 October 2017. Development of workforce development training by 31 January 2017. Scope numbers by 31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 October 2017.
7.	The DHR Panel recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can	Review of all local DHRs and collation of common themes.	DASV & SOC Strategy Lead	Review of current DHR recommendations to identify common themes 31 August 2016. Inclusion of

	take place with local organisations.			common themes in DASV Strategy 2016-20 by 31 November 2016. Quarterly reporting to DASV Strategic Group.
8.	Review of service specification for Outlook South West	• The Service Treatment guidance should be reviewed and updated to include guidance on pathological jealousy • It is further recommended that a) cases are referred on for specialist psychological therapy in secondary care, and b) that specific risk questions are asked. • Staff should receive training in identifying morbid jealously • Assessment tool used by therapists to assess the risk of harm to others. • Clinical Governance team will co-opt a working group to develop a tool for risk screening to others • Fast track referring to High Intensity	NHS Kernow and Cornwall Foundation Partnership Trust	Review completed by 30 November 2016 Service specification amended by 31 March 2017

		therapy for priority patients if there is an urgent need should be developed. This is to be discussed and reviewed by the Clinical Pathway team. • Guidance is to be produced for staff relating to situations where a proposal to refer to the CMHT is refused by the patient.		
9.	NHS England in association with the Care Quality Commission audit/confirm the completion of training by GP's and other primary care practitioners to ensure that appropriate training has been completed. GP's undertake an agreed formal process to identify thresholds that trigger joint multi professional assessments of particular cases. Paper record search to ensure that all relevant information is included on electronic record Consideration of how to tighten	Safer Cornwall will ensure that national recommendations are sent with a copy of the DHR to NHS England within one month of Home Office endorsement of the report	NHS England	Safer Cornwall has no influence on the timescale for national recommendations

	documentation regarding any referrals, outcomes or follow up?			
10.	Agree and design joint approaches and thresholds for multi-agency working when risks to individuals have been noted and include further exploration of the needs of the wider family to enhance joint family care.	Development of MARAC plus which will consider support and safety planning for victims, management of perpetrator and safeguarding of children		Review current MARAC model by 31 May 2016 Endorse model by MARAC Steering Group by 31 August 2016 Implement development plan and complete by 31 March 2017.
11.	The full impact of understanding and acting in a timely way where individuals display symptoms of depression, particularly where it is apparent that other family members are being identified is one of the key causal factors. A requirement for relevant early history, such as fostering, to be included as an integral	Safer Cornwall will ensure that national recommendations are sent with a copy of the DHR to NHS England within one month of Home Office endorsement of the report	NHS England	Safer Cornwall has no influence on the timescale for national recommendations

	part of GP records.			
12.	That the learning from domestic homicide reviews are routinely shared with children's safeguarding teams to facilitate early joint approaches where children may be involved	Safer Cornwall will ensure that national recommendations are sent with a copy of the DHR to NHS England within one month of Home Office endorsement of the report	TBC as new arrangements for national Serious Case Review is yet to be confirmed	Safer Cornwall has no influence on the timescale for national recommendations
13.	That consent issues pertaining to engaging and sharing information in a timely way for the purposes of contributing to this Domestic Homicide review, is clearly understood by all health partners, to minimise any unnecessary disputes or delays.	Safer Cornwall will ensure that national recommendations are sent with a copy of the DHR to NHS England within one month of Home Office endorsement of the report	Home Office & General Medical Council	Safer Cornwall has no influence on the timescale for national recommendations