BIRMINGHAM COMMUNITY SAFETY PARTNERSHIP
WORKING TOGETHER FOR A SAFER CITY

Domestic Homicide Review under section 9 of Domestic Violence Crime and Victims Act 2004

In respect of the death of a woman

BDHR2012/13-02

Report produced by Gill Baker OBE, BA (Hons)

Independent Chair and Author

Presented to Birmingham Community Safety Partnership on 9th May 2013

GLOSSARY

BCC: Birmingham City Council

Birmingham & Solihull NHS Cluster: Primary Care Trusts responsible for commissioning local health services (until April 2013 when statutory responsibilities were transferred to the new Clinical Commissioning Groups)

BSCP: Birmingham Community Safety Partnership

BSMHFT: Birmingham & Solihull Mental Health Foundation Trust – the organisation providing local mental health services

CCG: Clinical Commissioning Group

CORE: Clinical Outcomes in Routine Evaluation

DHR: Domestic Homicide Review

GP: General Practitioner

IMR: Individual Management Review – reports submitted to review by agencies

MAPPA: Multi-Agency Public Protection Arrangements

MHA: Mental Health Act

NICE: National Institute for Health & Care Excellence

PHQ: Patient Health Questionnaire

RCGP: Royal College of General Practitioners

SCR: Serious Case Review

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1. Introduction

1.1 In the early hours of 8 May 2012, a telephone call was received by West Midlands Ambulance control from a male, now known to be the alleged perpetrator who stated that his wife, the victim, had been choked at their home address. West Midlands Police were also informed and upon arrival at the home address police officers had to force entry into the property as it was found secure and in darkness. The officers found the alleged perpetrator slumped on the stairs supported by a ligature tied around his neck from the top banister post. He was unconscious and the ambulance technicians commenced CPR (cardiopulmonary resuscitation). The body of the victim was found in the main bedroom and efforts to resuscitate her proved unsuccessful. She was pronounced dead at the scene. The alleged perpetrator had a weak pulse and was immediately taken to hospital. A post mortem took place and the cause of death of the victim was found to be strangulation. Indications from the injuries sustained by the victim are that a struggle had taken place before her death. The police were unable to question the alleged perpetrator about the events leading up to the death of his wife as he sustained a severe hypoxic brain injury and required constant nursing supervision and was unable to communicate until his own death later in 2013.

1.2 Birmingham Community Safety Partnership (BCSP) was notified of the death of the victim on 11 May 2012 and subsequently the Domestic Homicide Review Steering Group reviewed the circumstances of this case against the criteria set out in the *Multi Agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2011)*. On 18 May 2012 the DHR Steering Group recommended to the Chair of Birmingham Community Safety Partnership that a Domestic Homicide Review should be undertaken. The Chair ratified the decision to commission a Domestic Homicide Review (DHR) on the 03 June 2012 and the Home Office was notified on 06 June 2012.

1.3 In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The BCSP has balanced

the need to maintain the privacy of the family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

2. Purpose, Scope and Terms of Reference

2.1 The purpose of this DHR is as outlined in section 3.3 of the Multi Agency Statutory Guidance, namely to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to the policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2.2 A DHR is not an inquiry into how a victim dies or into who is culpable as those matters are for Coroners and criminal courts to determine. DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges during the course of a DHR which indicates that disciplinary action should be initiated then the established agency disciplinary procedures should be undertaken separately to the DHR process.

2.3 It was determined that this DHR should focus on events from four years prior to the date of the victim's death. This time parameter was chosen due to the

fact that it was apparent that the death of relatives and friends, particularly the death of his mother seemed to have a detrimental effect upon the alleged perpetrator who was subsequently treated for depression. However it was stipulated that should agencies identify information from an earlier date which is relevant to the findings of the DHR then that should be included.

2.4 The most important issues to be addressed by agencies, in trying to learn from this case were identified in the Terms of Reference as:

Generic issues identified in Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2011)

- *Were practitioners sensitive to the needs of the victim and perpetrator, knowledgeable about potential indicators of domestic violence and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them, given their level of training and knowledge to fulfil these expectations?*

- *Did your agency have policies and procedures for risk assessment and risk management for domestic violence victims or perpetrators and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence? Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a MARAC?*

- *Did your agency comply with domestic violence protocols agreed with other agencies?*

- *What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?*

- *Did actions or risk management plans fit with this assessment and decisions made? Were appropriate services offered or provided or relevant enquiries made in the light of the assessments, given what should have been known at the time?*

- *When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?*

- *What was known about the perpetrator? Were they being managed under MAPPA?*

- *Had the victim disclosed to anyone and if so, was the response appropriate?*

- *Was any information shared and recorded appropriately?*

- *Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim/ perpetrator and their families? Was consideration for vulnerability and disability necessary?*

- *Were senior managers or other agencies and professionals involved at the appropriate points?*

- *Are there questions that may be appropriate and could add to the content of the case?*

- *Are there ways of working effectively that could be passed on to other organisations or individuals?*

- *Are there lessons to be learned from the case relating to the way your agency works to safeguard victims and promote their welfare, or the way that it identifies, assesses and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training,*

management and supervision, working in partnership with other agencies and resources?

- *How accessible were the services for the victim and perpetrator?*

- *To what degree could the homicide have been accurately predicated and prevented?*

Additional specific issues to be addressed by:

General Practitioner

- *All aspects of care and treatment of mental health issues in respect of the victim and the alleged perpetrator*

- *Whether there were any safeguarding issues in respect of the victim, or others, and whether these were appropriately managed.*

- *Whether the assessment of risk was appropriate and adequate in the light of recent presentations and previous clinical history.*

3. Process

3.1 Notification of the DHR was sent to agencies who were asked to identify whether there was any involvement with the family and if so to undertake a management review of any contact with the victim and the alleged perpetrator. The agencies were requested to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. It was requested that a senior member of staff who had no involvement with the case, complete the Individual Management Review (IMR). Guidance notes which included a template for the review report were provided to each agency. It was requested that upon completion, each IMR be agreed by that organisation's senior managers who would be responsible for ensuring that their single agency

recommendations are acted upon. If agencies had no contact with the victim or the alleged perpetrator, they were asked to complete a 'nil' return. Those agencies which had minimal involvement provided an information report.

3.2 A DHR Panel was established to actively manage the serious case review process and to obtain all relevant information from agencies and any parallel processes. The Panel's role was to ensure robust analysis of IMRs and information reports, and that the overview report accurately reflected agency contributions and met the requirement specified in the Multi Agency Guidance. The Panel was set up with an Independent Chair/Author and representatives from a range of agencies relevant to this case. In addition expert opinion was sought from a Consultant Psychiatrist in relation to issues concerning the mental health of the alleged perpetrator, of his presenting behaviour and of the treatment provided.

3.3 At the first meeting of the DHR Panel, the terms of reference provided by the Domestic Homicide Review Steering Group, were reviewed and amendments were made.

3.4 In this case it has been established that there was very little involvement by agencies and professionals with the victim and family and as a result only two IMRs were provided. The authors of the IMRs were individually briefed by the DHR independent Chair/Author and a member of the DHR Panel.

3.5 Upon receipt of the IMRs, a composite chronology of events was produced. The IMRs and integrated chronology were discussed by the DHR Panel and any discrepancies or need for further information was resolved by verbal and written communication. The IMR authors were invited to and attended a panel meeting when they presented their reports and opportunity was given to

discuss the contents with panel members. Amended final IMRs were received from the agencies as indicated in paragraph 5.

3.6 Contact was made by the independent Chair/Author with the Senior Investigating Officer of the criminal investigation who attended a Panel meeting and provided information regarding the case.

3.7 The Review Panel met on five occasions to consider the IMRs, information reports and to progress this Overview Report.

Timeliness of Review

3.8 It was possible at the commencement of this review that a delay in completion may occur due to the criminal investigation and Inquest proceedings. It was agreed that legal proceedings should at no time be compromised. Criminal proceedings have not been instigated but information has been provided from the police investigation which has been included in this Review. The Inquest has been opened and the hearing is to be held early in 2014.

3.9 This review has exceeded the six months timeframe specified for the purpose of a DHR. Although momentum for the review was maintained during this period, delays were experienced whilst expert opinion was sought and whilst services provided to the alleged perpetrator via his employment were examined.

3.10 The Overview Report and Action Plan was presented to the DHR Steering Group of the BCSP on 23 April 2013 and to the Executive Board of the BCSP on 9 May 2013 when the DHR report and action plan was agreed.

4. Domestic Homicide Review Panel

4.1 **Independent Overview Chair and Author:** Gill Baker O.B.E.

The Chair and Author of the overview report is a retired police officer and is independent of all the local agencies and professionals involved in the case, and of the Birmingham Community Safety Partnership. During the last ten years of her thirty year police service she was a Detective Inspector specialising in child protection, domestic violence, sexual offences, sex offender management and vulnerable adult protection. Within her role she was responsible for compiling police individual management reviews and was a member of many Serious Case Review[1] panels across the West Midlands area. She was involved in the development of local, national and international multi-agency projects and initiatives as well as policy and procedures for the police service. Her work in this field was recognised when she was awarded an OBE in 2006 for services to the police. Since retirement she has been an independent Chair and/or Author of a previous DHR as well as eight serious case reviews. She has also chaired and authored a MAPPA[2] serious case review.

4.2 The members of the panel are senior managers from the key statutory agencies who had no direct contact or management involvement with the case and were not the authors of Individual Management Reviews.

Panel Members:

- Senior Service Manager for Violence Against Women – Birmingham Community Safety Partnership
- Designated Nurse – Safeguarding Adults and Children and Mental Capacity Act Lead for Solihull Clinical Commissioning Group (formerly Head of Safeguarding Adults & Children, Birmingham and Solihull NHS Cluster)
- Operations Manager, Birmingham & Solihull Women's Aid

[1] Serious Case reviews in respect of child deaths as per 'Working Together' guidance
[2] Multi Agency Public Protection Arrangements

- Safeguarding Lead, Women, Domestic Violence & Sexual Safety, Birmingham & Solihull Mental Health Foundation Trust

4.3 It should be noted that the Panel membership, although small, was proportionate to the involvement of agencies in this case and included voluntary as well as statutory representation.

5. Individual Management Reviews

5.1 IMRs were received from the following agencies who were involved with the victim and/or the alleged perpetrator.

Agency	**Original IMR received**	**Amended Final IMR received**
Birmingham and Solihull NHS cluster (GPs)	30.11.12	12.02.12
Staffcare – Birmingham City Council	21.1.13	17.04.13

5.2 Information Reports

Due to a minimal involvement with the victim and/or the alleged perpetrator, information reports were obtained from the following agencies on the dates shown.

Birmingham Community Healthcare NHS Trust	18.05.2012
Birmingham City Council Occupational Health	01.02.2013
Heart of England NHS Foundation Trust	23.05.2012
Sandwell & West Birmingham Hospitals NHS Trust	08.06.2012
University Hospitals Birmingham NHS Trust	25.05.2012

5.3 No agency involvement

Twenty two agencies made advised that they had had no contact with the victim or the alleged perpetrator. Those agencies are listed below:

- Aquarius
- Ashram (Domestic Violence Service)
- Birmingham and Solihull Mental Health Trust
- Birmingham City Council Adult Social Care
- Birmingham City Council Children, Young People and Families
- Birmingham City Council Legal Services
- Birmingham City Council Homeless Service
- Birmingham City Council Neighbourhood Advice Service and Contact Centre
- Birmingham Community Safety Partnership Safer Communities Team
- Birmingham MIND
- Birmingham and Solihull Women's Aid
- Birmingham Crisis Centre
- Birmingham Rape and Sexual Violence Project
- Birmingham Women's Hospital Foundation Trust
- Birmingham Drug and Alcohol Action Team
- Royal Orthopaedic Foundation Hospital Trust
- Shelter (Domestic Violence Service)
- Salvation Army (Domestic Violence Service)
- Trident Reach the Charity (Domestic Violence Service)
- West Midlands Police
- West Midlands Ambulance Service

5.4 Methodology, Quality and Timeliness of Independent Management Reviews

5.5 The Panel have considered two IMRs. Those two agencies reviewed their computer and paper records, details of which are itemised within their respective IMRs. Both agencies, conducted interviews of their staff to enhance the quality of their IMRs and to try and get an understanding of not only what happened but why something did or did not happen. Contextual information relating to volume of work, staff turnover, training, sickness, organisational change management and supervisory practice is contained within each IMR. Both IMR authors were individually briefed by the Chair/Author of this Review and by a member of the DHR Panel.

5.6 The Panel robustly scrutinised and quality assured each IMR and information reports. Specific issues were raised verbally and in written form with each of the IMR authors, which resulted in amendments and additions. There was a timely response from all of the agencies involved to the issues raised.

5.7 Both IMRs are of a satisfactory standard and for both IMR authors it was the first time that they had undertaken an IMR.

6. Family/Relationship Background

6.1 The victim and the alleged perpetrator were married for 36 years and had lived at the same address in Birmingham throughout. They have two adult children who both lived independently of the family home at the time of the incident. This was a close knit family who kept in regular contact and spent time together. Other extended family members live mainly in the same part of Birmingham. All family members are of white British ethnicity. The victim was employed as a teaching assistant and tutor for children with special needs at a local high school. The alleged perpetrator was employed as a property

assistant for a local authority. The victim's mother passed away in 2009 which was just over a year after the alleged perpetrator's mother passed away which had proved to be a very difficult time for the family.

6.2 The couple lived in an area of Birmingham where there is a wide variety of household types and in their particular vicinity, a patchwork of relatively affluent and less well off households. The unemployment rate and the long term unemployment rates are both higher than the city average.

6.3 By May 2012, the scale of spending cuts facing the public sector in general and the alleged perpetrator's employer in particular had been attracting headline news for some months. However, compulsory redundancies were not anticipated at this time although at one stage the alleged perpetrator had been interested in applying for voluntary redundancy from his employment but this never materialised.

6.4 The GP practice used by both the victim and the alleged perpetrator is part of a wider group of practices forming a partnership which provides the corporate business structure (including policy and procedural framework) behind the local service provided by individual surgeries. At their particular GP practice there are four GPs serving a population of 8,200 patients. The IMR author did not identify any significant events that would have impacted upon service delivery during the timeframe of this Review.

6.2 Equality and Diversity

Section 149 of the Equality Act 2010 introduced a public sector duty which is incumbent upon all organisations participating in this review, namely to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The review gave due consideration to all of the protected characteristics under the Act, and found both age and mental ill health to be relevant. In this particular case, it is evident that poor physical health and mobility issues, awareness of his age, together with the bereavement of elderly close family members seems to have had a detrimental effect on the alleged perpetrator's mental wellbeing and that his mental ill-health had so significant a long-term effect upon his normal day-to-day activity as to be considered a disability as defined by the Equality Act 2010. Had the Panel been made aware of any indication of domestic violence or abuse prior to the incident, then consideration would have been given to any issues of gender imbalance or inequality in their relationship. However, none were made known.

7. Chronological Sequence of Events

7.1 Information known to individual agencies and professionals involved with the family was aggregated together into a single detailed chronology. It should be noted that prior to the period subject of this review, contact with agencies and professionals by the victim and the alleged perpetrator was minimal and consisted in the main of routine health care appointments and there have been no significant events identified. During the period subject of this review however, the alleged perpetrator was a frequent visitor to his GP. No agency or professional has reported any knowledge or indication of domestic abuse within the relationship of the alleged perpetrator and the victim which is supported by information gleaned from family and friend interviews. The following extracts from the integrated chronology and from agency IMRs, are the independent author's view of the significant events which occurred prior to the death of the victim.

7.2 On **9 May 2008** the alleged perpetrator visited his GP (1) for a consultation about pain in his knees. It was noted that he was stressed due to his mother's ill health. During the following two weeks he and the victim were issued with sick notes by the GP relating to the bereavement of his mother.

7.3 During the next 14 months the alleged perpetrator was seen by GPs at the Practice on 11 occasions all of which related to physical health issues which included arthritis, hypertension (high blood pressure) and dyspepsia (indigestion), and he was to receive routine medical tests, such as blood pressure checks, blood samples and medication reviews. He was also referred to hospital for outpatient treatment in relation to these physical ailments.

7.4 On **17 August 2009** the alleged perpetrator was seen by a Counsellor of a short term counselling service which was provided by his employers. This confidential service is available to all of the employees of the organisation but is by self-referral only and no information is offered to managers or other agencies unless requested by the client. However any 'at risk clients' or those needing a longer or psychiatric intervention would be referred to the GP to access the appropriate support. The alleged perpetrator presented with issues of anxiety and of multiple losses (bereavements). It was initially assessed that there was a mild to moderate degree of risk of self harm and there was no risk to others. He was to state that he was not suicidal. The alleged perpetrator received a total of six counselling sessions, the last being on **12 October 2009** when it was assessed that *the 'risk of self harm significantly reduced – now within non clinical range. No risk of harm to others'.* There was no referral to any other agency or professional. It should be noted that at this time (prior to June 2010) the need for referral to a GP was considered on an individual basis and the 'at risk' clients would be discussed with the clinical manager in order to decide on any necessity for external communication. It

should be noted that the procedure currently is that the GP is automatically notified by letter if a client is assessed as 'at risk' and requires additional counselling.

7.5 During the period that the alleged perpetrator received counselling he was seen by his GP on two occasions and again these consultations and medical tests related to physical health matters.

7.6 During the next 15 months the alleged perpetrator saw GPs at the Practice on 21 occasions and again all of these consultations related to his physical health and included medical tests. There was referral from the GPs in respect of the alleged perpetrator to specialist services, including ophthalmology, podiatry, gastroenterology and orthopaedics, for investigations and treatments.

7.7 On **8 February 2012,** the alleged perpetrator saw his GP (1) when he reported being depressed about deaths and illnesses of family members and friends, problems at work, and he displayed introspective and anxiousness symptoms. A depression assessment tool, the PHQ questionnaire[3], was completed. The alleged perpetrator scored 22 out of 27 which indicated severe depression. He was given advice by the GP and copies of information leaflets to take with him. There is no record of exactly which leaflets he was given but typical leaflets given out by this GP practice would be information sheets on Anxiety and on Depression produced by Northumberland, Tyne & Wear NHS Trust. Included in these leaflets are national help and information lines, recommendations for further reading and basic self-help strategies. The alleged perpetrator was prescribed anti depression medication (10mg Citalopram daily).

[3] PHQ tool – the patient is asked 9 questions based on key symptoms of depression, and scores them 0-3 based on how frequently they have been experiencing the symptoms over the past two weeks. The score is totalled and depression severity is then graded as follows: 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe

7.8 On **24 February 2012** the alleged perpetrator saw his GP (1) when his condition was reviewed. He complained of insomnia and expressed some suicidal symptoms. His anti-depressant medication (Citalopram) was increased to 20mg daily. He was advised to speak to his occupational health at work and was given more advice leaflets.

7.9 On **1 March 2012**, the alleged perpetrator was seen by his GP (3) for a review when he stated that he felt unable to cope at work and had been sent home from work the day before. He was issued with a sick note for a two week period.

7.10 On **5 March 2012,** the alleged perpetrator was again seen by a Counsellor at the short term counselling service provided by his employer for an assessment when mild to moderate risk of self harm was identified but no risk of harm to others was found. This assessment of risk was achieved by using a procedure known as Clinical Outcomes in Routine Evaluation (CORE).[4] Presenting issues included low mood, anxiety, low self-esteem and depression, associated with the relocation of his work which was near to where his deceased mother had worked. He felt that this had caused feelings about her death and other losses to resurface. The alleged perpetrator disclosed that he had thought of jumping in front of a 'bus but decided not to due to the distress it would cause to his family'. The alleged perpetrator gave a verbal guarantee to the Counsellor that he would not hurt himself. A letter was sent to the alleged perpetrator's GP to the effect that he had indicated self harm due to low self-esteem. It was reiterated that the service provided short term 'occupational' health and that more long term psychological support was requested to enable the alleged perpetrator to manage the risk of self harm. The alleged perpetrator consented to, and signed a form, to the

[4] The CORE programme is used in conjunction with the therapist (counsellor)'s own assessment and consists of a therapist assessment and workplace assessment, both of which are completed by the therapist, and outcome measures which is a questionnaire completed by the client.

effect that his GP could be informed of this assessment. The letter was received at the GP practice on **9 March 2012.** The alleged perpetrator was advised by the Counsellor of the availability of the telephone helpline and requested a priority appointment for ongoing sessions.

7.11 The alleged perpetrator was seen by his GP (1) on **12 March 2012** when his PHQ score was 17 (moderately severe). The GP felt not able to increase previous medication and therefore the alleged perpetrator was prescribed Sertraline[5] (50mg). The alleged perpetrator was still feeling low and it was noted, 'he will have counselling at work and would speak with his manager about reduced hours and a phased return to work'. A sick note and prescription was issued.

7.12 On **16 March 2012** the alleged perpetrator attended a counselling session when his anxiety about the future and fear of death was discussed. He also ruminated over past losses and distress about his current loss of hair and libido. It was noted that he remained off work and anxiety management techniques were provided to him.

7.13 The alleged perpetrator was seen by his GP (2) on **19 March 2012** when his PHQ score was again 17 (moderately severe). It was recorded that the patient 'remains low, has started counselling – helping – Sertraline not kicked in yet'. It was recorded that they had a long chat 'no risk factors'. Also that the alleged perpetrator's employer had suggested he start back to work in one or two weeks or take unpaid leave. It was decided 'to increase Sertraline to 100mg in a few weeks if no better'. The alleged perpetrator was also prescribed medication (Zopiclone) for sleeping.

[5] Anti depressant

7.14 On **23 March 2012** the alleged perpetrator attended a counselling session when time was spent exploring his grief and regrets. He stated that he had been told by his manager of a referral to Occupational Health. However no referral was received by Occupational Health.

7.15 On **29 March 2012** the alleged perpetrator saw his GP (3) when he was reviewed and he stated that he wanted to try to return to work the next week on altered hours.

7.16 On **30 March 2012** the alleged perpetrator attended a counselling session when he stated he felt lighter in mood and intended to return to work the next week. Sleeping problems and possible strategies to aid his return to work were discussed.

7.17 On **11 April 2012** the alleged perpetrator saw GP (1) when he reported getting side effects from the Sertraline and that this medication was not helping. He felt anxious all the time and was having trouble sleeping. The alleged perpetrator's medication was changed from Sertraline to Escitalopram (anti-depressant).

7.18 On **13 April 2012** the alleged perpetrator attended a counselling session when he discussed a recurrence of 'sense of overwhelm at work' and negative self talk was identified. He was concerned about letting everyone down and stated that his manager was going to do a risk assessment and referral to Occupational Health. Again no referral was received by Occupational Health.

7.19 On **13 April 2012** and **27 April 2012** the alleged perpetrator was seen at the GP surgery for a blood test and a blood pressure test which were carried out

by practice nurses. Also on **27 April 2012** the alleged perpetrator attended a counselling session but arrived very late stating that he had been stuck in traffic but was very anxious and asked to leave because of other commitments. He did however report 'overwhelm at work' and it was agreed that he would attend two follow up sessions.

7.20 On **01 May 2012** the alleged perpetrator saw GP (3) and recorded in the patient record is "*had a chat, unable to cope at work, c/o feeling anxious and paranoid, feels brain is frozen on meds. Pt would like to be seen by private psychiatrist. Advised to ring with name of consultant and date and time of appointment."* When subsequently interviewed for this review GP (3) confirmed that the alleged perpetrator had presented as anxious and agitated on this date. He had been unable to cope upon his return to work, had been tried on various medications, had received short term counselling via the workplace with limited success and was now at the point that the GP offered to refer the alleged perpetrator to secondary mental health services. As he wished to be seen privately a suitable private hospital was suggested as one possibility.

7.21 On **8 May 2012,** in the early hours following a telephone call to the ambulance service, the body of the victim was found in the bedroom of the home address and the alleged perpetrator was found unconscious after what appears to have been an attempt to take his own life. The police commenced a criminal investigation.

8. Family/Friends/Colleagues Involvement

8.1 As part of this DHR the children of the victim and the alleged perpetrator, and a friend who was also a work colleague of the victim were contacted and were willing to contribute to the review. Subsequently the DHR independent

Chair/Author and a member of the DHR panel saw the children on 20 November 2012 and the friend on 6 February 2013. A work colleague of the alleged perpetrator was also contacted but declined to contribute to this review.

8.2 The victim and the alleged perpetrator were described by their children as generous and caring and they were a happy and very close family who maintained significant contact, often on a daily basis. They stated that there had been no stresses within the family apart from their father's deteriorating mental health which they believed had begun at the beginning of 2012. There was no violence, issues with alcohol or financial problems within the family. Their parents socialised with family and with a small group of friends. They stated that the alleged perpetrator had suffered physical ill health including a hip replacement and treatment to his knees, both of which had impaired his mobility and made him very cautious in his recovery. They described how the alleged perpetrator had found it increasingly difficult to go to work and his son recalled in February 2012 that his father had unusually asked him to pick him up from work as he felt unable to cope. They were also aware that their father had been taken home from work on other occasions by work colleagues. The victim had encouraged the alleged perpetrator to get to work and would ask him to email her to confirm that he was at his desk. The children had observed the alleged perpetrator behaving increasingly in an irrational way. He became pre-occupied with not having achieved anything, not having moved house and of being a failure. His daughter encouraged him to try and approach these negative thoughts by getting him to write them down to analyse the problems and to look at the pros and cons. The alleged perpetrator thought that the police were following him because he was not going to work, that he would be arrested and therefore he would make detours in journeys. He took to wearing his coat indoors as he felt safer.

8.3 The alleged perpetrator told his children that he was having side effects from the medication he was taking and described it as causing dryness to his

mouth and hands, plus he was having difficulty sleeping. The victim had become somewhat exasperated and worn down and was worried that the alleged perpetrator might injure himself. The children stated that the family had never had any experience of mental health problems and did not know how to handle the situation. They were unhappy with the way that their father was dealt with by the GPs who they felt had failed to involve or respond to concerns of the family. They recounted an incident whereby the son had driven his parents to the GP surgery and his father wanted the son to wait in the car whilst he was accompanied by their mother into the surgery. However their mother told them that when the GP asked the alleged perpetrator whether he had dark thoughts, she was asked to leave the room. Subsequently after being asked to leave, she felt it harder to approach the GP with concerns. They understood that their father had been told that it would take six months to get an appointment with an NHS Counsellor. Also the daughter described many attempts to engage with the GP practice to no avail and when she had enquired about a referral for the alleged perpetrator for a private health assessment, she was informed that the normal process takes six weeks. Their mother also told them that the GP would not sign the alleged perpetrator off work again but increased his anti-depressant medication instead. Their father was very pleased when at his last visit to the GP he was told that a referral letter for a private health consultation would be provided. The children stated that it was the victim's intention to contact the GP on the day of her death as she was very concerned about the alleged perpetrator. On a day out during the weekend, they had to return home early as the alleged perpetrator thought he was being followed by the police and that he would be arrested for not going to work. The GP surgery was due to reopen on the day of the victim's death, which was a Tuesday after a bank holiday weekend.

8.4 The friend who was also a work colleague of the victim stated that they had known each other for at least 15 years. The victim was described as a very strong, generous, affectionate, extrovert, bright, bubbly and sociable person who loved her work. She never took time off, readily took on responsibilities and was a person who 'never gave up on people', always encouraging of

others. The alleged perpetrator was described as a kind, nice man and the relationship between him and the victim seemed very close with them spending their social time together. The friend believed that the alleged perpetrator's mental health issues began after his hip operation and felt that he dreaded going back to work. He did not enjoy his job, partly because he did not feel busy enough but also because he felt exposed when he was moved into an open plan office. The friend believed that he did not want to do anything to change his work conditions but he did want to leave. The victim on the other hand encouraged him to go to work, would often take him to the bus stop to make sure that he went, sometimes following the bus. Initially she would ask him to ring when he got there but latterly would ask him to email her so that she knew he was there. The victim wanted the alleged perpetrator to stay at work and the friend reflected that she was trying to achieve normality which she felt would help to make him well. The victim had described difficulty in getting the alleged perpetrator to the doctor. She expressed a belief that the doctor did not understand how ill the alleged perpetrator was and that she was frustrated about not getting more help but did not know what to do about it. The friend understood that the alleged perpetrator thought that people were following him and that people were watching him. He would become agitated when watching the television and kept his coat on indoors as he felt safer. The victim was concerned about the alleged perpetrator harming himself and would not leave him alone which in turn placed great restrictions on her social life. An example was her not attending her daughter's hen party weekend as she felt it unsafe to leave him alone in the house. The victim would also check on the alleged perpetrator during the night and she herself had not slept properly for a couple of years. Upon reflection the friend believed that the victim had been stressed for some time. The friend saw the victim three days before her death when she said that she and the alleged perpetrator were going on a day trip but received a text message later that day to the effect that they had returned home early because the alleged perpetrator believed that people were following him. The message went on to say that the victim was to make an appointment with the doctor to 'make him see that he's unwell'. It wasn't clear whether the 'him' referred to was the alleged perpetrator or the doctor. The friend stated that

there was never any indication of any violence between the alleged perpetrator and the victim.

8.5 The Independent Chair/Author and a member of the DHR panel met with the son and daughter on 22 April 2013 when the findings of this DHR were verbally shared with them. They were handed a written summary of the information that they had provided and which has been included in the Review. They both agreed that this was an accurate account. They both stated that their father's reluctance to go to work seems to have been a symptom of mental illness as he had always previously enjoyed his work. They appreciated the fact that the Counselling Service had referred onto the GP the recommendation that their father would benefit from longer term psychological counselling and they both expressed concern about what they perceived as the inaction of the GPs.

9. Criminal Investigation and Inquest

9.1 The criminal investigation found that there was no evidence of third party involvement in the death of the victim. When the police attended the incident the property was locked and secure with no signs of forced entry. It was established that the victim died as a result of strangulation and that the alleged perpetrator called for an ambulance, made an admission to the call taker that he had 'choked his wife' and then attempted to take his own life. The alleged perpetrator's medical condition did not improve before his death later in 2013 and he was never fit to be interviewed about the death of the victim. Therefore criminal proceedings were not instigated.

9.2 During the criminal investigation, family, friends and work colleagues provided information regarding his behaviour and paranoia which was reflected during the interviews conducted for this Review in connection with family/friends involvement.

9.3 A police report has been submitted to the Coroner and an Inquest Hearing is to be held on a date in early 2014.

9.4 There are no other parallel investigations in relation to this case.

10. Analysis

10.1 The victim and the alleged perpetrator were married for 36 years and it is evident from the findings of this DHR and from the police investigation that there is no indication of an abusive or violent relationship between them. They had two children who are now adults and whilst they were living away from the family home at the time of the incident, the family unit maintained close and regular, almost daily, contact. It is evident that this was a close knit family who also resided near to extended family members. The family were to experience a difficult period after the bereavements of both the alleged perpetrator and the victim's mothers and it was from that time (May 2008) that the alleged perpetrator first showed signs of stress.

10.2 The only agencies involved with the victim and the alleged perpetrator were from health: primarily their GP Practice plus a short term counselling service provided to the alleged perpetrator by his employers. During the period of this review the victim was an infrequent visitor to the GP practice for routine matters linked to physical health. The alleged perpetrator on the other hand was a frequent visitor to the GP practice and was seen in person on 51 occasions. The majority of these visits related to physical ailments for which he was also referred to specialist services for investigations and treatment at hospitals. He underwent a hip replacement operation in August 2011 and it was established during the criminal investigation and from the information gleaned from family/friend contribution to this review that when he returned to work, his behaviour and personality seemed to change. It is clear that a rapid deterioration in the alleged perpetrator's mental health followed. At the beginning of February 2012 he visited his GP and reported being depressed about bereavements, problems at work and he displayed introspective and

anxiousness symptoms. He was seen a further seven times at the GP practice in connection with his depression and was prescribed anti-depressant medication. He was signed off work from 1 March 2012 for a month after he had been sent home from work. The alleged perpetrator referred himself and received a course of short term counselling which was provided by his employer.

10.3 There was no interaction between the GPs and the family of the alleged perpetrator despite attempts by the family to engage. The GPs were reliant upon what the alleged perpetrator disclosed and as their recording is fairly scant, it seems likely that the full extent of the fairly rapid deterioration and increasingly paranoid behaviour of the alleged perpetrator was not known by those health professionals. A referral for secondary mental health services was not made although it was decided on the alleged perpetrator's last visit to the GP that he was at the stage where this was appropriate. Of concern is the perception that such a referral would always involve a lengthy wait which seems to have influenced the alleged perpetrator's request for a private consultation. The suggestion from the counselling service that the alleged perpetrator would benefit from long term psychological support did not appear to have been taken into consideration in a timely manner. The alleged perpetrator was assessed as presenting a risk of self harm but there was no indication that he posed a risk to others.

Key Issues

- **Ability of family to engage with GPs**

10.4 It is apparent from family/friend involvement in this review that the family experienced difficulty in engaging with the GP practice: there was the incident when the victim was asked to leave the consulting room which seemed to serve to deter her from further attempts to engage; there was their daughter's attempts to engage and also the belief that the best option was for the alleged perpetrator to receive specialist treatment from private health services. Whilst the right to patient confidentiality is of course fundamental to a GP and patient

relationship, family members should be able to seek help from GPs in respect of coping with the behaviour of, and of how to provide support to a person with mental health problems. In this case the family have indicated that they had never experienced issues with mental health and did not know what to do. There is of course, generally a stigma associated with mental health which can prevent people from talking to others and from seeking help. It is therefore important that when family members are so concerned that help and advice is sought that they are not deterred or frustrated by a lack of interaction. There is currently a national programme, funded by the Department of Health entitled *Time to Change* which aims to challenge mental health stigma and discrimination. Their website provides comprehensive information about the nature of mental health and includes research and details of organisations who can provide help and support. The programme includes various projects including a pilot training scheme for GP surgeries to improve healthcare professionals' knowledge, attitudes and behaviour in relation to mental health. Initiatives such as this could encourage and enable engagement by family members seeking help and support.

Recommendation

NHS England Birmingham, Solihull and Black Country Area Team to work with key stakeholders (including Health Education England and local Clinical Commissioning Groups) to ensure that all frontline health professionals have access to good quality healthcare information about mental health and psychological interventions that will assist them to better support patients and their families and signpost them to the relevant, available support where appropriate.

- **Primary and secondary mental health services**

10.5 The alleged perpetrator only received primary care, i.e. GP treatment, for his mental health problems. He was assessed using a recognised screening tool and within a 12 week period he was prescribed three different anti-depressants in an attempt to find one that suited him and arguably never

achieved a therapeutic dosage. During the course of his treatment he was seen by three different GPs. It is unknown whether the GPs were aware of the full extent and rapid deterioration of the mental health of the alleged perpetrator and of his increasing paranoia, i.e. people were watching him, the police would arrest him for not going to work, keeping his coat on indoors which made him feel safer. The GPs were reliant upon what they were told by the alleged perpetrator and as the notes of the consultations were brief and lacked detail that would prove difficult for individual GPs to fully assess the alleged perpetrator from the records. For example the side effects that the alleged perpetrator complained of were not noted within his patient records. It is of course accepted that patients only receive a short time period for an appointment which limits the amount of detail that is recorded. The GPs were aware that the alleged perpetrator received short term counselling provided by his employer during this period and were advised by letter from that service that he would benefit from long term psychological support, but there was no indication that the GPs acted, or intended to act, upon the recommendation in a timely manner.

10.6 At the alleged perpetrator's last visit to the GP (1 May 2012), noted in the GP records for the first time were paranoid feelings and it was at this point that the GP offered to refer him to secondary mental health services. During interviews for this review the GPs at the practice stated that they use their clinical judgement to assess when and if to refer a person for secondary mental health care. NICE (National Institute for Health & Care Excellence) provides guidelines on assessing depression and its severity. The guidelines list two key symptoms and seven associated symptoms for depression which mirror the nine questions asked in the PHQ-9 screening tool used by the GPs. Listed are factors that favour the following options:

- General advice and monitoring
- More active treatment in primary care
- Referral to mental health professionals
- Urgent referral to specialist mental health services

From the information that appears to have been known by the GPs, the alleged perpetrator was at the stage of the third option – referral to mental health professionals. During interview the GPs stated that they tend to apply a 'rule of three', that is if the medication has not been successful, the patient has thoughts of self harm and has presented plans for self harm, then a referral would normally be made. It appears that on this basis, the alleged perpetrator was offered a referral into specialist services but wanted to be seen privately. Information gained from the family was that he believed that this would be quicker. This perception appears to have originated from enquires made by the alleged perpetrator and the family with the GP Practice and indeed the GPs have stated that they had experienced some inconsistencies when making referrals to secondary mental health services with some referrals being 'bounced back' for continued treatment in a primary care setting but in other cases patients had been seen very promptly. Opinion gleaned from the Consultant Psychiatrist who assisted the DHR panel was that the GP records were not very detailed which as well as causing difficulty for individual GPs to assess the patient, meant that the quality of any referral for secondary mental health care either to the NHS or to private health care would have been lacking and further detail of the symptoms of anxiety, paranoia and the alleged perpetrator's deterioration over a short period of time would have been necessary. The DHR panel are satisfied that recommendations 1 and 2 for the GP practice address these issues in respect of recording, referral processes and thresholds for referral to secondary mental health services.

- **Assessment & Management of Risk**

10.6 The alleged perpetrator was never subject of a formal risk assessment tool but both the GP and the Counselling service utilised a questionnaire (PHQ-9 by the GP and CORE34 by the Counselling Service). In both cases these questionnaires aided the assessments made by the professionals involved. Indications from both were that the alleged perpetrator presented a risk of self harm but not a risk of harm to others. The Counselling Service did notify the

GP of this finding by letter which suggested that the alleged perpetrator would benefit from long term psychological support. The DHR panel did express concern that whilst the CORE questionnaire asked whether the client had ever been violent towards, intimidated or threatened another person it did not explore any thoughts of harming others. This issue was subsequently raised with CORE system trustees who responded that the CORE outcome measure questionnaire was not designed to be a risk management tool. It was a broad measure and when selecting the questions it was decided to include threatening and intimidating thoughts rather than thoughts of harming others for the following reasons:

- A recognised subset of the population experience ruminations or obsessions about harming others and these, though greatly distressing to most people who experience them, are generally thought to have low or zero association with increased actual physical risk to others.
- The sheer range and difference between different targets for thoughts of harming others make it essentially impossible to design a simple self-report item covering all those possible targets and retaining good psychometric properties.
- Most importantly, including an item in a measure about thoughts of harming others would be likely to cause many people to refuse completion or be offended, resulting in an unnecessarily negative experience for many and reduced reliability and validity.

It is the view of the DHR panel that the counselling service has addressed the concerns about their risk assessment procedures in their recommendation which strengthens their practice.

10.7 There is no indication that the victim was ever at risk of harm from the alleged perpetrator. She was fearful that he would harm himself rather than others and it appears that she never disclosed to anyone, family, friends or professionals that she felt at risk.

Ancilliary Issues

10.8 In respect of this case there is no evidence of domestic abuse being a factor in the relationship between the victim and the alleged perpetrator. The only agency/professionals who would have been in a position to enquire about this would have been healthcare professionals but it is apparent that there was no incident, or set of circumstances which would reasonably trigger such an enquiry to be pursued. The GP practice did not however have a standalone policy on domestic abuse; staff at the practice had not received training on domestic abuse; there was no identified lead for domestic abuse and no formal pathway for responding to disclosure. The IMR author identified that the specific GP practice, and the partnership to which it belonged, would benefit from a clear policy framework being developed for domestic abuse in line with the latest Royal College of General Practitioner (RCGP) Guidelines and hence ancillary recommendation 3 for the GP practice are endorsed by the DHR Panel.

11. Good Practice

No examples of good practice over and above expected levels of service were identified during this Review.

12. Progress of IMR Recommendations

12.1 The following recommendations made in IMRs have been progressed by those agencies whilst this domestic homicide review was ongoing:

GP Practice Recommendation 1: A more robust referral process and threshold for referral to be agreed with secondary health services to ensure that patients receive prompt initial assessment and appropriate treatment.

GP Practice Recommendation 2: Patient records to include full details of incidents and behaviour disclosed when a patient has indicated or been assessed as posing a risk of harm to self or to others.

GP Practice Ancilliary Recommendation 3: Improve the quality and consistency of responses to domestic violence and safeguarding adults from the practice

BCC Staffcare Recommendation: Risk assessment processes, including recording practices be strengthened to ensure that potential risk of harm to others are fully explored and referral

12.2 BCSP requires that all agencies implement the internal recommendations contained within their Individual Management Reviews, to evidence that action has been taken prior to the publication of this overview report.

Recommendation

Birmingham Community Safety Partnership requires all recommendations contained in agencies IMRs be fully implemented. In addition agencies are required to confirm that action has been taken where management or practice has fallen below expected standards of professional behaviour.

13. Lessons Learnt

- The family was inexperienced in dealing with mental health problems and found it difficult to engage with the GP Practice which resulted in no help or support being provided to them.

- GPs were reliant upon information gleaned from the alleged perpetrator and may have been unaware of the full extent of the increasing and rapid deterioration of his mental health and paranoia.

- GPs' recording was not detailed which would incur difficultly for individual GP and potentially for secondary mental health care assessment.

- Expectations of referral to secondary mental health services were inconsistent.

- Issues of potential self harm were identified but the risk of harm to others appeared not to have been probed in sufficient depth.

14. Conclusion

14.1 Throughout this Review and the criminal investigation there has been no evidence or indication that the relationship between the victim and the alleged perpetrator was ever abusive or involved physical violence. The alleged perpetrator first showed signs of stress after the bereavement of his mother and mother in law. After his hip replacement operation symptoms of depression began to emerge, particularly when he returned to work. In a short period of time his behaviour and paranoia increased rapidly, the extent of which was not perhaps fully known by his GPs as they were reliant on information provided by the alleged perpetrator himself, details of which were not recorded in detail. It is possible that had the extent and speed of his deteriorating condition been known then a referral for secondary mental health services could have been made which should have resulted in an assessment of his mental health and an opportunity to provide effective treatment.

14.2 Opinion sought from the Consultant Psychiatrist who assisted the DHR Panel was that it was uncommon for someone to suffer such deterioration in their mental health resulting in them committing homicide followed by attempted suicide. The alleged perpetrator had no previous psychiatric or psychological history and the rapid decline in his condition was rare.

14.3 It is known that the alleged perpetrator was due to return to work on the date of the death of the victim and that she was keen for him to do so as this would be a return to normality. He on the other hand had become fearful of work and of being arrested by the police for taking time off work 'fraudulently'. His paranoia had manifested itself again on the bank holiday weekend prior to the date of his return to work and it was the intention of the victim to arrange a further GP appointment for the alleged perpetrator. It is apparent that the victim had become exasperated and stressed. What caused the fatal attack upon the victim is not known and is unlikely to be ascertained but it is of course perceivable that the impending return to work was a trigger.

14.4 It is concluded by the DHR Panel that the death of the victim could not have been predicted. However there is a possibility that it could have been prevented had the alleged perpetrator been subject of a mental health assessment together with a more robust treatment of his depression.

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Responding to Domestic Abuse: Guidance for General Practices – Royal College of General Practiotioners (2012)

Time to Change- tackling mental health stigma – Department of Health (October 2011)

Appendix A

Home Office

Violent Crime Unit
2 Marsham Street
London
SW1P 4DF

T 020 7035 4848
F 020 7035 4745
www.homeoffice.gov.uk

Ms Paula Harding
Domestic Homicide Review Co-ordinator
Birmingham Community Safety Partnership
PO BOX 11762
Birmingham
B3 3PL
2 October 2013

Dear Ms Harding,

Thank you for submitting the Domestic Homicide Review (DHR) report from Birmingham (regarding the 2012 case) to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in September.

The QA Panel would like to thank you for conducting this review and for providing them with the final report. In terms of the assessment of DHR reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

The QA Panel would like to commend you on the report, which the QA Panel felt had a good finding of prevention in the report at paragraphs 8.1 to 8.5 of the overview report. The review also reflected very helpful input from friends and family.

There were some issues that the Panel felt might benefit from more detail and/or analysis, and which you may wish to consider before you publish the final report:

- Consider reviewing the chronology to include any potentially relevant events that may have occurred in the week before the homicide; and,
- Consider including a national recommendation regarding training for GPs to deal with domestic violence issues that may arise in discussion with their patients, including how to deal with disclosures from one patient about potential domestic violence or abuse they may be perpetrating or contemplating against their partner.

The QA Panel noted that the review panel had a small membership and suggests that for future reviews a wider panel membership be considered.

The QA Panel also noted the need to raise awareness and train GPs on domestic violence and abuse where there are links to mental health. We will explore ways to progress this issue with officials at the Department of Health.

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Mark Cooper, Chair of the Home Office Quality Assurance Panel

Head of the Violent Crime Unit

Domestic Homicide Review BDHR2012/13-02
Action Plan

Recommendation 1: NHS England Birmingham, Solihull and Black Country Area Team to work with key stakeholders (including Health Education England and local Clinical Commissioning Groups) to ensure that all frontline health professionals have access to good quality healthcare information about mental health and psychological interventions that will assist them to better support patients and their families and signpost them to the relevant, available support where appropriate.

	Action (SMART)	Lead Officer and Agency	Target Date for Completion	Desired Outcome	Outcome/Progress	Written Evidence/ Location	Status (RAG)
6.1.1	NHS England Birmingham, Solihull and Black Country Area Team to work with Health Education England and local Commissioning Groups to map available signposting resources for professionals	NHS England Birmingham, Solihull and Black Country Area Team	Nov-13	Families are consistently guided to support and information needed	The Review identified that mental health signposting information is readily available. Awareness of this information will now be promoted through Safeguarding Practice Leads across all Practices.	*Report/ BCSP*	

Individual Agency: GP Practice							
GP Practice Recommendation 1: A more robust referral process and threshold for referral to be agreed with secondary health services to ensure that patients receive prompt initial assessment and appropriate treatment.							
6.i.1	Meeting to be arranged between GP surgery and local Community Mental Health Teams. Threshold/referral process into secondary care to be agreed and consolidated. All relevant staff at surgery to be made aware of process.	GP Practice Manager	Jun-13	All frontline healthcare professionals to have appropriate access to signposting resources.Patients and Families to feel that that they have appropriate information about services and supports available to them	*On-going negotiation for a collaboration evet between all GPs at GP practice and Community Mental Health Teams the date is yet to be finalised*	*GP Surgery*	
GP Practice Recommendation 2: Patient records to include full details of incidents and behaviour disclosed when a patient has indicated or been assessed as posing a risk of harm to self or to others							
6.i.2	Review current record keeping systems. Audit against GMC guidelines for recording work clearly and responding to risks to safety (Good Medical Practice, para 19-21, 24-27, GMC 2013,)	GP Partners	Jun-13	A clear and accessible picture of identified risks and actions taken in response to risks is available in the patient record	Completed	*GP Surgery. Report to be provided to BCSP*	

GP Practice Ancilliary Recommendation 3: Improve the quality and consistency of responses to domestic violence and safeguarding adults from the practice							
6.i.3	GP surgery to develop a policy on domestic abuse, ensuring that this policy reflects the recent guidelines from the Royal College of General Practitioners on the subject.	Clinical Birmingham South Central Clinical Commissioning Group safeguarding team domestic abuse lead	Sep-13	The quality and consistency of responses to domestic violence and abuse is ensured for all patients in contact with the Practice	*A Lead Nurse for Domestic Abuse was appointed by Birmingham CCG's, who is in the process of completing a final draft of policy for use by Birmingham GP*	*In progress Birmingham South Central Clinical Commissioning Group*	
6.i.4	GP surgery to source training for staff on safeguarding adults and on domestic abuse.	Clinical Birmingham South Central Clinical Commissioning Group safeguarding team domestic abuse lead	Sep-13	Staff in the practice have a thorough understanding of how to respond to domestic violence and safeguarding adults within the Practice's Policy and Procedures	*A Lead Nurse for Domestic Abuse was appointed by Birmingham CCG's funding has been identified and will enable the provision of training for Birmingham GP*	*In progress Birmingham South Central Clinical Commissioning Group*	
6.i.5	GP surgery to identify named leads for domestic abuse and to establish clear pathways for responding to concerns and assessing level of risk	Clinical Birmingham South Central Clinical Commissioning Group safeguarding team domestic abuse lead	Sep-13	The quality and consistency of responses to domestic violence and abuse is ensured for all patients in contact with the Practice	*A Lead Nurse for Domestic Abuse was appointed by Birmingham CCG's and a register of safeguarding leads for Birmingham GP practices*	*Birmingham South Central Clinical Commissioning Group*	

Individual Agency: Birmingham City Council Staffcare							
BCC Staffcare Recommendation 1: Risk assessment processes, including recording practices be strengthened to ensure that potential risk of harm to others are fully explored and referral for specialist services actioned							
6.i.7	Ensure that therapists keep explicit notes in conjunction with CORE outcome measures to fully demonstrate therapist assessment of risk and actions taken	BCC StaffCare, Manager	Nov-13	Risk of harm to others identified and referral for specialist services actioned	*More comprehensive records of risk assessments introduced by therapists (January 2013)*	*Report/ BCSP*	
6.i.8	Regular case management and case note audits to ensure that therapist risk management complies with protocols and DHR guidance	BCC StaffCare, Senior Core Team Members:	Nov-13	Risk of harm to others identified and referral for specialist services actioned	*Weekly case note audits conducted since Sept 12 but since March 13 recorded on spreadsheet.Increased vigilance by case managers in action since Jan 2013. Records of Case Management kept.*	*Report/ BCSP*	
6.i.9	Liason with other agencies with expertise in domestic violence to obtain expert advice in the management of risk of harm to others and ensure that StaffCare knowledge of guidance and legislation is current.	BCC StaffCare Manager	Nov-13	Risk of harm to others identified and referral for specialist services actioned	*Engagement with DV Services to be facilitated by DHR Team- preliminary discussion April 2013*	*Report/ BCSP*	