RESTRICTED

Colchester Borough Council

Community Safety Partnership

Domestic Homicide Overview Report

REPORT INTO THE DEATH OF Mr and Mrs A

Report produced by David Murthwaite

Date 31 March 2015

Contents

INTRODUCTION

This report, of a Domestic Homicide Review (DHR), examines agency responses and support given to Mr A and Mrs A; who were residents of Colchester, Essex prior to their death on 24 May 2014.

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 those lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

The review will consider agencies contact and involvement with Mrs A, the victim and Mr A, the perpetrator, in detail, from June 2011 until 24 May 2014.

The key purpose for undertaking this Review is to enable lessons to be learned from this homicide, where a person was killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

Those contributing to this Review would like to express our sympathy to family and friends of Mr and Mrs A whose lives ended in such tragic circumstances.

TIMESCALES

The statutory guidance for DHRs requires the Community Safety Partnership (CSP) to make a decision on whether or not to proceed with a review within 1 month of the homicide coming to their attention. Mr. and Mrs. A's deaths occurred on the 24 May 2014 and the local Community Safety Partnership was advised of this on 27 May 2014.

The CSP sought further guidance from the Home Office on whether the circumstances of this case fell within the criteria for formal review. On the 21 August 2014 the Home Office Domestic Violence Policy Team confirmed that a DHR was required and acknowledged that "*This may in the event result in a proportionate DHR review, given that initial indications are that they had no history of violence..*"
Reviews, including the overview report, should be completed, where possible, within six months of the commencement of the review. The DHR was commissioned on 21 August 2014, the chair appointed on 15 October 2014 and the review was concluded on 17 March 2015 which is a month outside the timescales set by the guidance.

CONFIDENTIALITY

The findings of each review are confidential. Information is available only to participating officers and their line managers until approval by the Home Office and subsequent publication in an anonymised format.

DISSEMINATION

The following have received a copy of this report:

Essex County Council - Adult Operations (including an access copy for Ms C)
Essex Police
NHS North East Essex Clinical Commissioning Group
Anglian Community Enterprises - Safeguarding Adults
North Essex Partnership NHS University Foundation Trust
Colchester Hospital University Foundation NHS Trust
North Hill Medical Group
East of England Ambulance Service Trust
Swan Housing Group
Victim Support Essex (Independent Domestic Violence Adviser)

Independent Chair Mr David Murthwaite
An independent chair, David Murthwaite was appointed by Community Safety Partnership (CSP) to chair the Domestic Homicide Review panel. David, an independent Business and Development Consultant was until 2005 Chief Superintendent with Essex Police. Since his retirement he has been an independent consultant for the Metropolitan Police Service - Special Operations responsible for Counter Terrorism and Protection including the Cabinet and the Royal Household. In 2005 he worked as a consultant for ACPO Terrorism and Allied Matters offering strategic support in building the embryonic national structure, policies and protocols in response to terrorism and later to introduce an appropriate performance philosophy

EXECUTIVE SUMMARY

THE REVIEW PROCESS

This summary includes an outline of the process undertaken by Colchester Borough Council, Community Safety Partnership's, Domestic Homicide Review panel in reviewing the suspected murder of Mrs A, 78 years by her husband Mr A, 82 years.

An inquest was opened and adjourned on 28 May 2014. It is due to be reopened on 17 March 2015.

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 those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

To ensure that all relevant information was secured the Community Safety Partnership instigated a trawl of all agencies who may have had contact with the victim or the perpetrator.

A meeting was held on 29 July 2014 of the agencies that potentially had contact with Mr A or Mrs A prior to their deaths. Ten Agencies were identified as holding some record, 19 Agencies made a negative response. These are listed below.

An independent Chair for the Domestic Homicide Review (DHR) Panel was appointed on the 15th October and contact was made with the Police Senior Investigating Officer and Coroner to identify any issues that the DHR may have with the inquest procedure. No difficulties were identified and a date was set for the appropriate representatives to attend a DHR panel meeting on the 9th December 2014. Liaison has been maintained with the SIO and Coroner.

At the meeting on 9th December the Panel membership was established (though subject to continuing review) and terms of reference were agreed. Agencies were identified who would be requested to complete Individual Management Reports (IMR), a timetable for completion of the reports was also fixed.

The family chose not to be involved in the process but were updated on progress and have been shown a copy of the report and invited to express any views they may have.

Agencies participating in this case review are:

Essex Police
Essex County Council - Adult Operations
NHS North East Essex Clinical Commissioning Group
Anglian Community Enterprises - Safeguarding Adults
North Essex Partnership NHS University Foundation Trust
Colchester Hospital University Foundation NHS Trust
North Hill Medical Group
East of England Ambulance Service Trust
Swan Housing Group
St Helena Hospice

The ten agencies above have responded with information indicating some level of involvement with Mr A and Mrs A. One of those agencies, St Helena Hospice, was asked for and submitted a chronology of contact with Mrs A, the latest entry recording a telephone request for a future appointment. Their involvement is not considered directly relevant to the events leading to the deaths and no IMR was requested.

The remaining nine Agencies were requested to complete an IMR and were supplied with the template provided in Home Office guidance. This ensured that the reports addressed relevant matters, including a chronology of contact, a professional assessment of the Agencies involvement and a review on each Agencies policy and training in respect of safeguarding and in particular Domestic Abuse.

The agreed Terms of Reference were:

- From June 2011 up to the death of Mr. and Mrs. A, establish the timeline of events and relevant actions of each agency, their inter-agency contact and the involvement of other people, e.g. family, friends

- Examine all documentary records relevant to the timeline to enable an assessment of the efficiency and effectiveness of each contribution, whether all reasonable steps had been taken to manage the unfolding scenario and the role of any risk assessments

- Assess the extent to which agencies followed relevant legislation, guidance, policy, procedure and recommended best practice emanating from formal reviews

- To propose recommendations that may help to prevent a similar incident occurring and the further development of the way each agency works individually and in partnership.

In setting the Terms of Reference there was a working assumption that each agency would provide all relevant material along with full and frank commentary.

The reports were completed by experienced personnel who did not have involvement in the case or line management for staff involved in the case. There was one exception to this,

North Hill Medical Group where the report GP author had visited the couple; the DHR panel considered that this did not influence the objectivity of the report. Reports were supervised by an Agency manager and then signed off by a senior manager before submission to the DHR panel.

On 23 May 2014, Mrs A had made enquiries by telephone to the Nayland House care home and the Blackbrook House care home regarding the possible future care provision for both herself and her husband. The review has not sought reports covering involvement from either of these establishments as they are not considered directly relevant to the events leading to the deaths.

In total, 19 agencies have responded as having had no contact with or entries on their database or general registry for either Mr A or Mrs A.:

Essex Probation
ECC Children's Social Care
Essex Fire
Basildon Women's Aid
Colchester Women's Refuge
Braintree District Council
Basildon Borough Council
Brentwood District Council
Castle Point District Council
Chelmsford City Council
Colchester Borough Council
Epping Forest District Council
Harlow District Council
Maldon District Council
Rochford District Council
Tendring District Council
Uttlesford District Council
Thurrock Council
Southend on Sea Borough Council

The completed IMRs were discussed at a DHR panel meeting on the 2nd February 2015 where following individual presentations the panel confirmed:

- They covered all the facts as known,
- That the aim of IMR's has been met
- What each agency believed to be the key issues for them and if they were soundly represented in action
- If it is believed that there were any gaps or omissions,
- What the response to those gaps or omissions should be
- Whether another agency could compliment the actions suggested.

The panel also specifically considered the facts as known against the circumstances of particular concern as described in Home Office Guidance.

A draft overview report was then completed from the information identified and the report was discussed at a final DHR panel meeting on the 10th March 2015. There were no dissenting views expressed and the report was submitted to the CSP meeting on the 17th March 2015.

KEY ISSUES IDENTIFIED FROM THE REVIEW

At 06:37 hours on Saturday 24th May 2014, a 999 telephone call was made to Essex Police by a man identifying himself as Mr. A and he provided his address. He informed the Police operator that he had just shot his wife and was going to shoot himself in the very near future.

Mr. A stated that he and his wife were,
'in love, enjoyed life but can now only see death and horrible things in front of them'.
When asked by the Police operator what had happened, he stated he was going to shoot himself and terminated the call. Attempts were made to re-contact the number but there was no reply. A Police Firearms team and an ambulance were then immediately dispatched to the address.

At 07:09 hours police officers entered the rear garden and found Mr. A's body lying on path directly outside the kitchen doorway situated to the rear of the property. He was lying on his back with a shotgun lying across his chest. He appeared deceased.

At 07:10 hours entry was gained to the property via the kitchen door by police officers and a search made of the downstairs rooms. Mrs. A was slumped in a 'chaise-lounge' chair in the living room with wounds consistent with being caused by a firearm.

Once the property was declared safe to enter, an Ambulance crew was allowed inside and after examination paramedics confirmed the death of both Mr. A and Mrs. A.

The home environment.

Mr A and Mrs A had been married for nearly 60 years, Mr A, 82 and Mrs A, 78, had lived in their rural cottage for over 40 years. Although their home lacked some modern day amenities, washing machine, central heating, it was well cared for and maintained. They enjoyed a somewhat independent and isolated life style appearing content with limited contact with their relatives, even though they lived within the county.

The couple had one child, a daughter, who, aged 56 years remains in long term local care, suffering with severe learning difficulties. The daughter is described as non-verbal in communication. Mrs A had visited her daughter on her birthday and at Christmas.

Prior to the 24th May 2014 there is no record, evidence, or any indication of violence or other aspects of domestic abuse, at any time by either occupant of the household. No person identified in this review has raised any information that would indicate any presence of Domestic Abuse in the relationship.

Over the last few years their health began to deteriorate. Mr A received treatment for bowel cancer and he experienced the onset of dementia. This was of increasing concern to his wife especially when she was diagnosed, in early May 2014, with lung cancer. The prognosis, which gave her life expectancy of 6 to 9 months, appears to have been the catalyst for Mrs A to commence arrangements to leave their home and secure ongoing support for her and her husband by moving into care.

What triggered the violent end to their lives can only be speculative. No note was found in explanation and although Mr A had described some tension between him and his wife the evening before their death to a visiting carer, it was not in itself significant enough to raise concerns. Specifically as he walked the carer to her car he had said something like "Things were a little heated and unhappy in there" The carer had been surprised at this comment as the mood had been happy with all joining in laughter.

In his final call to the police he explains that his actions were because he "*can now only see death and horrible things in front of them*". His actions were in contrast to the outlook and behaviour of Mrs A, witnessed over the last few days, where she informed a number of people of her intentions and was making enquiries to enable them to leave their home and move into care.

Given Mr A's comments in his final call to police an apparent disparity existed between how they saw their future or at least their response to it. However there is no evidence to indicate that they disagreed over the plans of Mrs A.

The couple are described as "very much routine people and never went on holidays...Their life was their home - and they didn't like to leave it." A neighbour describes the couple as "unable to do without each other". Another friend describes them as "a private couple but very much in love".

What must be acknowledged is that experiencing such a range of dilemmas at once: terminal illness; worsening dementia; leaving your home and moving into care; was likely to be extremely challenging and stressful to confront and manage alone.

Mrs A had declined a carer's assessment whilst in hospital and one was to be arranged for the week beginning 26 May after she returned home. Although the focus of this meeting would be support to Mrs. A in her role as carer to her husband, the ensuing discussion may have included Mr A and may have given the couple an opportunity to discuss and explore options for their future. Such a meeting may have informed and broadened the available options before them, relieving some of the immediate pressure to decide on their future.

Possession of Firearms

The shotgun was lawfully possessed by Mr A, a certificate holder since 1968, the most recent renewal was 2011. The major requirements for this renewal were followed, although Essex Police policy was not adhered to in respect of contacting the previous counter signatory, as a different individual had signed as counter signatory on the last renewal application. The policy will be restated by Essex Police and monitored to ensure compliance.

The renewal process included a letter sent to Mr A's GP, asking for any concerns over safety to be notified to the police. No facts were known to the GP that would warrant raising any concern in respect of Mr A's suitability to hold a shotgun certificate.

Whilst not required to do so North Hill Medical Group retained a copy of this letter on the patients file, but without any additional flagging it was not immediately visible on any subsequent viewing of the record.

Since 1 September 2014, Essex Police have taken part in a Home Office pilot scheme to strengthen the grant and renewal process for Firearms Licences (including Shotgun certificates). This includes a provision that the certificate holders' medical record be

endorsed and 'flagged' by the GP, highlighting possession of a Firearm as a permanent feature on record. This improvement is welcomed.

The pilot scheme only instigates contact with a Firearm Licence holder's GP when the licence is due for renewal; there remains therefore a potential 5 year window before any change in suitability is highlighted for consideration. In this case, the file would have been flagged in 2016, when Mr A's licence was due for renewal. In the worst case for other records it could be 2019 before a flag is raised, notification should therefore take place as soon as possible and not wait until the point of renewal. [**Recommendation 1**]

Where there is justification, a licence can be revoked at any time by Police. There were opportunities since 2011 to reflect on this issue as some agencies were aware of Mr A's worsening dementia and of his possession of a shotgun.

In August 2012 following discharge from hospital, where he had delirium, Mr A is visited by a Doctor at home, the notes indicate– "*patient saying the cottage is under siege. Impression is delirium? due to ongoing infection*" The absence of flagging on the patient record at this time is likely to have led to no consideration being given to the risks presented by a lethal weapon being available to the patient, or the possibility of a temporary surrender of the weapon.

In November 2012 as a result of referral from his GP, Mr A attended the North Essex Partnership NHS University Foundation Trust Memory Clinic (NEP). The result of the assessment, sent to his GP, included his interests and hobbies and also referred to the possession of a shotgun.

This assessment did not trigger further consideration of risk associated with the shotgun by NEP, as the patient did not exhibit a condition included within Home Office Guidance on Firearms Licensing Law, (since updated 2013 and amended 2014). This guidance lists conditions worthy of referral to police as *'has exhibited or is exhibiting signs of serious depression, suicidal tendencies or long standing or intermittent periods of emotional instability or unpredictable behaviour*'.

Dementia can lead to people displaying behaviours that are out of character and these will require assessment in respect of a person's suitability to hold a Firearms Licence. To ensure that this occurs consideration should be given to including some reference to Dementia in the existing guidance. [**Recommendation 2**]
The same agency reassessed Mr A at a Memory Clinic in July 2013, where the assessment was updated and vulnerability was identified as a *'risk due to cognitive impairment with dementia*'. The issue of the shotgun was not documented in respect of any risk, lack of risk to others, or security of the weapon in NEP's report to the GP.

NEP has identified this as an area of learning, where information from earlier assessments should be carried forward, and in particular they will amend their report template to ensure that an assessment of risk is always included in the update provided to patients GP. [**Recommendation 3**]

In this case none of the Agencies involved with Mr. A believed that they had any grounds to report to police concerns as to his suitability to hold the weapon.

In the absence of a flagging system to ensure that those professionals interacting with a person are aware that the person holds a Firearms Licence it is difficult to be certain that full consideration is being given as to a person's continuing suitability to retain a weapon. As

such it is recommended that the Home Office pilot is evaluated and rolled out as soon as possible. [**Recommendation 4**]

Care Provision and Connectivity

The Review has identified that both Mrs A and Mr A had numerous interactions with Health and Care providers in the period within the scope of the review. The relevant IMRs assess that the services provided were timely and appropriate. Nothing in this review has indicated that this was not the case.

In the last few weeks of their lives there were over 30 visits to Mr and Mrs A's home by the Rapid Response Team, a pilot scheme to assist in transit from hospital to home, in addition to visits by the Community Matron Service and the GP practice.

Whilst these health centred agencies, offered significant support, connection or liaison between them, and the county centric, social care services, were less well defined. It is accepted that the approach to the couple was as separate individuals rather than also considering them as a couple with strong interdependencies.

The various Agencies provided appropriate services, though when viewed holistically they appear task driven in terms of the Agency delivering their statutory responsibilities on an individual, rather than the 'patient centric' ethos that is aspired to.

Lack of connection was evident in the early stages of the DHR process when initially the primary agencies were not fully sighted on the service being offered by the Rapid Response Team to Mr And Mrs A. Without this knowledge any handover of service provision, or coordination of such provision, is likely to be ineffective.

Access to the full Coroners file was a vital ingredient and essential in outlining the breadth of information, forming the foundation for the review.

Being able to visualise how these separate agencies fit together and complement one another would be helpful, but finding such a document was elusive. Without such visible and auditable reassurance, the question of duplication, gaps and confusion for service providers and users exist.

Care, readily offered and given, was focused on a needs led assessment and planned intervention based on each Agencies remit. Whilst this approach often encompassed more than individual needs and circumstances, a more holistic care assessment incorporating an awareness of what others were doing would assist in understanding Mr and Mrs A's environment and the significant life changing events they were experiencing The principle of promoting individual well-being as set out in Care Act 2014 Part 1 and Promoting integration of care and support with health services Care Act 2014 Section 3 should be taken forward. [**Recommendation 5**]

Such a picture will help in the development of a more informed and strategic, joint pathway of care. At the very least, the process would have ensured consultation with both, likely prompting reflection of how Mr and Mrs A saw their future. It may have assisted in repositioning or at least slowed down the fast moving plans of Mrs A, and the ultimate violent and sudden response of her husband.

Although agencies quote aims including collaborative working, integration and information sharing, in reality, these worthy and essential aspirations, were not achieved. Recording of information relating to the couple appears in different formats and on different data bases.

Information is therefore held in a manner that tends to reflect an agency's role and responsibilities rather than the service users holistic needs. This can make it difficult for those operationally delivering a service to be in possession of all relevant information. As a result it becomes even more difficult to draw together an overview of vulnerability.

The review identified that a number of Agencies had numerous contacts with Mrs A and Mr A, and there was communication between these Agencies. Indeed where the couple had declined services a GP visit was conducted to assess the capacity to make such decisions. This is not a case where significant omissions occurred, yet the purpose of this Review is to identify where improvements can be made.

Given the difficulty, and until we have developed a fully integrated information sharing and monitoring system, the identification and appointment of a case manager or key worker may well have improved communication across agencies.

An individual whose role included bringing the disconnected strands of information together may have established a wider ranging joint agency plan and facilitated a greater understanding of the options to Mr and Mrs A, including reassurance that their future held more than just "*horrible things in front of them*".

The introduction of the provisions Care Act 2014 should be seen as an opportunity to move in this direction and appropriate training to practitioners should be provided to include a holistic approach to the person's requirements. **[Recommendation 6]**

Risk Assessment and Sharing

Risk assessment appears at all levels and in itself, is well developed. However, assessments are focused on the individual agencies view of risk. Risk is often qualified by care agencies on an individual's capacity rather than wider issues of risk to others such as availability of a lethal weapon, impact of significant life changing issues or the effect or situation of their partner.

What is seen as low risk against the statutory responsibilities of one Agency may be seen as high risk for another.

For instance, a shotgun certificate holder suffering from worsening dementia, or whose partner, on whom they depend, has recently been diagnosed with a terminal illness, may well be seen as low risk for one agency, but differently by others.

Certainly the police and the carers attending the property may view the same information, if they were aware of it, with more concern, given their respective roles and responsibilities. Further, DASH, the established model for risk evaluation in domestic violence does not specifically incorporate significant stressful life changing events in its check list. Consideration should be given to including such events in the DASH model. [**Recommendation 7**]

It is important therefore, as improvements are made in consolidating data systems that sharing of information is not constrained or dependent on its risk classification. The

recommendation is that Agencies should, within legal guidelines, review their information sharing to ensure that they have not drifted into a position whereby, in the worst case, information is only shared when the holding Agency assess it as high risk. Information may be assessed as low risk but will still be relevant to the effective performance of partner Agencies. [**Recommendation 8]**

Key risk elements were appropriately identified by various agencies over the period covered by the review. They included possession of a lethal weapon and identification of significant life changing impacts. Issues affecting data recording, sharing, retrieval and analysis with no clear case manager, meant these were not easily carried forward, integrated or flagged for consideration at the time or later, within an Agency or identified as relevant to partner Agencies. The information may well have been there but was it easily accessible?

Liaison between the Health and Care providing agencies should be improved by providing a strategic pathway of care, coordinated through a single point of contact. There already exists a framework within Agencies to develop a coordinated plan, such as Care Plan Arrangements (CPA). There may be an opportunity to link current procedures. The provisions of the Care Act 2014, particularly sections 3 and 6 should drive a working group to establish guidance for Essex. [**Recommendation 9]**

If the case to identify and appoint a case manager was substantiated, at the moment, the only agency privy to the information may well be the GP, it would, by default, place the burden to adopt that role on them. A position which may not be seen either appropriate or most suitable.

It is acknowledged that national reviews examining information sharing regarding firearms are well advanced and the introduction of the Care Act 2014 will lead to improvements in coordination in the future.

Currently, the 'go to' most informed information system appears to be held by the GP. Even so, the ability for the GP to share the information is governed by client confidentiality. In the key area of firearm possession, other than in extreme circumstances outlined in the BMA's guidance on Firearms 2011, sharing is constrained unless the patient consents.
Unless an element is introduced requiring consent to share information as a prerequisite to the grant or renewal of a Firearms licence, it is difficult to see how, other than in extreme circumstances, any relevant information will come to the notice of interested agencies who can give a valid view on the continuing suitability of a person to hold a Licence. [**Recommendation 9**]

Without greater sharing of information the ability to prevent the use of lethal weapons in violent acts is restricted to a position much closer to the likely point of use; often this can result in the information only being shared after a tragic event.

Awareness of Domestic Abuse indicators

The definition of **Coercive behaviour** is: An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Whilst the review found that coercive behavior was not present in this relationship, it has identified that the Agencies involved with Mrs. A and Mr. A do have policies and procedures in place to ensure that staff are trained and aware of safeguarding issues, including Domestic Abuse.

There were instances however, such as the nature of guidance and the monitoring of contracts where agencies identified that improvement could be made.

Agencies have included activity in their action plans to ensure that appropriate training is provided to staff, this includes Anglian Community Enterprise updating their policy of safeguarding to include adult focused Domestic Abuse material as well as the existing child focused guidance; North East Essex Clinical Commissioning Group ensuring that NHS contracts are used to allow for safeguarding training to be monitored through performance indicators, and North Hill Medical Group ensuring that safeguarding training continues to be rolled out.

Whilst accepting that there is no supervisory responsibility for the Community Safety Partnership, it is recommended that they receive an update on compliance with mandatory safeguarding training from the relevant local Agencies at their meetings. [**Recommendation 10**]

The number of Agencies and staff engaged in providing services that impact on Domestic Abuse may lead to a lack of understanding on the roles and responsibilities of other Agencies. There will be an advantage in joining up some of the training that takes place to facilitate better understanding and contact between practitioners. [**Recommendation 11**]

CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

Conclusions

This was a tragic case. Mr. A's actions were violent, sudden, unexpected and out of character. The suspected murder of his wife is clear domestic violence. The review concluded that even if everyone having contact, or involved, with Mrs A and Mr A's case, were aware of the all the information, there was no evidence or indication to suggest such a violent and sudden end to their lives could be anticipated.

Examination of professional contact, provided through the IMRs, has not identified any evidence of a history of Domestic Abuse, nor do any of the interactions present as an indication of risk from Domestic Abuse.

The accounts of family and friends, whilst acknowledging that the couple enjoyed a private relationship, reinforce the picture of a loving couple who were happy in each other's company and were devoted to each other. These accounts were drawn from Police Records.
The broader context of the case has highlighted significant issues for consideration both strategically and operationally whilst acknowledging they may not have played a specific part in this case.

The review has identified two primary areas where it is believed that improvements will lead to a reduced risk of similar tragic incidents occurring in the future. These are access to firearms and integration of patient care; across these two strands are two further overarching themes of information sharing and training.

The first area is the accessibility of lethal weapons, the assessment of a person's suitability to hold such weapons must be a continuing process, which is a responsibility to be shared to a greater extent between Agencies than is presently the case.

Essex Police have done significant work in the area of Firearms Licences where there is an associated record of domestic abuse. 24 such licences have been revoked and a further 26 licences surrendered in the period from October 2013 to June 2014. This led to the seizure of 220 shotguns and other firearms. This and similar operations require as full an intelligence picture as possible.

To achieve this will require the sharing of information at lower thresholds. This will allow more Agencies to contribute to the assessment of a person's suitability. Any applicant for a Firearms Licence should be required to authorise the sharing of relevant information to any relevant Agency as a prerequisite to obtaining a Licence.

Home Office guidance on Firearms Licensing provides detail on medical conditions that would warrant notification to Police. The absence of Dementia in that guidance could result in insufficient consideration being given to the risk presented, as such it is recommended that reference to Dementia be included in the next update of that guidance.

The current Home Office pilot scheme on Firearms Licensing has introduced a requirement for a Licence holders GP to flag the patient record. This is welcomed. At present this pilot only affects a Licence at the renewal stage, and will mean that some licence holders are not readily identifiable for continuous assessment until 2019. It is recommended that notifications are done as soon as possible and do not wait until renewal.

The Inquest concluded that Mr A took his own life and Mrs A was unlawfully killed. The Coroner submitted a Regulation 28 Report (REPORT TO PREVENT FUTURE DEATHS) on 25th March 2015 to the Home Office in relation to GP's recording and reporting of Firearms Licenses which supports recommendation 1.

The second area where there are lessons to be learned is in the integration of patient care. The Review has not identified any deficiency in such care but in seeking to learn lessons for the future it became apparent that a more holistic view of what the recipient of services required would be helpful in reducing any stress and pressure felt.
The introduction of provisions within the Care Act 2014 will go some way towards addressing the lessons learned from this Review. The identification of a post holder to coordinate the care requirements of patients will lead to a position where the person is more supported to identify a care pathway, rather than be the mere recipient of a range of statutory services. This will also introduce a more holistic approach, ensuring that a person is not only seen in isolation as an individual.

In respect of overarching themes the Review identified that sharing of information is at risk of being constrained by the classifications of risk. The result of this is that information relevant to other Agencies is not always being passed, due to the holding Agency judging the facts low risk on their assessment.

The 'need to know' principle is not limited to restricting the sharing of information, but where appropriate should also be applied to ensure that other Agencies have all relevant information on which to base their own professional assessments.

Whilst certain defined life changing situations are included within the DASH risk assessment tool, the DHR panel did not consider that it would capture a significant life changing event

as stressful as the circumstances in this case. Consideration should be given to slightly amending the tool to allow it to consider such events.

Education and training in respect of safeguarding and specifically Domestic Abuse was evidenced in the IMRs received, individual actions have been raised to ensure that this continues. In addition it would be beneficial for the CSP to receive regular confirmation that any agreed mandatory training is being delivered within accepted target ranges.

In an area of multi-agency service provision, where a number of Agencies are working to achieve safeguarding, there may also be some benefit in bringing practitioners together for elements of any required training. This would allow a broader base within each Agency to gain some understanding of the roles, responsibilities and procedures within other Agencies operating in North East Essex.

There was no evidence presented which suggested any equality or diversity issues in relation to age, gender or any of the other protected characteristics. However, this is an issue that should be considered in relation to any care pathway and access to services.

There are lessons to be learned. Independently the agencies involved have examined their role and have introduced or are introducing changes to processes and working practices for the future.

These will be further enhanced by the wider recommendations of this review.

Recommendations:

The following recommendations have been informed by the Independent Management Reviews. Agencies submitting IMR's have introduced their own local action plans details of which are included and compliment the Overview Report's Action Plan.

1. That Essex Police inform GPs of current firearms licence holders as soon as possible, requesting them to flag patient records, and do not wait to the licence renewal date. This recommendation should be considered nationally.

2. That the Home Office review and broaden the medical conditions within the Home Office Guidance on Firearms Licensing Law 2014 regarding psychiatric assessment, to specifically include consideration of Dementia.

3. A patient's GP should be notified of any assessment of risk completed in the course of a memory clinic appointment; this will allow the GP to have a more complete picture in assessing any required disclosure to Police in respect of the continuing suitability to hold a Firearm.

4. That the Home Office approved Firearms Licensing - Medical Pilot Scheme, which strengthens the grant and renewal process by notifying GPs that a patient holds a firearms licence and requiring that record to be flagged , be rolled out for adoption nationally.

5. The principle of promoting individual well-being as set out in Care Act 2014 Part 1 and Promoting integration of care and support with health services Care Act 2014 Section 3 should be taken forward. Care Act 2014 training should include material to

ensure that any care assessment broadens its focus to embraces an holistic approach which considers impact and effect of other family members and life changing situations.

6. Previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey

7. That the DASH template includes the impact of significant life changing events.

8. Agencies should, within legal guidelines, review their information sharing to ensure that they have not drifted into a position whereby, in the worst case, information is only shared when the holding Agency assess it as high risk. Information may be assessed as low risk but will still be relevant to the effective performance of partner Agencies.

9. Liaison and communication between the care providing agencies is improved by the provision of a strategic pathway of care, coordinated through a single point of contact or care manager to assist information gathering, analysis, assessment and sharing. There may be an opportunity to link current procedures. The provisions of the Care Act 2014, particularly sections 3 and 6 should drive a working group to establish guidance for Essex.

10. That it should be a prerequisite to the grant/renewal of a Firearms Licence that the applicant allow their GP to share relevant information to the holding of a Firearms Licence, with other agencies; which may otherwise fall within patient privilege.

11. Agencies should report to the Community Safety Partnership compliance rates with mandatory safeguarding training.

12. That the Colchester Community Safety Partnership organise a seminar to facilitate joint training and learning between Agencies in North East Essex on safeguarding and particularly their separate roles in preventing and addressing Domestic Abuse.

COLCHESTER COMMUNITY SAFETY PARTNERSHIP DOMESTIC HOMICIDE REVIEW PANEL CONCLUDING REPORT

INTRODUCTION

This Domestic Homicide Review seeks to understand the circumstances surrounding the tragic deaths of Mrs and Mr A who died on 24 May 2014.

All those involved in this review wish to extend their sympathy to the family and friends of Mr and Mrs A in what has been very difficult and painful circumstances.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). This DHR has been commissioned by Colchester Borough Council in line with the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

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 those lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims, their children and/or other relatives through improved intra and inter-agency working.

There is a statutory expectation that certain bodies will have regard to the Statutory Guidance for the Conduct of DHRs and that these bodies can be directed by the Secretary of State to participate in a review (section 9(2) of the Domestic Violence Crime and Victims Act 2004).

There is no legal sanction or power to enforce a request made by the Review Panel Chair or Overview Report Writer that an individual attend for an interview. A report will include reference to any gaps in the information available, as a consequence of any agency not sharing information for the review. In this instance all Agencies were fully compliant in sharing the information that they held.

The Domestic Homicide Review Chair wishes to thank the agencies involved and individuals working within them for their time, cooperation and commitment in contributing to this review.

The Chair for the Review was also the overview report writer. The guidance directs that the Chair and author should be an experienced individual who is not directly associated with any of the agencies involved.

The Chair is a retired senior police officer who commanded a Borough Police Division prior to working as a consultant for the Metropolitan Police and the Association of Chief Police Officers on Terrorism and Allied Matters. He has chaired a multi-agency Local Strategic Partnership and currently chairs the company board for the Colchester local community stadium. The Chair has no connection with agencies involved in the review.

The Chair was supported in the DHR by a panel that met on three occasions to agree the Panel membership; terms of reference; review the IMR's and additional reports and to endorse the overview report. Assistance was also provided independently by Andrew Slater, retired Detective Inspector, Metropolitan Police Service, whose experience as a Senior Investigating Officer involving Domestic Violence was invaluable.

The panel members were selected to bring a range of expertise and perspectives relevant to the circumstances of the review. In appointing to the panel, the Chair ensured there was no conflict of interest and that the panel members did not have direct line management responsibilities for workers who had been involved with Mr. or Mrs A.

The Chair greatly valued the commitment that the panel members brought to the review. The panel comprised:

David Murthwaite	Chair and overview report writer, independent consultant
Melanie Rundle	Community Initiatives Manager, Colchester Borough Council
Caroline Venables	Inspector Essex Police
Catriona Wheadon	Safeguarding Consultant Practitioner, Adult Operations Essex County Council
Vera Atkinson-Padmore	Operational Team Manager, Essex County Council
Lisa-Jayne Poynter	Safeguarding Adults Lead, Anglian Community Enterprise
Mel Arthey	Clinical Specialist, North Essex Partnership NHS University Foundation Trust
Jane Whitington	Safeguarding Adults Lead, NHS North East Essex Clinical Commissioning Group
Dr Claire Cooper	MBBS MRCGP - General Practitioner, North Hill Medical Group

Helen Edwardson	Acting Nurse Consultant for Older People and adult safeguarding, Colchester Hospital University Foundation NHS Trust.
Caroline Sexby	Head of Safeguarding, East of England Ambulance Service Trust.
Peter Watts	Director Care and Support Swan Avivo Housing

The agencies that contributed to the report and staff involved, have had the opportunity to review the draft report in relation to accuracy and to comment on any actual or potential criticism as it concerns them. Family members also had the opportunity to review and comment on the final draft.

This report is an anthology of information and facts from ten agencies, all of which were potential service providers or support agencies for Mr and Mrs A. They were the agencies who had records of contact with Mr. and Mrs A, and were relevant to the circumstances of the review.

None of the accounts provided bear a direct relation to the victim's death, the ten agencies providing information are:

Essex Police	Provided information on legislation, policy and procedure regarding shotgun licensing. Provided a chronology, factual summary, analysis and an Individual Management Review. Provided a copy, including all statements, of the Coroners File.
Essex County Council Adult Operations	Involved in social care requirements of both. Provided a chronology, summary and analysis in an Individual Management Review.
NHS North East Essex Clinical Commissioning Group	Responsible for commissioning agencies, provided a strategic review of their role in the Individual Management Review format.
Anglian Community Enterprises - Safeguarding Adults	Involvement in health care requirements of both, provided chronology, summary and analysis in an Individual Management Review.
North Essex Partnership NHS University Foundation Trust	Provided psychiatric assessment of Mr A. Provided a summary and analysis in an Individual Management Review.

Colchester Hospital University Foundation NHS Trust	Involved in health care requirements of both. Provided admission and attendance details, summary and analysis using the Individual Management Review format.
North Hill Medical Group - General Practice	Provided a detailed clinical chronology for both, summary and analysiss using the Individual Management Review format.
East of England Ambulance Service Trust	Responded to both. Provided a chronology and summary in the format of an Individual Management Review.
Swan Housing Group	Provided immediate post hospital and care and home safety support, to both. Provided an Individual Management Review report. Statements of Swan Housing Group Carers and supporting documents which remained part of the Coroners file as exhibits were also examined.
St Helena Hospice	Briefly involved as a result of Mrs A's diagnosis. A record of contact was provided.

A more detailed account of agencies involvement is contained later in the report.

INVOLVEMENT OF FAMILY AND OTHERS KNOWN TO MR AND MRS A

Mr. and Mrs. A had one child, a daughter. Now 56 years old Ms C suffers from severe learning difficulties and epilepsy, and is described as non-verbal in her communication. Mrs. A visited her daughter on her birthday and at Christmas.

She was seen by Officers in the presence of care home staff on Sunday 25th May 2014 and notified of her parent's death, she provided no response or understanding of the information provided.

The Panel agreed, given the circumstances, Ms C would not be asked to contribute to the review. Arrangements will be made however to make a copy of the Overview Report available to those caring for Ms C should it be appropriate and helpful in the future to share it with her.

Family relationships

Name	Relationship
Mrs F	Biological Niece to Mrs A
Ms C	Biological daughter to Mr and Mrs A
Ms S	Biological sister to Mr A
Mr B	Partner to Ms C sister in law.

After initial contact Ms S and Mrs. F indicated a preference that Mr B be considered the point of contact for the family regarding the review.

The family were consulted about the terms of reference for the review but declined any direct involvement. Contact was maintained through the families preferred point of contact. These arrangements were endorsed and supported by earlier family liaison arrangements.

Mr. and Mrs. A enjoyed a somewhat independent and isolated life style appearing content with limited contact. The couple are described as "*very much routine people and never went on holidays...Their life was their home - and they didn't like to leave it.*" A neighbour describes the couple as "unable *to do without each other*". Another friend describes them as "a *private couple but very much in love*". These accounts were drawn from Police Records.

REVIEW PANEL METHODOLOGY

The panel met on three occasions. They reviewed panel membership, agreed Terms of Reference and facilitated the provision of the IMRs; at a second meeting the Panel scrutinised the IMRs and additional reports; and at a final meeting the panel reviewed the draft Overview Report.

The panel worked to create an environment which enabled the debate and the information before it to be rigorously and intrusively tested. Seeking to ask the right question first time around.Questions that both Mr and Mrs A and their family would want asked.

The guidance that accompanied the Terms of Reference enforced the 'ask the right question first time around' principle to ensure the panel remained focused and IMR and report writers were equally robust and intrusive in their task. This enabled the panels analysis to be fully informed and able to focus on key themes relevant to the review.

The agreed Terms of Reference:

From June 2011 up to the death of Mr. and Mrs. A, establish the timeline of events and relevant actions of each agency, their inter-agency contact and the involvement of other people, e.g. family, friends

Examine all documentary records relevant to the timeline to enable an assessment of the efficiency and effectiveness of each contribution, whether all reasonable steps had been taken to manage the unfolding scenario and the role of any risk assessments

Assess the extent to which agencies followed relevant legislation, guidance, policy, procedure and recommended best practice emanating from formal reviews

To propose recommendations that may help to prevent a similar incident occurring and the further development of the way each agency works individually and in partnership.

In setting these Terms of Reference there was a working assumption that each agency would provide all relevant material along with full and frank commentary.

Guidance notes accompanied the Terms of Reference:

These notes are intended to assist each agency respond to the Terms of Reference. For ease of reading each paragraph refers to the numbered Terms of Reference;

1.Relevant knowledge would include such contacts as the Police; statutory and voluntary agencies contacted for support in connection with their care and mental ill-health.
Agencies with relevant knowledge of either before this time are asked to provide a brief synopsis of their involvement.

2.The quality and scope of actions, services and care provided by the agencies involved should be considered. The range and extent to which these were communicated.

3.The extent to which Mr. and Mrs. A's age and or mental assessment influenced the decision making of individuals and agencies involved.
The effectiveness of single or inter-agency communication and information sharing, in particular knowledge of Mr. A's possession of a shotgun or being a certificate holder, should be considered.
Previous Domestic Homicide Review findings should be considered.

4.To what extent are existing policies and procedures up to date and fit for purpose in assisting staff to practice effectively.
Issues regarding the possession of a shotgun should be highlighted.

With the exception of St Helena Hospice (where there was limited contact) those Agencies identified as having contact with Mr and Mrs A were asked to conduct Individual Management Reports, the aim of which is to:

Allow agencies to look openly and critically at individual and organisational practice and the context within which people were working to see whether the homicide indicates that changes could and should be made;
Identify how those changes will be brought about;
Identify examples of good practice within agencies.

These aims were the focus at the second meeting of the review panel where they examined and analysed the content of Individual Management Reports on the 2nd February 2015. The Panel specifically queried if the separate IMRs:

Covered all the facts as they were known;
Met the stated aim of IMR's;
Identified what each agency believed were the key issues and if they were soundly represented in action;
Identified any gaps or omissions.

The IMRs then provided the detail for this Overview Report, a draft of which was subject to scrutiny at the final panel meeting on the 10th March 2015.

THE FACTS

The circumstances of the homicide

On Saturday 24th May 2014 Police Officers found Mr. and Mrs. A dead at their home in Essex.

At 06:37 hours on Saturday 24th May 2014, a 999 telephone call was made to Essex Police by a man identifying himself as Mr. A and he provided his address. He informed the Police operator that he had just shot his wife and was going to shoot himself in the very near future.

Mr. A stated that he and his wife were,
'in love, enjoyed life but can now only see death and horrible things in front of them'.
When asked by the Police operator what had happened, he stated he was going to shoot himself and terminated the call. Attempts were made to re-contact the number but there was no reply. A Police Firearms team and an ambulance were then immediately dispatched to the address.

At 07:09 hours police officers entered the rear garden and found Mr. A's body lying on path directly outside the kitchen doorway situated to the rear of the property. He was lying on his back with a shotgun lying across his chest. He appeared deceased.

At 07:10 hours entry was gained to the property via the kitchen door by police officers and a search made of the downstairs rooms. Mrs. A was slumped in a 'chaise-lounge' chair in the living room with wounds consistent with being caused by a firearm.

Once the property was declared safe to enter, Ambulance crews were allowed inside and after examination paramedics confirmed the death of both Mr. A and Mrs. A.

Post mortem examinations were conducted on Sunday 25th May 2014 at Colchester Hospital the provisional cause of death in both cases was given to be shotgun wounds to the head.

No third party is being sought. An inquest was opened and adjourned on 28 May 2014. It is due to be reopened on 17 March 2015.

Background information

Mrs A was born in Burnham on Crouch, Essex and had one brother who is deceased as are both her parents.

She married Mr. A when she was 20 years old and gave birth to their only child Ms C in October 1957. Ms C was then diagnosed with epilepsy at six months old which caused severe learning disabilities and resulted in her being placed into social care a short time later where she continues to reside.

Mrs. A's only other known next of kin is her late brother's daughter, Mrs. F who also lives in Essex.

Mr. A was born in Maldon, Essex and has a sister Ms S who also lives in Essex.

Mr A and Mrs A had been married for nearly 60 years, Mr A, 82 and Mrs A, 78, had lived in their rural cottage for over 40 years. Although their home lacked some modern day amenities, washing machine, central heating, it was well cared for and maintained. They enjoyed a somewhat independent and isolated life style appearing content with limited contact with their relatives, even though the relatives lived within the county.

The couple are described as "very much routine people and never went on holidays...Their life was their home - and they didn't like to leave it." A neighbour describes the couple as “unable to do without each other". Another friend describes them as "a private couple but very much in love".

Over the last few years their health began to deteriorate. Mr A received treatment for bowel cancer in 2012 and he experienced delirium and the onset of dementia. This was of increasing concern to his wife especially when she was diagnosed, in early May 2014, with lung cancer. The prognosis, which gave her life expectancy of 6 to 9 months, appears to have been the catalyst for Mrs A to commence arrangements to leave their home and secure ongoing support for her and her husband by moving into care.

Prior to the 24th May 2014 there is no record, evidence or any indication of violence or other aspects of domestic abuse, at any time by either occupant of the household.

INVOLVEMENT WITH AGENCIES

There follows a description of Agencies involvement. Including key elements drawn from the Information Management Reports and other documentation.

Essex Police

The Independent Management Report (IMR) author was a retired detective with 30 years police experience including the role of Senior Investigating Officer. He had no direct involvement with Mr. or Mrs. A. The methodology used was researching and reviewing the records on relevant individuals using Police held databases/records and contact with various police departments and officers.

CONTEXTUAL INFORMATION

HANDLING OF DOMESTIC ABUSE INCIDENTS

Following a number of earlier domestic homicides, Domestic Abuse policy and procedure within Essex Police underwent review, resulting in significant changes.

The changes include:

- Prompt inputting of reports of domestic abuse onto the child and domestic abuse (PROtect) database, using nationally adopted DV/1 booklets.
- Initiation of the Domestic Abuse Intelligence Team within Force Control Room (FCR)
- FCR operators prevented from deferring reported incidents of Domestic Abuse
- Circulations of persons wanted for incidents of Domestic Abuse have to be entered
- onto PNC (Police National Computer) prior to an officer retiring from duty
- Formation of the Central Referral Unit (CRU) on 5thNovember 2012 based within the Public Protection Command, providing a central point of contact and intended to ensure accurate recording, grading and research into Domestic Abuse referrals and relevant information sharing in a timely way.
- Domestic Abuse Awareness (DASH) training to all Police officers and operational staff such as Customer Contact Advisors (CCA's), Force Control Room (FCR) and Crime Bureau staff; additionally since 11thOctober 2012 any member of police staff involved in victim contact or in a public protection decision-making role must also complete this training.

In September 2011 a facility was introduced within FCR (Police Force Command & Control Room) known as the Domestic Abuse Intelligence Team (DAIT), this consists of officers who upon receipt of reports of domestic abuse incidents, are responsible for researching police databases to update attending officers regarding past and on-going calls at the relevant address or involving known persons; then updating the STORM record. This function reverts to the responsibility of the FCR operator when there are no DAIT personnel on duty.

Since March 2012 Essex Police comprises three Local Policing Areas (LPA's) - South, North & West, each having a corresponding specialist Child Abuse Investigation Team (CAIT) and Domestic Abuse Safeguarding Team (DAST). Their line management form part of the HQ Crime & Public Protection Command, which is led by a Detective Chief Superintendent.

In November 2012 a Central Referral Unit (CRU) was formed, which is based at Police Headquarters. The DAST was re-aligned with the CRU. The CRU is a central point of contact for police officers and partner agencies. Its role is to ensure that domestic abuse incidents are accurately recorded, researched and risk assessed appropriately, ensuring necessary sharing with partners. All incidents assessed as being of high risk are, in addition, subject of more immediate contact, with the CRU to progress.

In August 2014 Domestic Abuse Investigation Teams Crime Units (Operation Juno) were set up across the Local Policing Areas. These teams will oversee all domestic abuse investigations and work alongside our partner agencies. This will help to ensure the force is able to give the best possible support for victims and a strong, coordinated response to those responsible.

There is a facility on Police command and control database (STORM) to flag addresses considered potentially noteworthy and/or repeatedly requiring Police attendance particularly for incidents of a potentially violent nature.

Officers attending domestic abuse incidents are advised to take positive action and deal with offenders, complete a DV/1 booklet before going off duty and ensure its timely delivery to the CRU; this includes conducting a DASH risk assessment (Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification).

Following completion the DV/1 report must be checked and authorised by a DASH trained supervisor, who will quality assure the content; agree the risk assessment, and where appropriate consider referrals e.g. Social Care/CAIT. If the risk assessment is either 'Medium' or 'High', the officer completing it must discuss the grading with a Domestic Abuse Safeguarding Officer (DASO) within the CRU.

If assessed as Standard or Medium risk, the case is handled and managed by the CRU, ensuring that details are accurately recorded, researched and risk assessed.

If assessed Medium risk, a Domestic Abuse Safeguarding Officer (DASO) makes any referrals considered necessary to partner agencies and will also send a letter to victims offering advice and support. On occasions this will also include a phone call to the victim.

If the risk is assessed as High, the case will be referred to, then handled and managed by the Central Referral Unit; during office hours (8am to 10pm) the incident must be highlighted to a nominated DAST safeguarding officer. A DASO will contact the victim that day by phone. If no contact made after several attempts, officers will be dispatched to the address to check the victim's welfare.

Out of hours safeguarding issues immediately following an incident, and prior to a DAST safeguarding officer being nominated, must be dealt with by attending officers and notified to the local Response duty inspector.

A Safety Plan is discussed with the victim. A marker is also placed onto STORM flagging the address as having previous domestic abuse incidents. An automatic referral is made to the next MARAC (Multi Agency Risk Assessment Conference), these are held monthly and Detective Sergeants attend on behalf of the Police. The MARAC is a multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic abuse between Criminal Justice, Social Care, Health, housing providers, IDVA's (Independent

Domestic Violence Advocates) as well as other specialists from the statutory and voluntary sector.

An email is sent to the PPU Detective Inspector notifying of a High Risk domestic abuse case, and also to the Inspector managing the local Neighbourhood Policing Team (NPT) to raise awareness.

If an offender is charged/bailed or to be arrested a referral is made to an Independent Domestic Violence Adviser (IDVA) who is part of the Victim Support System. IDVAs are trained specialists who provide a service to victims who are at high risk of harm from intimate partners, ex-partners or family members, with the aim of securing their safety and the safety of their children. Serving as a victim's primary point of contact.

In addition to the MARAC there is a further process within Essex Police called 'Risk Management Conferences'; these are chaired by the Public Protection Unit DCI or DI and attended by DAST Sergeants, Dangerous Offender Sergeants, and other relevant post holders. Each Local Policing Area is required to hold these meetings monthly. Amongst other items on the agenda will be domestic abuse cases focusing on risk managing persons identified as posing risk in such incidents. Essentially these are seen as a link to the MARAC and a counterpart for dealing with the persons regarded as the cause or responsible for 'High' risk domestic problems.

Crime File is the Essex Police database used for recording and managing all reported crime. This system which facilitates the recording of all stages of an investigation with various localised tiers of supervision. Where timed supervisory and management reviews are not completed, red 'flags' appear on the system.

In regard to domestic abuse related crimes, the following applies:

High Risk cases must be updated every 24 hours and be subject to review by a supervisor every 48 hours.

Medium Risk cases must be updated every 4 days, and supervisor reviewed every 7 days.

Standard Risk cases must be updated every 6 days and supervisor reviewed every 14 days.

In addition to the above, where a suspect for a Standard or Medium Risk Domestic Abuse Investigation is outstanding for 28 days a review must be conducted by a Detective Inspector.

FIREARMS LICENCING

Mr. A was the holder of a shotgun certificate so it is useful to provide some contextual information in relation to the grant and renewal of firearms certificates by Essex Police.

Firearms licensing is governed by Home Office Firearms Guidelines 2014, the Firearms Security Handbook 2005 and the Firearms Act 1968.

The Firearms, Shotgun and Explosive Licensing section (FSEL) of Essex Police is based at Police Headquarters, Chelmsford, Essex. This department manages the issue, renewal and variation of around 5,000 licences annually. There are 24500 licence holders within the Essex Police district.

They provide specialist support to members of the public, Firearms Enquiry Officers, Police Officers and the Home Office. They maintain an up-to-date and accurate computerised record of certificate holders held within the PNC linked, National Firearms Licensing Management System (NFLMS) database.

The administration office is supported by 9 Firearms Enquiry Officers (FEO) who are supervised by a Senior Firearms Enquiry Officer, all are Police Staff employees. The FEO's are responsible for undertaking detailed enquiries relating to the grant, renewal or variation of all firearms certificates within the Essex Police district. This includes the interview of applicants and their referees to ensure suitability and the inspection of security arrangements around the storage of the weapon(s).

A shotgun certificate is now valid for a period of 5 years but prior to 1996 it was renewed every 3 years. A licence can be revoked by the police at any time and the weapons and ammunition seized.

Where Essex Police attend a domestic abuse incident which involves a firearms or shotgun certificate holder, the weapons, ammunition and certificates are seized and removed from the premises as a matter of course at the time officers attend the incident.

An application to Essex Police for the grant or renewal of a shotgun certificate is made on a Firearms form 201, within the application the applicant must answer questions relating to their general health, and they have to include details of their GP. They sign a declaration within the application giving Essex Police permission to approach the GP to obtain factual details of their medical history.

Following receipt of an application, intelligence and criminal records checks are conducted by FSEL staff, the results of which are recorded and the file is passed to a Firearms Enquiry Officer (FEO) to arrange a home visit.

During the home visit the FEO questions the applicant relating to the applicant's general attitude and responsibility around firearms, the type of weapons possessed, the security arrangements around the weapon and ammunition and where the weapon is likely to be used, i.e. on their own land or other land with the owner's permission. In addition, if the applicant is over 70 years of age the FEO must comment upon the applicant's mental and physical fitness.

Guidance to the FEO states that 'if the referee or counter signatory is different from the previous applications the reason for this change should be obtained from the applicant. The referee/counter signatory should be contacted to ascertain if they were asked to be a referee/counter signatory by the applicant and if they refused the reasons must be obtained and a report giving details attached'.

Upon issue of a shotgun certificate the holder is entitled to possess any amount of weapons and ammunition. Once the certificate is granted Essex Police send a letter to the holders GP. The letter contains details relating to an information sharing agreement between the Police and the British Medical Association and relates to disclosure of information. It informs the GP that a certificate has been issued and requests that if the GP has specific concerns

over the safety of the applicant or any person, then they are requested to make the concerns known to the police in order that they may be considered, but that the ultimate decision on granting a certificate remains with the police.

Essex Police has recognised that over the period of 5 years a person's health or mental well-being may deteriorate and that, as an organisation, the Police cannot adequately assess a person's continuing suitability to hold a firearm or shot gun without up to date medical information.

Therefore since 1st September 2014 Essex Police have taken part in a Home Office approved Firearms Licensing- Medical Pilot Scheme where GP's are written to at the application or renewal stage.

GP's are asked to place an 'alert flag' on patient records showing the patient to be the holder of a firearms/shotgun certificate. This allows GP's to be more vigilant when treating patients who are firearms/shotgun certificate holders and allows them to highlight any concerns to the police. The GP could also encourage patients who are certificate holders to self-report medical issue to police.

The last renewal date for the shotgun certificate in respect of Mr. A was in 2011 therefore he would not have been included in this pilot scheme until his next renewal which would have been 2016.

The Review Panel recommend that Essex Police consider contacting GP's as soon as practicable in respect of Licence holders, and do not automatically wait until the renewal date.

ANALYSIS OF INVOLVEMENT

Save for the critical incident in May 2014 the only contact Essex Police had with the victim and perpetrator within the scope of the review was in September 2011 when they were visited by a Firearm Enquiry Officer at their home in connection with an application to renew a shotgun certificate.

At the time of the visit Mr. A presented as a man who was both mentally and physically alert and there was nothing to suggest that his shotgun certificate should not be granted.

There would appear to be one minor deviation in Essex Police policy in that if enquiries were made with Mr. A regarding the change in counter signatory from his previous application then these were not recorded, and there is no record to show if follow on enquiries were made with the previous counter signatory in this regard. Attempts were made by the IMR author to contact the previous counter signatory without success.

The Review Panel considered this point and in view of the other evidence existing at the time in respect of the suitability of Mr. A to hold a shotgun certificate it is believed that any additional steps to trace and contact the previous counter signatory would not substantially affect the outcome.

The Panel felt the minor deviation in policy would also not substantially affect the outcome of this case though its disclosure should initiate action by Essex Police to prevent similar omissions.

EFFECTIVE PRACTICE AND LESSONS LEARNT

Since 1st September 2014 Essex Police have taken part in a Home Office approved Firearms Licensing- Medical Pilot Scheme where GP's are written to at the application or renewal stage. This review recognises the importance of this pilot scheme and will make a recommendation that Essex Police progress their liaison with the Home Office in an effort to have this scheme adopted nationally and a formal information sharing agreement put in place.

Essex Police have just completed Operation Wishbone, a review into Domestic Abuse incidents within the Essex Police area where the perpetrator was the holder of a firearms licence and weapons. All 24500 licence holders were the subject of the review which resulted in various outcomes including the seizure of 220 shotguns and other firearms, as well as the surrender or revocation of 50 firearms licences. The review considers this operation as Good Practice for adoption nationally.

The detailed changes that have been introduced in respect of Domestic abuse investigations have been listed earlier in this section of the report, in addition Essex Police currently run Operation Shield.

The Operation utilises a weekly Recency, Frequency and Gravity (RFG) system to identify Domestic Abuse perpetrators who are actively offending or not responding to statutory powers. Operation Shield seeks to proactively target the very highest risk perpetrators, utilising every tactic currently available.

The operation is centrally-governed through the Police Crime and Public Protection Command and is managed by a dedicated coordinator. The primary function of this coordinator is to provide local policing areas (LPAs) with timely and relevant intelligence packages, to liaise with partner agencies, to construct initial tactical plans and to provide on-going guidance to front line staff.

In 2014 in conjunction with Essex County Council the Police launched '*Standing Together*' against domestic abuse campaign which was the largest ever Essex wide domestic abuse campaign.

The introduction of this initiative was timed to coincide with the summer months and in particular the World Cup football tournament. Information was provided (written and social media) as to how Essex Police and partners can help victims and survivors to leave an abusive relationship or how to stay safe within one.

RECOMMENDATIONS WITHIN THE IMR

It is recommended that all Firearms Enquiry Officers are reminded that where there is a change in referee/counter signatory from a previous application then the reason for the change should be obtained from the applicant. The referee/counter signatory on the previous application should be contacted to ascertain if they have been asked to be a referee and refused and if they refused, the reasons must be obtained and recorded.

Having taken part in a Home Office approved Firearms Licensing- Medical Pilot Scheme regarding the renewal of Firearms Licences this review recommends that Essex Police progress their liaison with the Home Office in an effort to have this scheme adopted nationally and a formal information sharing agreement put in place.

Essex County Council - Adult Operations

The IMR author is a Safeguarding Consultant Practitioner and has no line management responsibilities for any of the individual functions or staff from Essex County Council (ECC) Adult Operations who had involvement with Mr. or Mrs. A. The author had no direct involvement with Mr. or Mrs. A.

The methodology used was a search of databases and recording systems held by ECC Adult Operations for the personal details of Mr. A and Mrs. A; perusal of past case-lists for Colchester MARAC (which author of the IMR attends in the current role of Safeguarding Consultant Practitioner); the compilation of a chronolator from the personal records held; an interview with the staff member involved in assessing Mr. A for Virtual Ward and the response to questions sent by e-mail to the staff member from the Hospital Assessment Team involved in carrying out a Community Care Assessment of Mrs. A on 19.5.14. Virtual Ward is an initiative aimed at integration across health and social agencies to keep people with multiple needs out of hospital and in their own homes.

CONTEXTUAL INFORMATION

Adult Operations is responsible for delivering Essex County Council's statutory duties for looking after the county's vulnerable adults. This means offering appropriate assessments, reviews, safeguarding and care to meet identified needs of residents. The function aims to promote independence through enablement and prevention.

DOMESTIC ABUSE

The Panel concluded that coercive behaviour was not present in this relationship, There are no reported incidents of domestic abuse recorded for either Mrs. A or Mr. A. on ECC Adult Operations records. Previous MARAC case-lists for Colchester MARAC have been checked and no record was found of either party being referred to, or known to MARAC.

In ECC Domestic Abuse training is commissioned through Essex Safeguarding Adults Board. Adult Operations

Practitioners have both e- learning and face to face learning available to them on the subject of Domestic Abuse. There is also training available in respect of MARAC and DASH risk assessment.

ECC Adult Operations participate in the twice monthly MARACs in each locality of the County. Safeguarding Consultant Practitioners provide information to the MARAC regarding any known interventions that Adult Services have regarding adult victims or perpetrators. Adult operations practitioners are encouraged to attend the MARAC both as observers and where appropriate to present cases where they are involved.

SUMMARY OF AGENCIES INTERVENTION

The first recorded contact for the ECC adult operations with Mrs. A was on 25th April 2014 and the last was on 19th May 2014.

The first recorded contact that ECC Adult operations had with Mr. A was on 17th August 2012 and the last was on 15th May 2014. After the first contact with Mr. A there is a period of 16 months when there was no recorded referrals made for or any recorded involvement of Adult Operations with either Mrs. A or Mr. A.

Mrs. A had contact with the following areas of ECC Adult Operations:

Telephone call to Customer Care Centre on 25th April 2014 regarding her husband's needs whilst Mrs. A was in hospital. The outcome was to call Mrs. A back for an update on 28th April 2014.

Telephone call to Customer Care Centre on 28th April 2014. Outcome for Mr. A to be re-visited and re-assessed.

Telephone call to Customer Care Centre on 1st May 2014. Advice and information provided then no further action required.

Hospital Assessment Team 19th May 2014. Outcome, initial assessment of Mrs. A, advice and information provided and meals on wheels arranged.
A referral was made for a Carers Assessment of Mrs. A to Older Peoples Community Team on 20th may 2014. This task was allocated to a member of this team for week commencing 26th May 2014.

Mr. A had contact with the following areas of ECC Adult Operations:
Hospital Assessment Team, whilst Mr. A was in hospital, outcome was advice and information given, prior to his self- discharge home on 17th August 2012.

Crisis Response Service home visit to Mr. A undertaken on 17th August 2012 and meals on wheels provided as a result.

Virtual Ward carried out a face to face assessment of Mr. A in his home on 26th April 2014 (this was whilst Mrs. A was hospitalised for treatment). Outcome of this visit was no further action as both Mr. And Mrs. A felt he did not need any further support whilst his wife was in hospital.

Telephone call to Customer care centre on 8th May 2014. No further action required.

ANALYSIS OF INVOLVEMENT

From the information gleaned the author of the IMR formed the following impressions of Mr. A and Mrs. A's situation. Their home has been described by practitioners as an old, period cottage, in a fairly remote location. The cottage was not modernised and Mr. and Mrs. A had no access to certain amenities e.g. washing machine or central heating .They also has limited access to certain community amenities e.g. Mrs. A stated there was no launderette nearby and the distance of their cottage from pub, shops etc. necessitated the use of their car to access these.

Mr. and Mrs. A also appear to have been quite socially isolated. The assessments do not mention contact or support from relatives, friends or neighbours, however an exception to this was the willingness of some neighbours to make telephone calls to Mr. A to check on his welfare, whilst his wife was in hospital.

Prior to June 2012 Adult Operations had no knowledge of or involvement with either Mrs. A or Mrs. A. There is no evidence of any safeguarding concerns being raised for either Mrs. or Mr. A. There were no reported concerns relating to any domestic abuse or violence involving either Mrs. or Mr. A.

ECC first contact with Mr. A occurred on 17th August 2012, due to Mr. A discharging himself from hospital against medical advice and without the opportunity for an assessment of his needs to take place. A visit took place at his home by the Crisis Response Team, on the same day, to ensure that he was able to meet his needs and offer advice on what services support were available.

There was no record of needs or circumstances of Mrs. A at this time. The visit by Crisis Response resulted in meals on wheels being provided but no further action as Mr. A felt he could meet his needs, and declined any further assistance.

Meals on wheels was discontinued at some point in 2012 but it is unclear whether this was by Mr. and Mrs. A, or by ECC. There is then a period of 16 months where there are no recorded contacts or involvement with Adult social care for either Mr. or Mrs. A.

The first recorded contact with Mrs. A was when she was hospitalised on 22nd April 2014 with chest pains. It was noted that Mrs. A was the informal carer for her husband. Whilst Mrs. A was in hospital she was contacted by Customer care ECC to gain a clearer picture of what support her husband might require at home. Mrs. A described Mr. A as having '*memory problems*'

Contact with Mr. A was made by the Virtual Ward who made a home visit to him on 28th April 2014 to ascertain how he was managing whilst his wife (and informal carer) was hospitalised. The information in the Virtual ward assessment suggests that Mr. A had good insight into the effect of his dementia on his memory and that he was managing to meet his needs whist his wife was in hospital without any additional support or services.

Mrs. A appears to have discharged herself home without any prior assessment on 30th April 2014 and to have remained home for 5days. Mrs. A was re-admitted to hospital on 6th may 2014. On this second hospital admission Mrs. A was diagnosed with lung cancer. She was aware of the diagnosis and had been offered chemotherapy.

A community care assessment of Mrs. A's needs took place on 19th May 2014 before her discharge home. She was offered a Carers assessment and declined this. She did agree to referral to the Older Persons Team NE for a Carers Assessment to take place at some time in the future. Meals on Wheels was commissioned through ECC for Mr. and Mrs. A and started on 20th May 2014.

During Adult Operations involvement with Mrs. and Mr. A no doubts were raised by social care practitioners regarding their mental capacity to make informed decisions regarding their day to day care and needs. This includes their decisions to decline assessments and services /support offered to them. It is noted that this view was also informed by information provided by other professionals i.e. home visit by their GP to Mr. A on 15th May 2014 stating G.Ps opinion that *'on balance he(Mr. A) is able to make decisions for himself*'

Throughout Mrs. and Mr. A's contact with Adult Operations, the IMR author considered that they both appeared to have remained ambivalent as to whether they needed or wished to consider services or support commissioned via Social care. Mr. A declined an assessment

of his needs on several occasions. Both Mr. and Mrs. A made contact with customer care on several occasions but subsequently declined either assessments or services. During her first hospital admission Mrs. A initially agreed to meals on wheels being commenced, but then changed her mind prior to discharging herself home, stating that she thought it was better to '*leave things as they were'.*

Apart from general advice and information the only services and support which were accepted by Mr. and Mrs. A via Adult Operations were:

- Meals on wheels for a short period in 2012
- Meals on wheels commissioned by the hospital assessment team on 20th may 2014
- Referral for a Carers Assessment in respect of Mrs. A to Old Peoples Community, made on 20th May 2014.

The IMR author assessed that there was no evidence in ECC Adult Operations interventions with Mrs. and Mr. A of any:

- domestic abuse in Mrs. and Mr. A's relationship,
- breakdown or stress in their relationship,
- any intention of Mrs. or Mr. A ending their own lives.

The IMR concluded that the deaths of Mrs. A and the Mr. A were not events which could have been predicted by the information available to ECC Adult Operations or prevented through any interventions by ECC Adult Operations. This is a conclusion supported by the Review Panel.

EFFECTIVE PRACTICE AND LESSONS LEARNT

ECC Adult Operations interventions with Mr. and Mrs. A in response to referrals were timely and resulted in community care assessments of their needs being offered.

Throughout Adult Operations interventions with Mr. and Mrs. A their rights to decline both assessments and services and make informed decisions were respected. There was no evidence to suggest that either person lacked mental capacity to make decisions regarding their needs or support.

Advice on universal services, care services and how to contact social care for further information or future assistance were provided. This is evidenced by the fact that Mr. and Mrs. A both contacted care services.

Information Systems Information recording and retrieval

The IMR author found that compiling the IMR necessitated a search of different databases this highlighted the following difficulties:

It was very difficult to gain a complete picture of either Mrs. or Mr. A as information was recorded in many different parts of different databases. Retrieving information is a very time consuming process which social care practitioners are unlikely to have time to complete.

There is ambiguity regarding which database certain information should be recorded on and in which field. Leading to inconsistent recording.

There were errors and omissions in some recordings e.g. Information regarding the deaths of Mrs. A and Mr. A are recorded on Mr. A's records but not recorded on Mrs. A's record.

Practitioners operating in the field do not even have access to these databases to inform their interventions.

Work is already in hand to replace the two current databases used by ECC Adult Operations with one new database, MOSAIC. This will hopefully centralise, simplify and improve the efficiency of recording accessing and retrieving relevant information regarding ECC customers. However once access to information is improved it is important that it is channelled to effective use.

Carers Rights and Carers Assessments

Mrs. A was acknowledged and recorded as an informal carer for her husband since 25th April 2014. The reliance of Mr. A on his wife for emotional support and possibly advice is indicated by his 2-3 times a day telephone calls to his wife and his daily visits to her whilst she was in hospital.

Informal carers have rights to an assessment of their own needs either as a joint assessment with the person they provide care for or as a separate assessment of their own needs irrespective of whether the person they are caring for has had an assessment of their own needs. (Carers and Disabled Persons Act 2000) Social Services have a duty to inform carers of their right to an assessment (Carers Equal Opportunities Act 2004).

From the start of Adult Operations interventions with Mr. And Mrs. A there appears to have been an emphasis on assessing and meeting the needs of Mr. A as a cared for person, rather than offering Mrs. A a separate assessment of her own needs as a carer. It was the IMR author's view that there were earlier missed opportunities by Social Care Direct to offer a Carers Assessment to Mrs. A.

Practitioners involved in the Community Care assessments of Mr. And Mrs. A had both received training regarding Carers (Carers Assessments-Getting it Right and Our offer to Unpaid Carers).

Mrs. A was finally offered a Carers Assessment during her period of hospitalisation on 19th May 2014 which was declined but she accepted the offer of a referral being made to the Older Persons team for a Carers Assessment at later date. Unfortunately Mrs. A was killed before this assessment could take place.

RECOMMENDATIONS WITHIN THE IMR

Replacement of databases

Work is completed to replace the two current databases used by ECC Adult Operations with one new database MOSAIC. This will hopefully centralise, simplify and improve the efficiency of recording accessing and retrieving relevant information regarding ECC customers.

Provisions for Carers in Care Act 2014

The previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey.

North East Essex Clinical Commissioning Group

The IMR author is Adult Safeguarding Lead and has 24 years clinical nursing practice in the field of learning disabilities. The North East Essex Clinical Commissioning Group (NEECCG) commissions services and in particular Swan Housing Group's Rapid Response Team, who visited Mr. and Mrs. A in the days leading up to their deaths.
The author had not had any direct involvement with Mr. or Mrs. A or any direct involvement with Swan and their staff.

The focus of the IMR was to test the existing contractual or service level agreements in place between the commissioning group and Swan Housing Group, the service provider. The methodology used was to examine and review the documents and agreements with Swan Housing Group and in particular the Rapid Response Team, to ensure expectations were met.

CONTEXTUAL INFORMATION

North East Essex CCG is responsible for commissioning the majority of health services for the people who live in the areas covered by Colchester Borough Council and Tendring District Council.

Over the next 5 years, the CCG's commissioning approach will evolve from one that commissions for services and pathways, to one that commissions for people's multiple health and social care needs. As part of this, the CCG is developing an outcome based commissioning approach that allows patient-reported outcomes and quality outcomes to be measured and linked to contracting mechanisms.

In May 2014 NEECCG were commissioning a pilot for the hospital to home, rapid response service, from Swan Housing Association in partnership with Vivo Support Limited, which is a subsidiary company of Swan Housing.

Aims and objectives of the service

The Rapid Response Service scheme aimed to facilitate a swift and safe discharge from hospital for older people by ensuring their home environment is safe and ready for their return. The service also incorporates the provision of minor adaptation equipment, basic provision of shopping, prescription collection, ensuring utilities are operational and adequately charged, risk assessment for trips and falls, access to welfare services and signposting to other support agencies.

Service description/care pathway

Referrals into the service will come from a number of existing services, mainly from community nursing teams, GPs, ambulance rapid response car and acute providers.

At day 4 of the 6 day maximum package, a further assessment will be undertaken by Hospital to Home rapid Response Service to determine the patient's ability to regain independence within the 6 day period.
Where a patient has not been made fully independent and will require on-going social care support to remain at home, the original referrer will, where appropriate, pass the person to the full reablement Service. Where a patient is not eligible for the reablement service and has not been made fully independent the original referrer will, where appropriate, pass the person onto ECC Social Care Direct for on-going social care. The intention always being to maximise the person's independence and to minimise the need for on-going social care support.

The identified Key Health Worker, in this case the GP, will be responsible for ensuring all health needs are met in partnership with rapid response carers.

On discharging patients from the service, Hospital to Home Rapid Response Service will provide the referrer/key worker with discharge documentation identifying the support given and the decision criteria used in completing the service provision. The discharge letter must be provided within 24 hours of discharge.

ANALYSIS OF INVOLVEMENT

NEECCG commission the services of many of the provider Agencies that have been involved in this particular DHR. The DHR Review panel chair asked that for the purpose of this DHR the IMR author focused on the CCG's contractual arrangements with Swan.

At the time within the period of the DHR Terms of Reference, in particular May 2014, the Swan rapid response team service was not under a Standard National Health Service (NHS) contract but had a defined service specification due to its 'pilot' status. The CCG have analysed the service specification and are assured that the specification was robust and fit for purpose. Another added assurance was that the service specification had service standards incorporated into it.

Below are certain areas that have been highlighted.

Monitoring of the service

At the time of the incident in May 2014 the service was being monitored by the Head of Urgent care whose title then was Business Delivery Manager. Monthly reports on the whole Swan service specification were being sent through to the Business Delivery Manager and no significant concerns had been noted.

At that time the Quality team of the CCG were not involved in the monitoring of the contract. The links between business managers and the quality team were not as well developed as it is currently. All teams within the CCG now work much more collaboratively to ensure the quality perspective is now incorporated into each new business case and the procurement process of new services.

Reporting on deteriorating patients

There is a feedback requirement within the specification. The service specification highlights that it is expected that whoever medically assesses the patient will remain the key health worker to ensure continuity of care. In this case the referrer was the GP so they would have been the significant health worker for any of the Swan staff to feedback to if they observed or had concerns re deterioration of the couple.

To ensure there is continuity of care and monitoring the service specification also states that if the patient has not been discharged from the service by day 4 a further assessment will be undertaken. This will be done jointly by the key health worker and a member of the rapid response team to assess what level of care is required ongoing.

Safeguarding practices

The contract specification contains service standards which require providers to have policies and procedures in place for safeguarding. All staff are required to be trained in safeguarding of vulnerable adults. This includes conforming and following the Southend, Essex and Thurrock (SET) safeguarding guidelines.

The SET safeguarding guidelines include the different types of abuse and their possible indicators.

The guidelines clearly advise staff via flowcharts on what actions to take in safeguarding situations. This includes the responsibility of staff to notify their manager or nominated senior person on duty as soon as possible of any safeguarding concerns. There was also an expectation that Swan would have their own internal procedures for escalating concerns in potential safeguarding situations.

There is also a section on domestic violence and abuse with examples and risk assessment flow charts and guidance.

The risk assessment checklist is designed to prompt staff to identify immediate risks that need to be minimised and managed. If the worker identifies that there is a possible domestic abuse situation then they can complete a Domestic Abuse, Stalking and Harassment, Honour based violence (DASH) checklist. If a high risk is identified consideration must be made of police involvement and a referral to MARAC (Multi agency risk assessment conference)

NEECCG were therefore assured that safeguarding and escalation of concerns were included in the service specification with Swan.

At the time of the incident in May 2014 because the service specification was handled differently to a Standard NHS contract there were no key performance indicators (KPI's) included relating to safeguarding. This would have allowed another level of assurance. There was no monitoring of the numbers of staff trained at that time.

This is something that has been identified as an area of improvement and has now been addressed through the service now being under the NHS standard contract.

In the current contract Swan must achieve the threshold level that 95% of all staff as a minimum has completed safeguarding adult training. If the KPI's are not achieved the service is required to provide an exception report as to the reasons for not achieving this and a remedial action and trajectory is agreed with the provider.

Serious Incidents

Serious incidents (SIs) in healthcare are uncommon but when they occur the National Health Service (NHS) has a responsibility to ensure that there are systematic measures in place for safeguarding people. This includes the responsibility to report, investigate and learn from the incidents to minimise the risk of reoccurrence.

NEECCG are responsible for holding to account commissioned providers with compliance with the NEECCG serious incident management policy which follows the NHS Commissioning Boards Serious Incident Framework (2013). The CCG quality team assumes responsibility for the overall management of SI's.

Swan did not raise the incident as a serious incident to the NEECCG. At the time of the incident in May 2014 Swan was not under a standard NHS contract so may not have been aware that they must comply with the NHS serious incident framework.

EFFECTIVE PRACTICE AND LESSONS LEARNT

The Swan service at the time of the incident was not subject to the same rigour of monitoring and scrutiny as other commissioned services as it was a pilot scheme.
Key performance indicators on safeguarding training were not included in the pilot project.
The links between business managers, contracts and the quality team were not well developed at the time of the incident.

RECOMMENDATIONS WITHIN THE IMR

Future short term, pilot projects should be commissioned via a standard NHS contract.

All pilot or short term projects must have a requirement to comply with specific key performance indicators (KPI) on safeguarding training.

North East Essex Clinical Commissioning Group contracting team, business managers and quality team which incorporates the safeguarding team needs to collaboratively review and monitor contracts.

Anglian Community Enterprises

The IMR author is the Safeguarding Adults Lead. Previously Lead for Community Nursing Colchester until the beginning of April 2014. Whilst in this role managed the Community Matron service for Colchester who have been identified as providing care to Mr. A on the 29th April 2014. The author was however, not in this role at the time of this intervention and had no previous involvement with Mr. or Mrs. A or their family. Neither had she line managed the Community matron involved in the case as she started working for the team after the author had moved on to her new role in Adult safeguarding.
The methodology used in constructing the IMR included:

- A review of the clinical records dating back to 2011.

- Review of available data relevant to service specification and referral criteria.
- Interviews/ meetings/ correspondence with staff.
- Consultation with line managers on clinical assessment and processes within the ACE services involved.
- Review of case management systems.
- Information collated during the DHR panel meetings.

Consideration was been given to the following policies and procedures.

- Data protection policy
- Risk assessment policy
- Clinical Supervision policy
- Mandatory safeguarding supervision policy
- The national competency framework for safeguarding adults
- SET training strategy for safeguarding adults
- Equality and diversity policy
- Adult safeguarding policy.
- Consent Policy
- Information governance policy
- Safeguarding Children and Young People Guidance No 4: Guidance for ACE staff on identification, prevention and action to be taken in response to domestic abuse

CONTEXTUAL INFORMATION

Overview of ACE

Anglian Community Enterprise (ACE) is a Community Interest Company, limited by shares and employee owned. ACE was launched on 1st January 2011 as a new Social Enterprise. Before this, they were North East Essex Provider Services.

The separation from NHS North East Essex came in response to the Transforming Community Service Agenda, which required the PCT to focus on commissioning and separate from its provider arm.

ACE currently employs over 1,100 staff to provide over 40 community healthcare services (see appendix 8) to the population of North East Essex. This includes services within the areas of Specialist nursing; care closer to home, long term conditions, rehabilitation, end of life and health and wellbeing. They also provide some learning disability services to residents of North Essex (including Tendring, Colchester, Chelmsford, Braintree, Harlow and Uttlesford).

Service Involvement

Four of ACE's services have been identified as having had contact with Mr. and Mrs. A:

Intermediate Care Services (ICS)

Intermediate Care is a range of community based services targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute

inpatient care. The team consisted of six registered practitioners and was considered to be fully staffed at the time no issues were evident relevant in relation to staff capacity.

Crisis Response Service (CRS)

CRS was a joint pilot service initiated on 29th November 2010, between health and social care and the first pilot of its type in North East Essex where health and social care staff were commissioned to work together to provide rapid assessment and short term health and social care support to individuals experiencing or about to experience an immediate crisis, which without intervention would lead to a hospital attendance or admission. The team consisted of qualified nurses, social workers, physiotherapists, occupational therapists and health and social care support workers.

The service was decommissioned on the 28th April 2013 as it was considered too costly by commissioners and is therefore no longer in existence.

In effect the role offered by this service was replaced by Swan Housing Groups, Rapid Response Team.

Urology and continence Service (UCS)

General Overview of service
The service provides nurse led and consultant backed clinics in primary care settings for the management of lower urinary tract symptoms, prostate assessment and incontinence for patients across North East Essex. At the time of their involvement with the patient there were no vacancies within the team, staff turnover was low and there were no capacity issues evident.

Community Matron Service (CMS)

The Community Matrons proactively manage people with multiple long term conditions, supporting self-care, self-management and enabling independence through the sophisticated application of holistic person-centered approaches to care. At the time of their involvement with Mr. A the team of 7 Matrons and one Health Care Support worker was fully staffed with no capacity issues.

Safeguarding Adults

Ace's Safeguarding Adult Policy is supplementary to the Southend, Essex, Thurrock (SET) Safeguarding Adults Guidelines (2014) and promotes that staff have a duty to report concerns or suspicions of abuse promptly and without delay. The first priority of all staff and volunteers is always considered to be ensuring the safety and protection of the adult at risk. If concerns are raised individuals, professionals and support staff work collaboratively to protect the individual at risk and are expected to adhere to working practices in accordance with:

- Enabling control, choice and inclusion for the individual/ individuals concerned.
- Protecting the privacy and dignity of individuals involved.
- Ensuring and respecting the Human Rights of vulnerable adults and empowering them to make their own choices.
- Ensuring; timely, proportionate, professional responses to allegations of abuse raised against the organisation.

- Ensuring; timely, proportionate, professional actions to protect vulnerable adults at risk who may be experiencing abuse.
- Appropriate application of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DOL)
- Ensuring the promotion of safe and effective working practices that prevent and protect vulnerable adults from abuse.
- Ensuring staff across the organisation receive training that will support their knowledge to effectively safeguard vulnerable adults.
- SET safeguarding adults guidance
- Record keeping policy

Adult service employees are expected to attend Mandatory safeguarding induction training within 3 months of joining the organisation and Safeguarding training updates; as a minimum 2 yearly – this training is in accordance The National Competence Framework for Safeguarding Adults (2010) and Southend, Essex and Thurrock (SET) training strategy for safeguarding adults (2011-2012). The ACE safeguarding training provides employees at all levels, across the organisation with a basic awareness of domestic abuse, as well as how to respond where a disclosures is made or violence suspected.

The Lead for safeguarding adults, Lead for safeguarding Children and the named nurses for safeguarding children have undertaken DASH risk training and are competent to support practitioners in these matters in conjunction with other organisations. The adult safeguarding policy which was updated in 2014 and training directs all staff to these practitioners if domestic abuse is suspected. ACE also have Guidance for ACE staff on identification, prevention and action to be taken in response to domestic abuse.

When information is received directly from Essex Police and other police forces in the form of a DV1 this is checked against service records to establish if the individual is currently known to ACE.

Adult safeguarding is not a separately commissioned service and does not hold the same statutory requirements as child safeguarding supervision, however ACE has a clinical supervision policy in place which identifies staff should receive a minimum of four clinical supervision sessions each year with a maximum of one per month. The policy promotes clinical supervision as an educative process of developing the skills, understanding and abilities of the supervisee, ensuring the highest quality of practice.

Ongoing safeguarding Work in the organisation

ACE has designed a safeguarding template for the electronic records system which is currently in the process of finalisation, once completed; training in the use of this template will be cascaded across the organisation. The objective of this template is to enable appropriate information sharing across services in relation to adult safeguarding to ensure practitioners are informed of risk where appropriate and can support individuals accordingly.

In September 2014 ACE established a safeguarding working group; The overall aim of the group is to engage frontline staff in promoting effective clinical leadership of Adult Safeguarding services. Ensuring Safeguarding is embedded in the culture of the organisation by making it everyone's business through promotion of staff ownership, recognition of responsibilities and learning from actions. Work is currently underway to equip safeguarding champions across the organisation with the necessary skills to assist with the embedding of a proactive safeguarding culture across the organisation.

SUMMARY OF THIS AGENCIES INTERVENTION

The ICS team attended Mrs. A for a period from 27th July 2012 until the 02nd September 2012 for leg care and application of TED stockings. No other needs were identified and the patient was discharged from the caseload.

The CRS team visited Mr. A to undertake an assessment of needs on the 17th August 2012. The nurse undertaking the assessment was accompanied by a social care worker and other than meals on wheels no other needs were identified the patient was therefore discharged back into the care of his GP.

On the 03rd May 2013 a member of the UIS visited Mr. A to undertake an incontinence assessment. No needs were identified and the patient was discharged back to the care of his GP.

On the 28th April 2014 a member of the Community Matron service visited Mr. A to undertake an assessment of needs and ensure he was managing his medications. No needs were identified during the assessment and the patient was able to evidence he was managing at home and was able to self-medicate.

ANALYSIS OF INVOLVEMENT

It is clearly evident from the referral to ICS in July 2012 that the intervention requested for Mrs. A following a surgical procedure was leg care and assistance with the application of compression stockings. ICS are an integrated team that consist of a variety of MDT who are highly skilled in rehabilitation and supporting admission avoidance. The referral clearly identifies Mrs. A as being independent with personal care, transfers, mobility and states her family will help with kitchen activities. The initial visit to the patient was carried out by an occupational therapist (OT) that would be able to recognise any ongoing needs and seek assistance to support these. All visits are documented and no ongoing needs were identified at the time. There was no evidence that any concerns were present in relation to domestic violence or the patient owning a firearm.

The referral received from the health assessment team on the 17th August 2012 by CRS identified that Mr. A had been admitted initially due to delirium possibly caused by a Urinary tract infection (UTI) and that he had been assessed as medically fit the day prior to this referral. The referral did suggest that his wife was unable to cope and Mr. A required assessment for personal care and meals on wheels. There does not appear to be any identification of his suspected dementia. Nurse 1 considered the case could be complex and the patient had self-discharged from the acute hospital so sought the assistance of the social worker in assessment of the patient.

When Nurse 1 visited the patient following referral from the acute hospital Mr. and Mrs. A reported that they were managing. Mr. A informed her that he had not wanted to be in hospital, saw a chance to leave, so took it. He reported he was pleased to be home and feeling much better. Mr. A evidenced no signs of delirium during the visit.

During interview Nurse 1 was able to discuss and identify potential indicators of abuse and actions to take if required. Mrs. A was also given opportunity to participate in the assessment It is therefore considered by the IMR author that the nurse had no cause for concern and reached her decisions in an informed and professional way in accordance with patient choice, the information and patient history that was known to her. Her documentation of the visit did comply with the ACE record keeping policy.

When the referral was received by the incontinence team on the 26th April 2013 the intervention required was clearly stated as assessment for incontinence; no other needs were identified, as such this was triaged appropriately by a senior nurse as per service specification and allocated to HCSW 1. During interview he was able to demonstrate a good understanding of his scope of practice and actions to take relative to anything over and above.

On visiting Mr. and Mrs. A HCSW1 offered Mrs. A opportunity to participate in the assessment with her husband's consent. Neither Mrs. nor Mr. A recognised any concerns in relation to incontinence and no ongoing support in this matter was required. HCSW did not evidence any behaviour that concerned him and considered Mrs. A to be a little overprotective of her husband. He was unaware of there being a firearm on the premises.

During interview HCSW 1 was able to discuss and clearly identify indicators of domestic abuse and actions to take in accordance with ACE policy if he suspected it was occurring. He had no knowledge of Mr. A's likely diagnosis of dementia. He considered Mr. A to have capacity and considered him to engage in the assessment and respond appropriately to all of his questions, 'he seemed cognitive, he gave a history and answered all the questions'.

The author of the IMR concludes that the visit for Mr. A was appropriately assigned to the HCSW. Mrs. A was also given opportunity to participate in the assessment, as no concerns were identified or apparent and due to the patient having capacity to make an informed choice, the actions of HCSW 1 were appropriate and proportionate. It is therefore considered by the author that HCSW 1 had no cause for concern and reached his decisions in an informed and professional way in accordance with the information and patient history that was known to him.

The referral received by the Community Matron on Friday 25th April 2014 was very clear and concise and identified Mr. A as having dementia. It also identified that a referral had been made to social care direct the same day and contact had been made with the patient to ensure he was in no immediate danger. The referral was therefore triaged as non-urgent and Mr. A was visited on the Monday 28th. Due to the nature of the referral Nurse 2 asked the social care worker to accompany her to visit Mr. A to undertake a joint assessment of his needs.

On arrival at the property Mr. A presented as having capacity and demonstrated good cognitive ability. He was attending the pub daily for his meals, so wasn't isolated and appeared to be driving to visit his wife in hospital daily. He was well presented and the house appeared immaculate. The nurse had no concerns about his coping ability and he was able to clearly demonstrate ability to administer his own medication correctly and at the right time. He was approachable and not questioning of why Nurse 2 was there he was engaging and demonstrated no evidence of being defensive or indicators of a violent nature.

Mr. A reported that he was coping well and declined any further care input. Nurse 2 left an information leaflet with him so he had the contact details available along with details of the service should he change his mind and require further support.

During interview Nurse 2 was able to, discuss and identify indicators of abuse and domestic violence and reports she had no concerns at all in relation to this she stated; '*assessment starts the moment you are at the house, it includes the surroundings, there was no display of anger, he engaged and was very chatty from the onset, he wasn't questioning why we were there; his approach to greeting us would be a defining factor in some situations*'.

The IMR author concluded that the visit undertaken by Nurse 2 was as informed as it could be at the time due to the information known to the services. The assessment took into account the wishes of the patient who was deemed to have capacity, no concerns were identified and the patient declined ongoing support. Details of the visit were clearly recorded and information was provided to Mr. A to enable him to seek further support should he need it. The author of the IMR is therefore satisfied that the actions of Nurse 2 were appropriate and proportionate. She had no cause for concern and reached her decisions in an informed and professional way in accordance with patient choice, information available and patient history that was known to her.

ACE Staff that have been involved in the care of both Mr. and Mrs. are considered to have been appropriately skilled for the presented circumstances. It is considered ACE staff provided care in an appropriate and proportionate manner in relation to patient history that was known.

There were no evident concerns around domestic violence or adult safeguarding during the episodes of care that ACE staff undertook. Had they been aware of any facts related to these issues they would likely have undertaken risk assessment and have sought support from the mental health team or line managers for both Mr. and Mrs. A.

Had a case manager or key worker been identified for Mr. A it is likely that communication could have been improved across agencies, which may have facilitated a patient centred joint plan of care. This additional support may possibly have resulted in a different outcome for this case through the provision of assistance to both Mr. and Mrs. A in a structured and planned way that addressed their needs in a holistic needs orientated way.

EFFECTIVE PRACTICE AND LESSONS LEARNED

ACE strongly supports collaborative working with other agencies and endeavours to support this whenever possible. Both Nurse 1 and Nurse 2 considered the complexity of the referrals received and sought the assistance of the social worker in undertaking a joint assessment of the patient's needs to fully support effective assessment.

Staff were able to demonstrate knowledge and skills relevant to the Mental Capacity Act (2005) and capacity and consent. Staff treated the patient with dignity and respect and demonstrated a caring and compassionate attitude toward both Mr. and Mrs. A. Consent to assessment was sought from Mr. A prior to undertaking it and Mrs. A was included in the assessments where possible.

ACE is very proactive in its development of adult safeguarding matters and currently has work in progress to strengthen a proactive culture across the organisation. This includes the introduction of an adult safeguarding template for their electronic patient data records which will strengthen their ability to share information appropriately and proportionately internally and with other agencies.

The internal lessons learnt by undertaking this review are simple, but could strengthen the knowledge of staff around any relevant current or historical safeguarding or mental capacity issues. This could be achieved by the simple addition to referral forms requesting this information to enable them to be aware and offer the appropriate support to the individual.

Communication could be improved with external agencies to support vulnerable adults with mental health needs. Practitioners need to be appropriately informed in relation to these

needs to enable them to critically analyse situations and support individuals as effectively as possible through effective risk assessment.

ACE has a clinical supervision policy in place however the review identified that this is not being put into practice and staff are lacking the support required to help them develop as skilled and informed practitioners. This is an ideal opportunity for staff to reflect on safeguarding matters and develop strong and informed direction to support individuals. This should therefore be a priority action for the organisation.

Closer links also need to be made with the mental health team and clear pathways formed to help identify key workers or case managers for vulnerable adults with mental health needs. This however will not be a quick fix matter and will require the collaboration of all agencies; possibly in the form of a working group.

RECOMMENDATIONS WITHIN THE IMR

The domestic violence policy should be reviewed within the next three months to cover the services of both child and adult.

Set up a Working group to design a strategic pathway for identification of key workers/case managers for vulnerable adults with mental health needs. Within the next 6 months.

Establishment of a working group within the next three months to support Methods of monitoring of Clinical supervision offered to staff across the organisation

All referral systems should be reviewed to include a section that prompts the referrer to identify any mental health needs or safeguarding matters. Communication could be improved with external agencies to support vulnerable adults with mental health needs. Practitioners need to be appropriately informed in relation to these needs to enable them to critically analyse situations and support individuals as effectively as possible

North Essex Partnership NHS University Foundation Trust

The author of the IMR is a Clinical Specialist - Safeguarding, who had no involvement with Mr. and Mrs. A and had no line management responsibility for staff or teams involved. The methodology used to compile this IMR was to access and review paper files and the electronic clinical information system and the Electronic staff record to examine the training status of practitioners. The author also accessed the comprehensive Trust Serious Incident Investigation report where staff where interviewed as part of the report as well as records examined. All records were made available as part of this report. The Trust Safeguarding Policy was also reviewed.

CONTEXTUAL INFORMATION

North Essex Partnership NHS University Foundation Trust provides mental health care to North Essex. This includes a liaison service with mental health nurses based at Colchester General Hospital to provide advice and assessment services to Colchester General Hospital with regards patients with mental health needs. The Trust also provides a 24 hour Crisis help line and service.

The Trust provides services for Dementia including diagnosis. The memory monitoring service provides ongoing monitoring for people with a diagnosis of dementia. The dementia service provides support including a 24 hour support hotline and carers groups. The follow up service from diagnosis had been in accordance with NICE guidance.

The Care Programme Approach is a national framework, a system of care that includes having a named coordinator of care, assessment, care plan and review of care.

Domestic abuse is covered in the Trust mandatory safeguarding training, the training provided includes levels1, 2, 3, and 4 Safeguarding Adult and Children training which is validated by the Essex Safeguarding Adult Board and Essex Safeguarding Children Board as well as being part of the Trust Safeguarding policy which is freely available to all employees – for example on the Trust intranet site. All Clinicians are required to attend and complete level 3 training (and remain compliant with level 1 and 2) on a 3 yearly basis. Level 4 training in Safeguarding Adults is recommended for those working with older adults, again 3 yearly.

The Consultant Psychiatrist was in date with level 3 Safeguarding training as was the Dementia Service Team Leader. The Community Psychiatric Nurse who had the last contact with Mr. A in the memory monitoring clinic in January 2014 was also in date with level 3 training

The Trust Safeguarding Team is available for advice and consultation by the whole of the Trust workforce as well as providing safeguarding supervision and clinics into clinical teams

SUMMARY OF AGENCIES INTERVENTION

Mr. A was seen by the Trust liaison service whilst a patient at the Colchester General Hospital in August 2012, he was later referred by his GP to the Trust in October 2012 and was then under the care of the Trust (Dementia Service and Memory Monitoring Service) as an outpatient until his death in May 2014. His last contact with the services was in January 2014, he had a routine clinic appointment booked with the memory monitoring service for 26th June 2014

ANALYSIS OF INVOLVEMENT

The care pathway from referral to diagnosis, including neuropsychometric assessment, was delivered in a timely manner. Information and support was available from the Dementia Service, and the patient was followed up according to NICE guidance.

The Trust Safeguarding policy includes policies and procedures for (DASH) risk assessment and risk management for domestic abuse victims/perpetrators however no risk indicators for domestic abuse were present in this case.

Information was shared with the GP regarding the care and management of the case as well as risk information; however in the letter to the patient's GP following the appointment on 6th January 2014, there is no reference to risk. In the appointment six months previously, risk of vulnerability was noted. It would be good practice for risk to be documented in the GP letter to the GP, even if no specific risks have been identified. The IMR author however notes that the lack of reference to risk in the last GP letter in this case did not have an impact on the following events.

In regard the accessibility of the services from the trust - both the Dementia Service, which Mr. and Mrs. A were given details of on 18th February 2013, and the Trust Crisis service have 24 hour hotlines. In addition Mrs. A demonstrated that she knew she could contact our services as she did, for example, regarding Mr. A's flushed face on 28th May 2013.

It was noted that the patient had a shotgun licence, and had access to firearms on 19th November 2012 as part of our holistic initial assessment process which includes social interests and hobbies. This was not a recent event, but part of the patient's way of life – '*the patient is a keen hunter and has a shotgun for which he is licensed for. He tells me these are secured on the property. He now uses the gun for pest control and has not hunted in a while*'. This was disclosed during the initial assessment on 19th November 2012, and the patient's GP was advised of this in a letter dated 30th November 2012.

The Police are the licensing authority for firearm and shot gun certificates (Guide on Firearms Licensing Law 2014). Certificates are valid for five years. With regard to suitability to hold a licence and unsound mind the guidance states:

'This is a particularly difficult and sensitive area and it is not possible to provide a definition that covers every eventuality. It is impractical for a psychiatric assessment to be conducted on an applicant's suitability to possess firearms.
However, chief officers of police should be alert to cases in which a GP report reveals that an applicant has exhibited or is exhibiting signs of serious depression, suicidal tendencies, or long-standing or intermittent periods of either emotionally instability or unpredictable behaviour'.

From the limited information available, the patient did not appear to exhibit any such signs or behaviours which may have triggered further consideration of any risks associated with holding a firearm certificate.

The Trust would have been able to work with Mr. and Mrs. A, and other agencies to provide extra support or interventions, had the Trust been alerted to any issues in between routine appointments, however the trust was not aware of any concerns from other agencies and neither Mr. or Mrs. A contacted us about any concerns so the question of extra support to them did not arise.

EFFECTIVE PRACTICE AND LESSONS LEARNT

With regard to the care and treatment provided by the Trust, regarding memory assessment, diagnosis of dementia and ongoing memory monitoring, this appears to have been appropriate.

The care pathway from referral to diagnosis, including neuropsychometric assessment, was delivered in a timely manner. Information and support was available from the Dementia Service, and the patient was followed up according to NICE guidance.

Both of the Trust's 24 help line numbers and contact details (crisis line and dementia support) were provided to Mr. and Mrs. A, as was the in hours services contact details, in a timely manner.

Regarding lessons learnt – the Trust identified in its Serous Incident Investigation as an improvement on good practice that, 'it would be good practice for risk to be documented in each letter to the GP from the Trust, even if no specific risks have been identified'.

RECOMMENDATIONS

In line with the recommendation from the Trust Serious Incident Investigation Review; Risk (including if none identified) to be documented in the GP letter following routine memory monitoring appointments.

It is noted that this has been implemented fully by the Trust.

Colchester Hospital University Foundation Trust (CHUFT)

The IMR author is and Acting Nurse Consultant for Older People and Adult Safeguarding. The author did not have any direct involvement with Mr. or Mrs. A and does not have direct line management any of the staff in the ward areas or emergency departments who had involvement with either Mr and Mrs A.

The methodology included accessing the Patient Administration System and securing the healthcare records for Mr. and Mrs. A. The author has undertaken a systematic review of these records from 1st June 2011 until the date of death for both Mr. and Mrs. A, 24th May 2014.

As part of the Investigation process the IMR TOR provided were adopted and the Trust DA policy was accessed.

CONTEXTUAL INFORMATION

CHUFT is an acute healthcare Trust. The Trust has 600 beds and provides emergency healthcare to in patients admitted and healthcare through an out patients service.

The Trust has a Domestic Abuse policy available to all staff within the organisation. Training is provided to all staff who require this through level One and Two safeguarding training.

The training is monitored and provided by the safeguarding team within the Trust and fully complies with Essex Safeguarding Adults Board procedures and SET guidelines and Care Quality Commission essential standard 7.

SUMMARY OF AGENCIES INTERVENTION

CHUFT were involved with Mr. and Mrs. A as below:

Mr A

8th August 2012	Conveyed by East of England Ambulance Service Trust for bowel obstruction
8th august 2012 - 16th August 2012	Emergency Assessment Unit via (A&E) transferred to Brightlingsea ward and treated for Small bowel obstruction
25 February 2013 – 11th March 2013	Elective Care Centre and underwent Laproscopic resection of splenic flexure tumour

Mrs A

16th October 2012	Dermatology outpatients for cryotherapy
3rd March 2013	ENT outpatients clinic for review and possible grommet insertion
22nd April 2014	Conveyed by East of England Ambulance Service Trust for chest pain
22nd April 2014 - 30th April 2014	Accident & Emergency (A&E) transferred to West Bergholt ward for shortness of breath, right sided pleural effusion and lethargy
06th May 2014 - 20th May 2014	Emergency Assessment Unit via GP transferred to Layer Marney ward shortness of breath and chest pain

ANALYSIS OF INVOLVEMENT

Mr. A was admitted to CHUFT on two occasions the first 08th august 2012 when he was treated appropriately for a bowel obstruction. During this admission Mr. A was diagnosed with SVD and appropriately referred to mental health services.

Mrs. A expressed concerns to the mental health liaison nurse that she would not be able to cope with Mr. A and was appropriately referred to social services for advice and support.

Mr. A was assessed as having capacity and was experiencing anxiety requesting to return home to his wife.

Mr. A was independent and was referred to social care for advice regarding support for him and his wife on 15th August 2012.

Mr. A discharged himself from Brightlingsea ward on 16th August 2012 against medical advice and without awaiting social service advice. The surgeons spoke to the GP practice the following day to express their concerns regarding his discharge.

Mr. A was reviewed in the outpatient clinic accompanied by his wife and was appropriately referred for an MRI scan to investigate on-going memory problems.

Mr. A attended a pre admission clinic appointment accompanied by his wife. Mr. A was appropriately consented to surgery for treatment of a cancerous bowel tumour.

Mr. A was admitted for surgery and underwent successful removal of cancerous bowel tumour.

Mrs. A attended outpatient ENT and Dermatology appointments where no concerns were identified by CHUFT staff or by Mrs. A

Mrs. A was admitted to CHUFT with chest pain on 22nd April 2014 and received the correct and prompt treatment. Mrs. A expressed concerns regarding caring for her husband and staff acted appropriately in contacting Mrs. A's GP who it is understood organised for social care to visit.

Mrs. A was admitted to CHUFT with chest pain and shortness of breath on 6th May 2014 and received the correct treatment promptly. Mrs. A was assessed as having capacity and expressed concerns regarding caring for her husband and staff correctly referred to specialist palliative care services, occupational therapy (OT) and social care for support, advice and assessment. Mrs. A was reviewed by a social worker.

Mrs. A did not disclose to staff any concerns regarding domestic abuse or safeguarding.

EFFECTIVE PRACTICE AND LESSONS LEARNED

Social care referral for Mr. and Mrs. A was appropriate on admissions to CHUFT. It remains a concern that Mrs. A did not consent to a carer's assessment by social care whilst on the ward. However it must be acknowledged that Mrs. A had capacity and wanted the assessment carried out on return home. Following review the IMR author suggests that had the need for the carers assessment been identified earlier in the admission of Mrs. A in April and May 2014 they may have been able to access support earlier. Although it is unclear what additional support may have been provided.

Discharge planning involved the palliative care team, ward staff, OT and social care.

RECOMMENDATIONS WITHIN THE IMR

Care arrangements should have been identified earlier on admission to CHUFT to avoid confusion as to what care was already in place for Mr. and Mrs. A and to assist social care in identifying whether a carers assessment was required.

North Hill Medical Group (NHMG)

The IMR author is a GP at North Hill Medical Group and on the 24th May 2014 was a GP registrar with NHMG. The author had one contact with the family – a visit to Mr A at his home on 15th May 2014.

As a result of discussion with the IMR author, the Review Panel chair is content that the limited contact referred to above is not detrimental and does not reflect bias within the report which was requested in the form of an IMR. It is considered an objective and forward looking record of GPs role in this case.

The methodology used was examination and review of Mr. and Mrs. A's patient records and the BMA guidance from the ethics department on firearms 2011 and current advice on BMA website.

CONTEXTUAL INFORMATION

North Hill Medical Group (NHMG) – provides NHS primary care to a rectangular area to the north of and including part of Colchester town centre with branch surgeries on North Hill, at West Bergholt and Nayland. Patients tend to access the surgery closest to their home but they may attend any of the surgeries.

NHMG is regulated by the Care Quality Commission and as such, staff are required to complete mandatory training covering a range of subjects relevant to different staff roles. This has long included child safeguarding training and has more recently expanded to cover adult safeguarding as well. This is completed via online modules which became available in December 2013 and have been completed as a rolling programme for all current NHMG staff members involved in the case.

BMA (British Medical Association) Ethics Firearms guidance can be found at: http://bma.org.uk/practical-support-at-work/ethics/firearms. In summary it states that doctors may be involved in the provision of firearms licences:

If the police request information about the medical history;

If asked to countersign an application or act as a referee as a person of good standing.

GPs will be informed by the police if a patient has been issued or reissued with a licence and asked to express any concern they may have about that person having access to a weapon.

Although the Essex Police letter, informing NHMG that Mr. A is a shotgun certificate holder, states that it does not have to be retained, the BMA has been advised that doctors can record the request for information in the medical record and what, if any, action is taken.

Doctors may breach confidentiality of a patient if there is reasonable belief that an individual holding a licence may represent a danger to themselves or others but they are advised to strongly encourage the applicant to reconsider or revoke their application and only break confidentiality if they refuse.

SUMMARY OF AGENCIES INTERVENTION

Routine primary care of Mr. and Mrs. A including:

- health prevention work (flu vaccines provision and COPD screening)
- chronic disease monitoring for Mr. A's COPD
- Seeing them for minor illnesses and acute illness both in the surgery and home visits as needed.
- Referral to secondary care providers where necessary (urology, audiology and ENT referrals for Mrs. A and gastroenterology, audiology, the memory clinic and plastic surgery referrals for Mr. A)

- Offers of input and referrals to the social care services for care input at home which was refused by Mrs. A when she was at home and during the final few weeks of their lives.

ANALYSIS OF INVOLVEMENT

From the review of the notes as summarised above there was never any mention or indication of domestic abuse between Mr. and Mrs. A.

Mr. and Mrs. A had multiple contacts with the practice and there was only one example of a problem with them gaining access which occurred because the patients did not want to see an advanced nurse practitioner or travel to a different site to see the duty doctor. It is a reality of the way the practice works in keeping the branch surgeries open that, although there is always provision to see people the same day when needed, it may mean either seeing an advanced nurse practitioner with minor illness training or travelling to a different site to see a GP. In this case they were signposted to the walk in centre which was acceptable to them.

At the time of the receipt of the letter regarding the renewal of Mr. A's firearms licence in 2011 there were no concerns expressed about Mr. A holding the licence. The letter was filled in his notes under a general letter and no alert was put on his notes at that time.

This is an area where improvement could be made. It would be appropriate for it to be common practice to code in a visible place in the patient's notes if they hold a firearms licence. This would then be more visible for the practice staff to be aware of should new health problems arise where the continued holding of such a licence may become an issue.

Mr. A did have the input of the memory services for his mild dementia and the fact he held a firearms licence was mentioned in their first letter to the practice. At that time it was not mentioned as an area of risk.

There were 2 episodes seen by our members of staff where Mr. A had worsening cognition – both were explainable as episodes of delirium associated with acute illness the first time and post operatively the second time.

The first time he was at home after absconding from the hospital, the second time he had respite care in a residential home. It is difficult to say whether, had the fact he had a firearms licence been obvious on the notes, there would have been discussions about the appropriateness of this. The IMR author did not feel that at any point there would have been cause to break the confidentiality of the patient to inform the authorities that the patient should have his licence revoked.

It is at these points where the Review Panel considers that the presence of an alert, or flag, on the patient record would have allowed the visiting Doctor to assess the risk in allowing firearms to remain accessible to the patient whilst suffering these episodes. If aware, at least consideration can be given to temporarily removing any weapons until the person recovers.

Mr. and Mrs. A were referred appropriately and in a timely manner to secondary care services as the need arose following guidelines where applicable (such as referring for investigation of haematuria).

Mr. and Mrs. A were signposted and offered help and support appropriately at various occasions during the time periods covered within the scope of the DHR terms of reference

in the IMR. Mrs. A had refused this and there was never any question about her competence to do so. Mr. A was known to the memory services with mild dementia but this did not seem to impair his ability to care for himself whilst Mrs. A was in hospital and it was deemed that he had competence to accept / decline care during the last home visit.

EFFECTIVE PRACTICE AND LESSONS LEARNED

Things done well:

- Minor illnesses were managed appropriately
- Referrals were made in an appropriate and timely manner
- The patients had appropriate access to the surgery
- They were offered access to extra help on multiple occasions

Areas for improvement:

- To put an alert on the patient's notes about them holding a firearms licence

RECOMMENDATIONS WITHIN THE IMR

To continue the rolling programme of safeguarding training for practice staff as per practice policy.

It would be appropriate to inform the out of hours service of firearms licence holders as they do not access our computer records. This would be relevant, for example, in cases of mental distress of the patient.

East of England Ambulance service Trust

The IMR author is the Named Professional for Children and Adults Interim (Head of Safeguarding) for the East of England Ambulance Service Trust (EEAST). The author has no line manager responsibility for the clinical staff that came into contact with Mr or Mrs A. The role is to support the Trust in its statutory duties and as part this role monitors and scrutinises Trust practice to ensure compliance to the legal obligations, Care Quality Commission (CQC) expectations, patient safety and Trust policy.

The methodology used was to examine data from the following systems:

- Computer Aided Dispatch (CAD) checking the system for 999 calls against the family's address (address only search)
- Patient Care Records (PCRs) are requested from stations, governance or secure storage; dependent on length of time from incident the PCR can be in different locations

- Patient Experience (PE) - checking the PE system for complaints or requests for information to ensure there is no data on the patient/family. (name and address search)
- Single Point of Contact (SPOC) –check the Trust referral database to see if any social care, GP referral or use of GP out of hours (OOH) services identified on the system (name and address search)

After systems interrogation and information retrieval the IMR author read all documents to identify any issues, concerns or worries. The IMR author conferred with identified staff to clarify points that are not clear from the collected information.

CONTEXTUAL INFORMATION

The Trust covers the six counties which make up the East of England - Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk and provides a range of services, but is best known for the 999 emergency service.

The Trust has policies for Safeguarding Adults and Children. Domestic Abuse is contained within these policies and the updated policies, awaiting sign off at the Trust Board, contain supporting documentation describing and exploring the different types of abuse recognised by the Trust. There is a low threshold regarding concerns and to this end crews are directed to make referrals via the SPOC in order that referrals are passed to the appropriate agency for further investigation.

With regards to domestic abuse where this is suspected crews are directed to inform the police.

Domestic abuse training is contained within the in- house training programme, all members of staff should receive mandatory professional update training each year and this is a rotating programme to encompass all training as outlined in the Intercollegiate document.

SUMMARY OF AGENCIES INTERVENTION

EEAST had 6 contacts with the patients. 4 were 999 emergency calls, 3 of which resulted in conveyance to Colchester Hospital and the final was on the day of the deaths. There were also 2 non-emergency journeys conveying the patient to their home address.

ANALYSIS OF INVOLVEMENT

8th August 2012	EEAST received a 999 call ‘a Health Care Professional’ (HCP) admission call for an 80 year old male
11th March 2013	Discharge request from Colchester hospital for Mr. A. Non-emergency journey to home address. Transport only, no clinical input
22nd April 2014	EEAST received a 999 call for a 77 year old female with chest pain.

06th May 2014	EEAST received a 999 call for 77 year old female with chest pain.-
20th May 2014	Discharge request from Colchester hospital for Mrs. A. Non- emergency journey to home address.
24th May 2014	EEAST call received from police 'shot his wife-now going to kill himself' Rendezvous point (RVP) arranged with police.

EEAST has policies and procedures in place for Safeguarding and promoting the welfare of vulnerable adults and children. Any concerns raised are referred via a Single Point of Contact (SPOC) which enables the concerns to be electronically passed onto the GP and Local Authority (as appropriate).

All staff are trained in equality and diversity and as such the thoughts, wishes and beliefs of each patient are to be respected and explored when planning care.

Nothing in the information collected provided evidence of Domestic Abuse.

EFFECTIVE PRACTICE AND LESSONS LEARNED

EEAST had limited contact with Mr and Mrs A. There were no obvious identified lessons. The use of the electronic patient care record (ePCR) enabled the IMR author quick and easy access to the patient documentation for each attendance.

RECOMMENDATIONS WITHIN THE IMR

There are no identified recommendations for EEAST.

Swan Housing Group

The IMR author is Director of Care and Support, Vivo Support Limited and does not directly line manage any of the staff who provided care for Mr. & Mrs. A, and has not had any direct contact with Mr and Mrs A.

The methodology used was to examine all relevant and available client records pertaining to Mr and Mrs A. Not all of the records were accessible to the IMR author in compiling the report. Due to the rapid nature of this service this agency operates a paper based system, which focuses mainly on the client file held within each property. When the property in this case became a crime scene these files became exhibits, awaiting Inquest, before being returned.

These documents however, including statements of the Rapid Response team and other relevant exhibits, were examined and reviewed by the Panel Chair and their impact is reflected within this report.

CONTEXTUAL INFORMATION

Part of the Swan Group of Companies, Vivo Support Limited is a domiciliary care company providing care and support in homes across Essex. Swan's Home Improvement Agency (Swan Care and Repair) are contracted to provide a Rapid Response Service including care and home safety support to people in the North East Essex area, and contract Vivo Support Limited to deliver the care element.

The contract is commissioned by the North East Essex Clinical Commissioning Group.

Vivo Support Limited activities are monitored and regulated by the Care Quality Commission (CQC). All CQC inspections to date have published reports showing that this agency is fully compliant with all standards, including staff training, recruitment and induction.

The Swan Group has a Domestic Abuse policy available to all staff within the organisation. Its last revision was in 2012.

All staff are trained in Safeguarding of Vulnerable Adults which is monitored by the Vivo Management Team, and the Swan Group. All safeguarding incidents are reported centrally within the Swan Group to identify trends and any reshaping of services required.

SUMMARY OF AGENCY INTERVENTION

Mr. A

1st May 2014	Dr Polak (GP) referred Mr. A to the Rapid Response Service.
1st May 2014	Senior Care Worker attended to conduct an initial Care plan and Risk Assessment
6th May 2014	Dr Polak (GP) re-referred Mr. A to our Rapid Response Service due to his main carer (Mrs. A) being admitted to hospital. Our initial service was due to end on that date as it is a 6 day service.
1st May 2014 – 12th May 2014	Frequent visits (20 in total) from Vivo Care Workers. The support offered includes. Bed making, grocery shopping, home care, medication prompting. No further concerns were raised other than memory loss and hiding wallets owing to his progressive dementia diagnosis (the reason for his referral).

16th May 2014	Mr. A was re-referred due to his ongoing progressive dementia and the fact that his main carer (Mrs. A) was in hospital.
16th May 2014	A swan handyperson attended the property to conduct a home safety check.
16th May 2014	A Vivo Care Worker conducted a personal risk assessment which shows risks associated with his medical condition.
20th May 2014	Day 6 Client Discharge form completed and assessment records, "(Mr. A) has severe dementia and will not progress or improve some assistance still needed as wife main carer and very poorly."
20th May 2014	Client satisfaction survey conducted. Mr. A scored the service excellent or very good in all applicable areas.

Mrs. A

1st May 2014 Dr Polak GP	Referred Mrs. A to the Rapid Response Service. Was suffering with health (Heart and Lung Conditions).
1st May 2014	Vivo Care Worker completed initial care plan and risk assessment.
1st May 2014 – 6th May 2014	Frequent visits (10 in total) from Vivo Care Workers. The support offered includes bed making, grocery shopping, home care, medication prompting. No further concerns were raised. Day 6 Client Discharge assessment, referral to Adult Social Care requested.
6th May 2014	On attending the evening call, we noted that Mrs. A had been admitted to hospital.
20th May 2014	Social Care Advisor referred Mrs. A to our Rapid Response Service on discharge from hospital. Referral comment - "Rapid Response were supporting Mr. (A) with medication, meal preparation and other domestic tasks. Mrs. (A) is going to be unable to fully support her husband as she is weak and tired following diagnosis of

	cancer. She is unsure how they will cope in the property without outside support. Social Care Direct need to speak to Mr. (A) tomorrow in order to gain consent to allocate to a community team for a face to face assessment, this will then take time to allocate to a worker to complete the necessary assessment."
21st May 2014	Vivo Care Worker completed initial risk and needs assessment. Noted that a lung cancer diagnosis had been given and that whilst in attendance social services rang arranging assessment meeting the following day.
21st May 2014	Swan Handyperson completed a home safety check
21st May 2014	Care Worker visit, Mrs. A speaks of the "*major situation*" they were in because of her recent diagnosis, Mr. A not being able to look after himself long term and the fact they were reliant on carers as they had no children to help them.
23rd May 2014	Care Worker visit between 2045 - 2115 hours. Mrs. A "*seemed a bit cross*" she stated that she didn't want a lunch visit the following day, one in the morning and one at teatime. Two visits were enough. She was "*fed up*" with people in and out as they had another company delivery meals. She again talked of the "*major situation*" they were in and said to Mr. A something like, *"....you're not taking anything in about my illness*." Later on during this visit however the mood became relaxed and good humoured. On leaving Mr. A said to the care worker something like, "*things were a little heated and unhappy in there.*"

ANALYSIS OF INVOLVEMENT

Both Mr. and Mrs. A were referred into the Rapid Response Service in May 2014. The Service were aware at the referral time that Mr. A suffered from progressive dementia, and that Mrs. A had difficulties breathing.

It was clear to Swan that both needed support, and Mr. A's support needs were exacerbated by his main carer, Mrs. A, being admitted to hospital.

The IMR author assessed that nothing in the presentation of either client warranted any additional increase in risk management approaches from care staff. All staff were sufficiently experienced to deal with people and families living with dementia, and the other health issues presented by the couple.

Swan were never informed by the client or referring agent that a shotgun was present within the property. Current policy does not require asking a specific question about firearms within its risk assessment process.

Staff are trained in safeguarding, and have regular access to their management team to raise any concerns, however conversations with care workers immediately following the death of Mr. and Mrs. A highlighted that both clients presented very 'normally' and that there was no indication of concern with regard to domestic abuse, or any other safeguarding concern.

At this time the Rapid Response Service was in its pilot phase. Following discharge of a client from service during this time no information was sent to any other party excepting a referral to a follow on service should that be required.

This has since changed, and the GP for each client leaving the service is now sent a letter detailing the service given and the discharge outcome.

EFFECTIVE PRACTICE AND LESSONS LEARNED

Vivo care workers provided a quality home care and support service to both Mr. and Mrs. A throughout 1st to the 23rd May 2014. The couple reported that they were very happy with the services offered, and given their varying health concerns were able to remain at home and feel safe, secure and respected with the Rapid Response Service in place.

The agency identified the need to keep GP's informed of the client's needs according to the assessment on each discharge from service, and this is now underway.

They also considered adding a question to their risk assessments about firearms, but felt that this may be inappropriate as a standard question for our elderly and vulnerable clients.

Reviewing this case from a domiciliary care point of view, and acknowledging that the atmosphere on the evening of 23rd May appeared a little tense, the IMR author is confident that nothing in the presentation of Mr. and Mrs. A would have alerted Swan to the final outcome.

Swan therefore would not have had cause to alert any agency as to a change in behaviour or serious concern in respect of Mr. and Mrs. A.

RECOMMENDATIONS WITHIN THE IMR

To consider working with GP's on referral regardless of referral route to identify any presenting risks that they are aware of, including gun licences. We will communicate with our commissioners (North East Essex Clinical Commissioning Group) to establish if this is a process that could effectively be implemented.

The agency identified the need to keep GP's informed of the client's needs according to the assessment on each discharge from service, and this is now underway

AGENCIES CONTACTED BUT CONFIRMED NO INVOLVEMENT

In total, 19 agencies have responded as having had no contact with or entries on their database or general registry for either Mr A or Mrs A.:

Essex Probation
ECC Children's Social Care
Essex Fire
Basildon Women's Aid
Colchester Women's Refuge
Braintree District Council
Basildon Borough Council
Brentwood District Council
Castle Point District Council
Chelmsford City Council
Colchester Borough Council
Epping Forest District Council
Southend on Sea Borough Council
Harlow District Council
Maldon District Council
Rochford District Council
Tendring District Council
Uttlesford District Council
Thurrock Council

ANALYSIS

The DHR Review Panel had reviewed the individual management Reports at a meeting on the 2nd February 2015. The Panel were of the opinion that all Agency intervention was appropriate.

The separate reviews identified some minor deviations from some policy and procedure and the Panel were satisfied that these matters did not materially affect the tragic outcome in this case.

Whilst concluding below that there is no evidence of an opportunity to intervene in this case, the purpose of a Review is to seek what can be done to prevent further similar acts. To that end this Review identifies areas where improvements can be made to reduce such risk.

These are actions that can be taken to ensure that the Police have improved information on a person's continuing physical and mental suitability to have access to lethal weapons, and that can reduce the stress on those who require health and social care at a time when they face difficult decisions.

Professionals should not be constrained in sharing information on the fact that a person holds a Firearms Licence. For example, on making referrals a GP should not have to seek the consent of their patient to inform other relevant professionals that the person holds a Licence.

In assessing information that Agencies hold, they should consider its potential relevance to other Agencies. An assessment of 'low risk' by the holding Agency should not automatically be a bar to that Agency providing the information to other relevant Agencies.

Such sharing of information will also help to identify appropriate coordinator roles in Health and Social Care to better understand the requirements of patients in receipt of services.

Improvements in these areas will firstly help remove weapons in situations where the potential for danger exists and secondly assist in the coordination of health and social care provision to reduce stress to those facing difficult decisions

Adoption of the recommendations made in this Review will assist in preventing future tragic events such as the case of Mr and Mrs A.

CONCLUSIONS AND RECOMMENDATIONS FROM THE REVIEW

Conclusions

This was a tragic case. Mr. A's actions were violent, sudden, unexpected and out of character. The suspected murder of his wife is clear domestic violence. The review concluded that even if everyone having contact, or involved, with Mrs A and Mr A's case, were aware of all the information, there was no evidence or indication to suggest such a violent and sudden end to their lives could be anticipated.

Examination of professional contact, provided through the IMRs, has not identified any evidence of a history of Domestic abuse, nor do any of the interactions present as an indication of risk from Domestic Abuse.

The accounts of family and friends, whilst acknowledging that the couple enjoyed a private relationship, reinforce the picture of a loving couple who were happy in each other's company and were devoted to each other.

The broader context of the case has highlighted significant issues for consideration both strategically and operationally whilst acknowledging they may not have played a specific part in this case.

The review has identified two primary areas where it is believed that improvements will lead to a reduced risk of similar tragic incidents occurring in the future. These are access to firearms and integration of patient care; across these two strands are two further overarching themes of information sharing and training.

The first area is the accessibility of lethal weapons, the assessment of a person's suitability to hold such weapons must be a continuing process that is a responsibility shared to a greater extent between Agencies than is presently the case.

Essex Police have done significant work in the area of Firearms Licences where there is an associated record of domestic abuse, under operation Wishbone 24 licences have been revoked and 26 were surrendered in the period October 2013 to June 2014. This and similar operations require as full an intelligence picture as possible.

To achieve this will require the sharing of information at lower thresholds. This will allow more Agencies to contribute to the assessment of a person's suitability. Any applicant for a Firearms Licence should be required to authorise the sharing of relevant information to any relevant Agency as a prerequisite to obtaining a Licence.

Home Office guidance on Firearms Licensing provides detail on medical conditions that would warrant notification to Police. The absence of Dementia in that guidance could result in insufficient consideration being given to the risk presented, as such it is recommended that reference to Dementia be included in the next update of that guidance.

The current Home Office pilot scheme on Firearms Licensing has introduced a requirement for a Licence holders GP to flag the patient record, this is welcomed. At present this pilot only affects a Licence at the renewal stage, and will mean that some licence holders are not readily identifiable for continuous assessment until 2019. It is recommended that notifications are done as soon as possible and do not wait until renewal.

The Inquest concluded that Mr A took his own life and Mrs A was unlawfully killed. The Coroner submitted a Regulation 28 Report (REPORT TO PREVENT FUTURE DEATHS) on

25th March 2015 to the Home Office in relation to GP's recording and reporting of Firearms Licenses which supports recommendation 1.

The second area where there are lessons to be learned is in the integration of patient care. The Review has not identified any deficiency in such care but in seeking to learn lessons for the future it became apparent that a more holistic view of what the recipient of services required would be helpful in reducing any stress and pressure felt.

The introduction of provisions within the Care Act 2014 will go some way towards addressing the lessons learned from this Review. The identification of a post holder to coordinate the care requirements of patients will lead to a position where the person is more supported to identify a care pathway, rather than be the mere recipient of a range of statutory services. This will also introduce a more holistic approach, ensuring that a person is not only seen in isolation as an individual.

In respect of overarching themes the Review identified that sharing of information is at risk of being constrained by the classifications of risk. The result of this is that information relevant to other Agencies is not always being passed, due to the holding Agency judging the facts low risk on their assessment.

The 'need to know' principle is not limited to restricting the sharing of information, but where appropriate should also be applied to ensure that other Agencies have all relevant information on which to base their own professional assessments.

Whilst certain defined life changing situations are included within the DASH risk assessment tool, the DHR panel did not consider that it would capture a significant life changing event as stressful as the circumstances in this case. Consideration should be given to slightly amending the tool to allow it to consider such events.

Education and training in respect of safeguarding and specifically Domestic Abuse was evidenced in the IMRs received, individual actions have been raised to ensure that this continues. In addition it would be beneficial for the CSP to receive regular confirmation that any agreed mandatory training is being delivered within accepted target ranges.

In an area of multi-agency service provision, where a number of Agencies are working to achieve safeguarding, there may also be some benefit in bringing practitioners together for elements of any required training. This would allow a broader base within each Agency to gain some understanding of the roles, responsibilities and procedures within other Agencies operating in North East Essex

There are lessons to be learned. Independently the agencies involved have examined their role and have introduced or are introducing changes to processes and working practices for the future.

There was no evidence presented which suggested any equality or diversity issues in relation to age, gender or any of the other protected characteristics. However, this is an issue that should be considered in relation to any care pathway and access to services.

These will be further enhanced by the wider recommendations of this review.

Recommendations:

The following recommendations have been informed by the Independent Management Reviews. Agencies submitting IMR's have introduced their own local action plans details of which are included and compliment the Overview Report's Action Plan.

1. That Essex Police inform GPs of current firearms licence holders as soon as possible, requesting them to flag patient records, and do not wait to the licence renewal date. This recommendation should be considered nationally.

2. That the Home Office review and broaden the medical conditions within the Home Office Guidance on Firearms Licensing Law 2014 regarding psychiatric assessment, to specifically include consideration of Dementia.

3. A patient's GP should be notified of any assessment of risk completed in the course of a memory clinic appointment; this will allow the GP to have a more complete picture in assessing any required disclosure to Police in respect of the continuing suitability to hold a Firearm.

4. That the Home Office approved Firearms Licensing - Medical Pilot Scheme, which strengthens the grant and renewal process by notifying GPs that a patient holds a firearms licence and requiring that record to be flagged , be rolled out for adoption nationally.

5. The principle of promoting individual well-being as set out in Care Act 2014 Part 1 and Promoting integration of care and support with health services Care Act 2014 Section 3 should be taken forward. Care Act 2014 training should include material to ensure that any care assessment broadens its focus to embrace an holistic approach which considers impact and effect of other family members and life changing situations.

6. Previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey.

7. That the DASH template includes the impact of significant life changing events.

8. Agencies should, within legal guidelines, review their information sharing to ensure that they have not drifted into a position whereby, in the worst case, information is only shared when the holding Agency assess it as high risk. Information may be assessed as low risk but will still be relevant to the effective performance of partner.

9. Liaison and communication between the care providing agencies is improved by the provision of a strategic pathway of care, coordinated through a single point of contact or care manager to assist information gathering, analysis, assessment and sharing. There may be an opportunity to link current procedures. The provisions of the Care Act 2014, particularly sections 3 and 6 should drive a working group to establish guidance for Essex.

10. That it should be a prerequisite to the grant/renewal of a Firearms Licence that the applicant allow their GP to share relevant information to the holding of a Firearms Licence, with other agencies; which may otherwise fall within patient privilege.

11. Agencies should report to the Community Safety Partnership compliance rates with mandatory safeguarding training.

12. That the Colchester Community Safety Partnership organise a seminar to facilitate joint training and learning between Agencies in North East Essex on safeguarding and particularly their separate roles in preventing and addressing Domestic Abuse.

Report Author: David Murthwaite

Appendix i Action Plan

Appendix ii Event Commentry

Appendix i - ACTION PLAN

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
1. That Essex Police inform GPs of current firearms licence holders as soon as possible, requesting them to flag patient records, and do not wait to the licence renewal date. This recommendation should be considered nationally.	Local	Police to amend current pilot scheme letter and send to each Licence holders GP. Risk assessment to be made on those cases where no local GP identified.	Essex Police	Agreement of suitable letter. Letters sent to all relevant GPs Dip sample to receive confirmation that patient records have been flagged	Dec 15	
2. That the Home Office review and broaden the medical conditions within the Home Office Guidance on Firearms Licensing Law 2014 regarding psychiatric assessment, to specifically include consideration of Dementia.	National	Scheduled for consideration at next opportunity for re drafting the guidance	Home Office	Acceptance that Dementia should be referred to in the guidance Publication of amended guidance	Dec 15	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
3. A patient's GP should be notified of any assessment of risk completed in the course of a memory clinic appointment, this will allow the GP to have a more complete picture in assessing any required disclosure to Police in respect of the suitability to hold a Firearm.	Local	NEP NHS Foundation Trust to amend their report template	NEP NHS Foundation Trust	Template amended and adopted for use	April 15	
4. That the Home Office approved Firearms Licensing - Medical Pilot Scheme, which strengthens the grant and renewal process by notifying GPs that a patient holds a firearms licence and requiring that record to be flagged , be rolled out for adoption nationally.	National	Essex Police report to Home Office with appropriate recommendation to adopt the scheme	Essex Police	Report received at Home Office. Medical Pilot scheme adopted as National practice with patient records flagged	Dec 15	

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
5. The principle of promoting individual well-being as set out in Care Act 2014 Part 1 and Promoting integration of care and support with health services Care Act 2014 Section 3 should be taken forward. Care Act 2014 training should include material to ensure that any care assessment broadens its focus to embraces an holistic approach which considers impact and effect of other family members and life changing situations.	Local	Review of current practice Care Act Training to Adult Social Care staff	Essex County Council- Adult Operations NHS input?	Completion of review Training programme in place and roll out of training to ECC staff NHS input?	Mar 2015	July 2015

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome

6. Previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey.	Local	Link to 5				
7. That the DASH template include the impact of significant life changing events.	National	Referral to tool designer for consideration	Home Office	Recommendation considered and decision communicated	Dec 2015	

Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**

8. Agencies should, within legal guidelines, review their information sharing to ensure that they have not drifted into a position whereby, in the worst case, information is only shared when the holding Agency assess it as high risk. Information may be assessed as low risk but will still be relevant to the effective performance of partner.	Local	Each Agency to review their information sharing agreements and Service Level agreements to remove any limitation imposed by assessment of risk level	All	Confirmation that reviews have taken place. Publication of revised agreements where identified	Dec 2015	

Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**

9. Liaison and communication between the care providing agencies is improved by the provision of a strategic pathway of care, coordinated through a single point of contact or care manager to assist information gathering, analysis, assessment and sharing. There may be an opportunity to link current procedures. The provisions of the Care Act 2014, particularly sections 3 and 6 should drive a working group to establish guidance for Essex.	Local	Nomination of lead post Proposal on which cases will be subject to coordination Ensure linked to provisions of the care Act 2014 Production of model	Essex County Council - adult operations	Agreement on which post holder will lead. Agreement on scope of the pathway Delivery of guidance to relevant Agencies	Mar 2016	

Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**

10. That it should be a prerequisite to the grant/renewal of a Firearms Licence that the applicant allow their GP to share relevant information to the holding of Firearms Licence with other agencies; which may otherwise fall within patient privilege.	National	Amendment of Firearms legislation to incorporate the change	Home Office		Mar 2016	
11. Agencies should report to the Community Safety Partnership compliance rates with mandatory safeguarding training.	Local	CSP to decide upon which Agencies should report Reporting schedule identified	Colchester Community Safety Partnership	Agreement on contributing Agencies Safeguarding Training listed within Agenda	Dec 2015	

Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**

12. That the Colchester Community Safety Partnership organise a seminar to facilitate joint training and learning between Agencies in North East Essex on safeguarding and particularly their separate roles in preventing and addressing DVA.	Local	Identification of relevant Agencies Agreement of itinerary for the day Agreement on date to be held	Colchester Community Safety Partnership	Agreement on Agencies Timetable for the day planned Seminar held	Mar 2016	

Specific to IMRs						
Recommendation	**Scope of recommendation i.e. local or regional**	**Action to take**	**Lead Agency**	**Key milestones achieved in enacting recommendation**	**Target date**	**Date of completion and outcome**
Having taken part in a Home Office approved Firearms Licensing- Medical Pilot Scheme regarding the renewal of Firearms Licences this review recommends that Essex Police progress their liaison with the Home Office in an effort to have this scheme adopted nationally and a formal information sharing agreement put in place	National		Essex Police			

Firearms Enquiry Officers to be reminded that where there is a change in referees/counter signatories the reason for the change should be recorded. The referee/counter signatory on the previous application should be contacted to ascertain if they have been asked to be a referee and refused and if they refused, the reasons must be obtained and recorded	Local		Essex Police			

Replacement of databases Work is already in hand to replace the two current databases used by ECC Adult Operations with one new database MOSAIC. This will hopefully centralise, simplify and improve the efficiency of recording accessing and retrieving relevant information regarding ECC customers	Local		Essex County Council- Adult Operations			
Provisions for Carers in Care Act 2014 The previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey	Local		Essex County Council - Adult Operations			

All new clinical services will be commissioned via a standard NHS contract.	Local	Interim head of contracts convening a meeting to agree consistent approach to service reviews/contract reviews for new procurements.	NHS North East Essex Clinical Commissioning Group	Meeting held		
Safeguarding KPI's to be included in all NHS contracts with providers of services.	Local	Develop KPI's for safeguarding adults training. Safeguarding adult KPI's to be included in all current NHS contracts where appropriate. Safeguarding KPI's to be agreed by NEECCG Quality Committee Safeguarding adult KPI's to be included in all outstanding contracts where appropriate.	NHS North East Essex Clinical Commissioning Group		March 2015	

The contracting team, business managers and quality team to work collaboratively.	Local	All commissioned services now go through the Programme Management Office (PMO) process. The matrix and team working approach is promoted and embedded within the organisation**.**	NHS North East Essex Clinical Commissioning Group	Completed		
• The domestic violence policy should be reviewed within the next three months to cover the services of both child and adult.			Anglian Community Enterprises			
• Set up a Working group to design a strategic pathway for identification of key workers/case managers for vulnerable adults with mental health needs. Within the next 6 months			Anglian Community Enterprises			

• Establishment of a working group within the next three months to support Methods of monitoring of Clinical supervision offered to staff across the organisation			Anglian Community Enterprises			
• All referral systems should be reviewed to include a section that prompts the referrer to identify any mental health needs or safeguarding matters. • Communication could be improved with external agencies to support vulnerable adults with mental health needs. Practitioners need to be appropriately informed in relation to these needs to enable them to critically analyse situations and support individuals as effectively as possible			Anglian Community Enterprises			

• Recommended from the Trust Serious Incident Investigation Review was that risk (including if none identified) to be documented in the GP letter following routine memory monitoring appointments – this has been implemented fully.			North Essex Partnership NHS University Foundation Trust			
• Care arrangements should have been identified earlier on admission to CHUFT to avoid confusion as to what care was already in place for Mr and Mrs A and to assist social care in identifying whether a carers assessment was required.			Colchester Hospital University Foundation NHS Trust			
• To continue the rolling programme of safeguarding training for practice staff as per practice policy.			North Hill Medical Group			

• Inform the out of hours service of firearms licence holders as they do not access our computer records.		Draft letter to be sent to patients on receipt of a firearms notification from the police to share this information with out of hours.	North Hill Medical Group	Letter drafted and put into use.	April 2015	
• To consider working with GP's on referral regardless of referral route to identify any presenting risks that they are aware of including gun licences. We will communicate with our commissioners (North East Essex Clinical Commissioning Group) to establish if this is a process that could effectively be implemented.			Swan Housing Group			

Appendix ii - Event Commentary

Date	Event	Agency	Comment	Recommendation/IMR Action
18.11.2011	Letter received at GPs from police notifying that patient, Mr A, held a shotgun licence	North Hill Medical Group	No grounds to indicate that Mr A not suitable to hold a Licence. Letter filed but not readily visible on the patient record. Current pilot scheme asks GPs to flag a patients record to clearly identify that a patient holds a Firearms licence	**IMR** North Hill surgery to flag patient records to enable an assessment to be made of a persons continued medical suitability to hold a licence as additional information becomes available.
24.11.2011	Mr A Renewal of shotgun certificate	Essex Police	Mr A is interviewed as part of the renewal process. Considered suitable to hold a Licence. The counter signatory had changed from the previous application but the previous signatory was not contacted. In this instance not viewed as critical as no evidence existed at this time to show that there were any grounds to refuse the Licence.	**IMR** Essex Police to remind staff of the policy requirement to interview previous signatories when there is a change. **Rec 4** Current pilot scheme requesting GPs to flag patient records in respect of a Firearms Licence be rolled out nationally. **Rec 1**. Essex Police do not wait for renewal dates to notify GPs of existing Firearms licences, request flagging now.
11.08.12	GP referral to Memory Clinic for Mr A	NEP NHS Foundation Trust	No reference in the referral to the fact that the patient held a Shotgun Licence as police notification not visible on the patient record and existing constraints on sharing information.	**NHMG IMR action & Rec 10**. Agreement to sharing information with relevant Agencies should be a prerequisite of being granted a Firearms Licence

13.08.12	Hospital referral to Memory Clinic for Mr A	NEP NHS Foundation Trust	Patient referred due to fluctuating confusion and concerns of wandering whilst in-patient	
16.08.12	Mr A. NEP Hospital liaison assessment.Likely cause of delusional ideation and increased confusion is delirium. Advised to see GP if symptoms increase or fail to subside	NEP NHS Foundation Trust	No assessment of risk in respect of the possession of lethal weapons as information not shared on earlier referral	*As above. Agreement to sharing information with relevant Agencies should be a prerequisite of being granted a Firearms Licence*
17.08.2012	Home visit by Doctor following MR A discharging himself from hospital. Mr A described as '*saying the cottage is under siege*'. Doctor's Impression is delirium? due to ongoing infection	North Hill Medical Practice	If the patient's record had been flagged with a firearms Licence marker there may have been consideration as to the risks of leaving a lethal weapon accessible at this time. Temporary surrender not considered.	*As above. North Hill surgery to flag patient records to enable an assessment to be made of a persons continued medical suitability to hold a licence as additional information becomes available.*

17.08.12	Referral received from Health assessment team suggested that that Mrs A was not able to cope in caring for husband, nurse sought assistance of social worker to help with assessment	Anglian Community Enterprise	At this early stage it is clear that Agencies are working together. Colchester Hospital, North Hill Medical, NEP NHS Foundation Trust, ACE and Essex CC Adult Ops have all cross referred and liaised.	**Rec 9**. Liaison between the Health and Care providing agencies should be improved by providing a strategic pathway of care, coordinated through a single point of contact. There already exists a framework within Agencies to develop a coordinated plan, such as Care Plan Arrangements (CPA). There may be an opportunity to link current procedures. The provisions of the Care Act 2014, particularly sections 3 and 6 should drive a working group to establish guidance for Essex
19.11.2012	Following referral Mr A attends Memory Clinic and discloses that he has a shotgun licence	NEP NHS Foundation Trust	The NEP assessment provided to the GP includes reference to the possession of a shotgun. However as the Home Office Guide on Firearms Licencing Law does not specifically refer to Dementia the risk assessment remained focused on vulnerability to the patient.	**Rec 2**. That the Home Office review and broaden the medical conditions within the Home Office Guidance on Firearms Licensing Law 2014 regarding psychiatric assessment, to specifically include consideration of Dementia**Rec 8**. Agencies should, within legal guidelines, review their information sharing to ensure that they have not drifted into a position whereby, in the worst case, information is only shared when the holding Agency assess it as high risk. Information may be assessed as low risk but will still be relevant to the effective performance of partner Agencies.

13.09.2013	DVLA medical questionnaire completed by Dementia service	NEP NHS Foundation Trust	No issues identified in respect of driving. Similar questionnaires may be useful to determine a persons continuing suitability to hold a Firearms Licence.	
06.01.14	NEP memory monitoring appointment. Reported general decline in mental abilities	NEP NHS Foundation Trust	This assessment does not mention the access to a shotgun that was disclosed at the clinic held on 16.08.12. Home Office Firearms Guide would not drive an assessment of risk in respect of the weapon and any assessment remained focused on vulnerability of Mr A as the patient, No mention of risk in the report provided to the GP.	**Rec 3.** A patient's GP should be notified of any assessment of risk completed in the course of a memory clinic appointment, this will allow the GP to have a more complete picture in assessing any required disclosure to Police in respect of the suitability to hold a Firearm
22.04.2014	Mrs A taken to Colchester Hospital	Colchester Hospital		
28.04.14	Mr A visited by Community Matron accompanied by social care worker to make an assessment of his needs as Mrs A in hospital	ACE	Joint working between Health and Social Care continues. The recommendation in respect of identifying a coordinator will assist in improving the effectiveness of this response.	

01.05.2014	GP referral to Swan. Commissioned to deliver a rapid response service, initial care and risk assessment undertaken. Assistance provided include bed making, shopping and home care.	NEECCG	Original contract with Swan was funded by additional winter funding which led to a non-standard NHS contract. In turn this resulted in the omission of standard performance monitoring indicators, including safeguard training. There is no issue though with the standard of service provided.	**IMR** NEECCG will now always use the standard NHS contract
06.05.2014	Mrs A readmitted to hospital		Further contact is made with Mr A to ensure that he is coping at home. Again the existence of a nominated coordinator for the couple would assist in providing clarity on what services are in place and how they link together in supporting the couple. In addition to the structural recommendation 9, further recommendations are made in respect of training.	**Rec 5**. The principle of promoting individual well- being as set out in Care Act 2014 Part 1 and Promoting integration of care and support with health services Care Act 2014 Section 3 should be taken forward. Care Act 2014 training should include material to ensure that any care assessment broadens its focus to embraces an holistic approach which considers impact and effect of other family members and life changing events.**Rec 6**. Previous legislation with regard to Carers rights to advice, assessments and services/support is updated by provisions in Care Act 2014. Training/re-training for all practitioners likely to be involved in assessments or reviews of carers will therefore be required and should be mandatory. This should include practitioners at all stages of the customer journey

15.05.2014	Mr A visited at home by GP to assess and consider mental capacity to decline services. GP happy that on balance Mr A is able to make decisions for himself. He assured GP that he would accept help from Social care.	North Hill Medical Group	Continued evidence of cross Agency involvement in supporting the couple. As they had declined help on previous occasions this event assessed mental capacity to make decisions.	**Rec 7**. That the DASH template includes the impact of significant life changing events.
16.05.2014	St Helena Hospice contacts GP following referral from Hospital	North Hill Medical Group	Again, joint Agency work to provide future support to Mrs A.	
20.05.2014	Mrs A referred to Swan on being discharged from Colchester Hospital	Swan	Results in further risk assessments at the home address. Continuous care visits undertaken. As this is a crisis service there is usually a 6 day limit on provision. As a measure against care being missed from those needing a service Swan will now notify patients GP when they stop service provision.	**IMR**. Swan to notify patients GP when service provision stops
24.05.2014	Police receive call from Mr A and attend to discover both Mrs A and Mr A dead.	Essex Police		
				There are 2 additional recommendations. One in respect of Agencies reporting compliance with training to the CSP and a second recommending the facilitation of a joint training day for Agencies to improve cross Agency knowledge of roles and responsibilities.