Stafford Borough Partnership

'Creating Competitive Advantage'

OVERVIEW REPORT

DOMESTIC HOMICIDE REVIEW

in respect of

S

Female Born 1962

Report Author: Sue Lane

Accepted by
Stafford Borough Strategic Board
which incorporates Stafford Community Safety Partnership

1. Introduction

1.1 Circumstances of the review

1.1.1 S was found dead as a result of a shotgun wound in her own home on a morning in October 2011. It was believed from an early stage that her adult son J was the perpetrator. Although J had an independent address it rapidly became apparent that he spent significant time on a daily basis at his mother's home. He was known to have current mental health problems and was believed to be using and dealing in illegal substances. He had a younger sister still at school and his mother earned her living as a child minder at her home address.

1.1.2 A DHR Scoping Panel met on 21/11/2011 to consider the circumstances leading to the death. The Panel were unanimous that the criteria for commissioning a Domestic Homicide Review had been met. This recommendation was endorsed by the Chair of the Stafford Community Safety Partnership who was present at the meeting and recorded in the minutes.

1.2 Terms of reference

1.2.1 Full terms of reference are attached at Appendix A.

1.2.2 The DHR considered the period that commenced from 01/01/2003 up to and including the events on the day that died. The focus of the DHR was maintained on the following family Members:

Name	**S**	**J**	**R**
Relationship	Subject of DHR	Son	Daughter
Date of Birth	Aged 49	Aged 22	Aged 14
Ethnicity	White British	White British	White British
Address of Victim:	Stafford, Staffordshire		

Key issues addressed within this Domestic Homicide Review as agreed by the Scoping Panel are outlined below for ease of reference. These issues were considered in the context of the general areas for consideration as outlined by Staffordshire DHR procedures.

- Were risks posed by J to his mother, his sister, children minded by S, professionals and the community as a whole appropriately understood/shared/acted upon?
- Were S's concerns for her personal safety recognised, appropriately risk assessed and responded to?
- Should J have been identified as a Potentially Dangerous Person?
- Agencies' and professionals' understanding of the impact of child on parent violence and whether S was seen as a victim of domestic abuse
- The nature and effectiveness of agency involvement with child minding services provided by S and adherence to regulatory guidance by agencies

- Provision of mental health services to J, S and her daughter
- Referral to children's safeguarding services in respect of S's daughter
- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration
- Was the homicide of S predictable and/or preventable?

Where an agency had involvement with the victim and either of her children a **single** Individual Management Report was requested which:-

- Discusses the circumstances and needs of each individual;
- Discusses the relationship that existed between the family members;
- Discusses the relationships with members of their immediate and extended family, which may have impacted upon them;
- Maximises learning from the circumstances leading up to the homicide:

1.3 Contributors

1.3.1 Individual Management Reviews were required from the following agencies:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Staffordshire County Council: Education Inclusion
- Staffordshire County Council: Child minding Support Services
- Staffordshire County Council: Families First Safeguarding
- Staffordshire Police
- Staffordshire Youth Offending Service
- Staffordshire Probation Trust
- Stafford Borough Council
- Staffordshire NHS Cluster of Primary Care Trusts
- Ofsted

1.3.2 Other agencies that had contact with the family outside the review period have provided background information.

1.4 DHR Panel members

1.4.1 Members

Head Of Policy And Improvement; Chair Of Community Safety Partnership; Policy, Improvement and Partnerships Manager	Stafford Borough Council
Chief Executive	Staffordshire Women's Aid
Co-ordinator	Domestic & Sexual Violence Local Development Project
Associate Clinical Director/Nurse Consultant, Mental Health Division - South Staffs	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
County Commissioner for Safer Communities	Staffordshire County Council – Community Safety
Specialist Safeguarding Development Manager;	Staffordshire County Council – Strategic Safeguarding
Strategic Lead, Specialist Safeguarding Delivery	Staffordshire County Council – Families First Safeguarding
Lead Nurse Safeguarding Adults (South); Designated Nurse;	Staffordshire NHS Trust Cluster of Primary Care Trusts
County Manager; Area Youth Offending Team Manager;	Staffordshire Youth Offending Service
Head Of Stoke Probation and Snr. Manager for Staffordshire Courts;	Staffordshire and West Midlands Probation Trust
Education Inclusion Partnerships Manager;	Staffordshire County Council – Education Inclusion Partnerships
Early years Services Consultant; County Improvement Manager;	Staffordshire County Council – Education Transformation
National Advisor, Early Years Foundation Stage	Ofsted
Detective Chief Inspector; Family Liaison Officer; Detective Constable ; Crime and Policy Review Manager	Staffordshire Police Major Investigations Department (MID)

1.4.2 The DHR Panel was chaired by Chris Few, an Independent Consultant and Chair of a Local Safeguarding Children Board. He has chaired Serious Case Review and Domestic Homicide Review Panels, undertaken agency management reviews and prepared overview reports for a number of Local Safeguarding Children Boards, Community Safety Partnerships and their partner agencies. In Staffordshire Mr Few has chaired three other Domestic Homicide Review

processes and two Serious Case Reviews. He has no other personal or professional connection with any agency in the County.

1.4.3 The Report Author, Susan Lane has undertaken similar enquiries and training commissions previously for safeguarding boards and is not employed by any of the agencies or associated bodies. She is an experienced and registered social worker and has previously held senior positions within children's social care and the Probation Service. She works part-time as an associate lecturer for the social work degree with the Open University.

1.4.4 The Panel met on 5 occasions and had the full support of the borough council as lead agency for the Community Safety Partnership.

1.4.5 Agencies submitted IMRs and reports as requested in the terms of reference with the exception of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSHFT). SSSHFT only submitted an IMR in late September 2012, and this IMR did not provide as full an analysis of the issues as expected. Discussion of the issues in a subsequent meeting and discussion with the IMR author clarified most relevant issues. The delay in receiving this IMR significantly delayed this report which might otherwise have been completed immediately after the trial of J.

1.5 Parallel Processes

1.5.1 J was charged with murder and was remanded to the regional forensic unit. He was found unfit to stand trial. Stafford Crown Court found that he had committed the killing and he was ordered to be detained indefinitely in August 2012.

1.5.2. At each meeting the Panel sought and received assurance that S's 14 year old daughter was safeguarded and supported appropriately.

1.6 Family Involvement

1.6.1 S's daughter R is living with her father. He was contacted by the Police family liaison officer and offered the opportunity for both of them to meet with the report author to provide the family's perspective on the events. This meeting did not take place at her father's request. Following revision of the report in 2014, R and her father were again contacted and both subsequently met with the Panel Chair and had opportunity to read the report.

1.6.2 R told the Panel Chair that she had felt ignored and unsupported by services dealing with her brother in the months before her mother's death. She believes that her brother was allowed to leave hospital following his compulsory detention too easily and when he was not fit. The impact of his behaviour on her and her mother was not well understood or considered and in particular she highlighted that no-one talked to her directly about her experiences and feelings at the time or appeared to consider that they mattered in coming to decisions about her brother. She was critical of the behaviour of the Community Psychiatric Nurse who visited and believes that she should not have arranged to see J at the family home. R's father was concerned that he was not sufficiently informed at the time of the situation his daughter faced. Minor factual matters have been amended as a result of the observations of R and her father but the account of events remains

substantially unchanged. Their concerns are discussed further where relevant to the events and analysis.

1.6.2 A friend of S has met with the Panel Chair and has provided additional insight into the relationship between the victim and the perpetrator. This information and source is referred to in the report where relevant. S's friend was also given an opportunity to read this report prior to submission to the Home Office.

2. The Facts

2.1 A detailed chronology was available to the Panel which merged the information available from the individual agencies. This is the basis for the matters described in this section of the report in addition to material in the Individual Management Reviews provided by the agencies.

2.2 The household background and circumstances

2.2.1 For the duration of the period of this review S lived and worked in a privately rented house in a suburban area of Stafford where her body was found on a morning in October 2011. She had spoken to a friend by telephone late on the previous evening and there was no indication of any concerns. Her body was discovered by a neighbour who was alerted by parents bringing their children to be minded for the day. The police were immediately alerted and initiated enquiries.

2.2.2 Post-mortem enquiries have confirmed that S died as a result of a single shotgun wound to the head.

2.2.3 S lived at the address with both of her children, a daughter R (14 years) and J (22 years) although J also had other addresses. Her children have different fathers. There was no known contact with J's father, but her daughter had regular contact with her father. S supported herself and her children through her work as a child minder and when parents arriving with their children could not get an answer at the door they alerted the neighbour who found S's body. Neither of her children was present. Her daughter was quickly discovered to be staying with her father for the half term holiday at his home some 20 miles away and her safety confirmed.

2.2.4 The only agency that knew S well in her own right was her family doctor. She had persistent health problems, requiring regular contact. She experienced good continuity of care from the practice and would have been in a position to confide in them if she had any concerns for her own safety. At no point did she present to the practice with any signs or symptoms that might have been the result of violence. S often attended the practice with J in connection with his mental health difficulties and the practice was able to observe a mutually caring and concerned relationship between mother and son.

2.2.5 The GP knew of her child minding business and was sufficiently concerned about J's unpredictable and impulsive behaviour to seek advice about the situation from children's social care on 18/02/2011 because J appeared to be spending all day at the family home. This discussion did not result in any record in children's social care. The practice's last contact with S was on 16/05/2011 when she appeared well and a review appointment in 2 months' time was agreed but did not take place. S continued to have contacts with the GP in respect of her son.

2.2.6 A close friend was aware of most of the problems identified by this review. She considers that S denied much of her son's illegal activities although they were obvious to friends. She was indulgent of him and supported him but told friends in 2010 that she was frightened of him and what he might do. S was also concerned for the impact he might have on her business. Despite that, he was at the house in the morning for breakfast and back in the afternoon. Her friend believes that S felt unsupported by the psychiatric services in respect of J's treatment and support. Her friend believes it is possible that she did not disclose fully her fears to professionals in case it resulted in the loss of her business.

2.2.7 The friend's information and views are confirmed by S's daughter R. Both concurred that S tried to protect her business in difficult circumstances while also wishing to support her son.

2.2.8 Other agencies had contact with S sporadically as her or her son's activities required but none of the agencies were able to provide the Panel with additional descriptions of her, her concerns or her personality.

2.3 Offending history of J

2.3.1 The police first came into formal contact with J when he was arrested in December 2003, shortly before his 15th birthday in respect of a violent incident in the home in which he assaulted his mother. This incident occurred at the same time as his formal exclusion from school for use of illegal substances on school premises. This is the only occasion on which any agency has any record of violence directed by J towards his mother before her death. J did not fully admit the offence when interviewed by the police. He subsequently apologised to his mother and she informed the police she would not be prepared to go to court on the matter. The police determined to take no further action. There is no mention in records of R at this time and she was unaware of these events until she read this report.

2.3.2 In January 2005, aged 16, J was arrested in respect of an assault on his uncle. On this occasion he admitted the offence and received a Final Warning. In August 2005 there was a further violent incident with his uncle. He received a Referral Order for this offence. During this period of community supervision by the Youth Offending Service he showed little victim awareness although the order was completed without breach.

2.3.3 J was offending prolifically throughout 2006/7/8. The offending related to crimes associated with substance misuse and the supply of illegal substances. He was frequently noted when arrested to be carrying knives and there were periods of curfew or bail conditions restricting his movements. He was living at his mother's home during this time including a period when he was 'tagged'. He received a variety of community sentences supervised by the Probation Service which he complied with minimally. Risk assessments were undertaken as required by local and national procedures but the Probation IMR noted that background information held by the Youth Offending Service was not consulted at this time and this may have resulted in a different appreciation of the risks he posed to the family. Probation were unaware of his mother's occupation. During this time there were curfew and bail decisions requiring his residence at his mother's home.

2.3.4 Further offending and the failure to comply with the terms of his orders eventually resulted in custody from 10/07/2008 to 20/10/2008 when he was released on licence. While in custody he assaulted a prison officer.

2.3.5 The last community order was completed on 10/10/2009, 2 months before his 21st birthday. He was assessed as being at low risk of harm on completion of this sentence. Again information from his period in custody was not integrated with the community record and the opportunity to assess the risk of further violence was lost.

2.3.6 He was not subject to any sentence at the time of the homicide although he had been charged and had appeared in court on several occasions. The progress of the criminal proceedings had been delayed by his repeated detention on Section 2 of the Mental Health Act 1983. He was charged with intimidating witnesses. These charges remained outstanding at the time of the death of S.

2.3.7 J was in contact with police or the subject of intelligence reports on a very frequent basis in late 2010 and 2011 until his arrest in connection with his mother's death. The report author and Chair of the Panel were given access to this material in addition to the edited information provided in the police chronology. While contacts or observations were about once a month in the first six months of 2010, they started to escalate over the summer and were very frequent by the time he was involved in a road traffic accident on 26/10/2010 which was associated with a brief pause in his activities.

2.3.8 He was found inappropriately in possession of knives both at home by his mother and when out by police and described by his mother as having a fascination for them. He had a dog that was perceived as dangerous, as well as there being low level intelligence reports in October 2010 that he acquired a hand gun but that was never confirmed. The intelligence was reviewed by senior officers at the time and it was considered that there was insufficient basis for action. J was arrested and charged in respect of some matters during this time but difficulties with witnesses and latterly his mental health problems, delayed the completion of the prosecution. The police assessed the risks he presented in terms of those to other offenders, rather than to his family. On one occasion in March 2011 community police officers were sufficiently concerned to alert children's services in respect of the child minding service provided by S.

2.3.9 J continued to exhibit episodes of unpredictable, paranoid and impulsive behaviour. Immediately before his mother's death J acquired a shotgun. This did not result in any intelligence reports. The alleged supplier of the weapon was subsequently identified through the criminal enquiry into S's death although there was insufficient evidence to prosecute.

2.4 Mental health concerns in respect of J

2.4.1 J was also well known to the GP practice at the time of S's death. His contacts were occasional until December 2010 when he was seen in early December reporting neck and back pain following a road traffic accident. This event seems to have triggered a significant change in his mental health too. He was seen on 20th and 24th December, the second occasion with his mother present, reporting significant weight loss, anxiety, headaches and blurred vision. S stressed changes in his behaviour at this consultation.

2.4.2 Further appointments both at the surgery and the family home occurred in January 2011. S was reporting disturbed and distressed behaviour of J and the GP recorded that there were risks to S and her daughter as a result of his agitated and violent state. J agreed to referral to the community mental health team. Despite this initial agreement the CMHT contacts were primarily with S. J eventually declined the service without any face to face contact and the GP was informed. The GP advised S to contact the police to remove J if he became unmanageable at home. On the same day he crashed his mother's car and was briefly detained by police in connection with this incident. There is no police record of S ever contacting them to request his removal.

2.4.3 Shortly after this, J was admitted to hospital for the first time from 30/01/2011 until 15/02/2011. It was as a result of a mental health assessment conducted following his arrest in respect of a dog being dangerous and he was detained under Section 2 of the Mental Health Act 1983 until 08/02/2011 and the remainder of this admission was on a voluntary basis. No clear diagnosis emerged although there was sufficient concern on discharge to ensure the involvement of the Early Intervention Team on a 'watch and wait' basis. Risk assessments in respect of suicidal and homicidal thoughts were completed as part of the assessment process and there is evidence of discussion of his fears and paranoia. As well as the usual uncertainties in the development of a psychosis, diagnosis was complicated by J's history of substance misuse and potential consequences of the accident in late 2010.

2.4.4 Two further admissions occurred, the second from 14/03/2011 to 15/03/2011, again as a detained patient under Section 2 of the Mental Health Act 1983 but was discharged because of an absence of psychotic symptoms, and the third from 17/03/2011 to about 13/04/2011, also as a detained patient. Risk assessments indicated at the time of his detention that he may harm others. Psychotic symptoms were noted during this last stay but there was insufficient evidence for a specific diagnosis. Toward the end of this period consideration was given to whether there was evidence for continuing detention. J himself wished to be discharged and a second medical opinion was secured before he was allowed to leave hospital.

2.4.5 As a result of these admissions it was recognised that further assessment was needed and that there was evidence of concerns for J's mental health. It is also clear that S made frequent contact with the professionals involved and provided much of the specific evidence of problems. Her accounts appear to conflict with his own descriptions and with observations when he was in hospital. After-care support was offered as required by the legislation and there was regular contact with community services.

2.4.6 S's daughter, R was surprised that J was not detained in hospital for longer although she acknowledged that he may well have been able to moderate his behaviour while there. Both R and S's friend, when seen by the Panel Chair, suggested that S felt unsupported by the services at this time. The Community Psychiatric Nurse appeared to have difficulty making contact with J and would contact his mother instead. He did not take his medication as prescribed and was in the friend's view insufficiently supervised when out of hospital. A referral for a carer's assessment was made by the Community Psychiatric Nurse as part of the after-care support offered to J but nothing appears to have happened as a result.

No one discussed with R how she felt about J's presence in the home or its impact on her.

2.4.7 Both the police and the health services record sporadic consultation about J's activities but it is not clear what each agency intended in terms of actions to resolve the problems presented by mental health concerns and criminal activity.

2.4.8 In May 2011 the Community Psychiatric Nurse visited J at S's address when children were on the premises. She reminded S that he should not be present, recorded significant concerns about his behaviour towards his mother, and reported the concerns to her managers. As a result she was offered additional support in her contacts with J. The SSSHFT IMR indicates that this meant that she would be accompanied when visiting J. The SSSHFT IMR also states:
"*She also contacted the Trust's Child Protection Team regarding her concerns for the children in the house and contacted the Medical Secretaries to pass the information on*".
It has subsequently been clarified this was to the 'medical team' but it remains unclear with what purpose.

2.4.9 The Community Psychiatric Nurse recorded this visit and that she contacted the Trust's Safeguarding Team. Children's social care recorded a telephone conversation from the Community Psychiatric Nurse 'for information' in respect of J at this time. Children's social care recorded the conversation as confirming previous information that he was not allowed on premises when the minded children were present. As a result, children's social care noted the information and no further action was taken. It does not appear that any further consideration was given to S's daughter and any additional risks in respect of her at this time either.

2.4.10 Over the summer period the Community Psychiatric Nurse recorded frequent and regular contacts with J to provide support and assist him with practical problems such as housing. A similar pattern persisted of significant information being provided by his mother while he minimised any mental health concerns.

2.4.11 On 01/08/2011 J attended an appointment with the consultant psychiatrist arranged at the request of his defence solicitor. The mental state assessment found his behaviour to be normal, and he denied auditory hallucinations or paranoid thoughts. S however reported significant continuing concerns at this time. J complained that his mother was annoying and this resulted in him pacing up and down when he visited her.

2.4.12 On the same day there was a meeting between the Community Psychiatric Nurse and the police where information sharing about recent offences and arrests took place. Both agencies recorded that he had been found in possession of items that could be used as weapons. The police agreed to keep the Community Psychiatric Nurse informed if J was arrested again and the Community Psychiatric Nurse agreed to inform the police "of anything that may put the public at risk".

2.4.13 J was last seen by a member of the community mental health team on 4 days before the death of S, at her address. The Community Psychiatric Nurse recorded observations of him being 'restless' and 'guarded'. This visit was primarily concerned with sorting out his benefits claim and he left as soon as that matter was completed. The SSSHFT IMR states this occurred during the afternoon when

children were normally on the premises. It does not indicate any action as a result of the observations in respect of either J's mental state or the safety of the children on the premises.

2.4.14 The SSSHFT IMR states that on the day before S's death the Community Psychiatric Nurse contacted S and informed her that she had been unable to make contact with J. The purpose of this was to inform S that she had not been able to contact J and provide support to her. The Community Psychiatric Nurse arranged to follow-up with a visit to S on the following day. This did not take place as S's body was found the following morning.

2.5 Contacts with other agencies.

2.5.1 In December 2003, when just 15, J was provided with support by Education Services following his permanent exclusion from school as a result of his use of drugs (smoking marijuana) on the school bus during Year 10. There had been a significant period of difficulty before his exclusion, when he had been well supported by school and his exclusion was in the interests of other pupils. He did not return to school although he did enrol for college courses and received continuing support with education until he reached school leaving age in May 2005. He also engaged in training activities when supervised by the Youth Offending Service in 2005. When engaged with education he made good progress.

2.5.2 The borough council received complaints in 2009 and 2010 from neighbours about noise and traffic nuisance from the child minding activity and allegations of drugs dealing by J in the immediate area. Initially these matters were dealt with within the planning powers available to the borough council. No breach of planning law occurred in respect of the child minding activity as S restricted her child minding numbers on a voluntary basis. On a further occasion environmental health officers were alerted concerning noise nuisance. The complainant was asked to keep a log of events but did not do so. S informed the council that she had been harassed by the complainant and was advised to contact the police should there be any recurrences of the incidents she described. The matter was closed.

2.5.3 During 2010 and 2011, J sought support with housing from the borough council. He received assistance within the housing duties of the council. The council were aware of his mental health status and observed the protocol agreed with the mental health services in providing support.

2.5.4 S's occupation as a child minder meant that she was known to Ofsted for the period of the review as the regulator and registration authority. Ofsted made enquiries following complaints about J's presence and about the numbers of children being cared for and the impact on neighbours. Complaints were made intermittently, starting in 2004; usually it appears from one or two neighbours. On each occasion and at formal inspections Ofsted accepted S's assurances that matters were well managed. Following the police contact in March 2011, the regulator accepted S's assurances that J was not allowed on the premises when children were present. No contacts were made with other agencies to corroborate this and Ofsted remained unaware of the risks presented by J.

2.5.5 S was also known to the local early years support service which provides training for child minders and support to meet standards. Their last contact was in 2010.

This service was unaware of the concerns about J recorded by police, social care, Ofsted or NHS agencies in 2011 although they were aware of some of the earlier concerns and had provided support to S. S herself did not contact them for support at this time and neither Ofsted nor children's social care considered alerting them.

2.5.6 Children's social care received referrals in respect of the safety of children being cared for by S in the light of J's criminal activities during 2011. There were no earlier contacts and they had no independent knowledge of J. The call for advice from the GP was not recorded by children's social care although the GP record is specific on this. The name of the person spoken to was recorded by the GP but that person has no recollection or record of the contact. The police made contact in March 2011 and were advised to make Ofsted aware of their concerns which they did. Neither agency considered whether there was a potential child protection issue outside of Ofsted's standards remit. Children's social care assessed whether there were any specific issues in respect of S's daughter at this time and concluded that she was receiving sufficient support through school and her mother was able to protect her. Contact from the Community Psychiatric Nurse in May 2011 did not result in further enquiries and there was no ongoing involvement at the time of the death of S.

3. Analysis

3.1 The Panel in reviewing the events, agency information and analysis in the IMRs focussed on the following key multi-agency issues that emerged in Panel discussions.

a) Domestic violence where the victim is the mother of the perpetrator;

b) Risks presented by J through offending behaviour and mental ill health;

c) Community Safety Strategies in respect of illegal substances and weapons;

d) Child protection matters in respect of S's daughter and in respect of child minding registration:

3.2 Domestic violence where the victim is the mother of the perpetrator.

3.2.1 The Panel consider that the incidence of violence within domestic settings by children on a parent is likely to be significantly under-reported and that parents will tend to minimise and underestimate the risks to themselves in the normal course of events, as appears to have happened in this situation. Effective prevention requires explicit strategies that provide accurate information about how to seek help and report fears. Agencies need to ensure that staff are alert to the issue, and encourage parents to recognise the facts, the risk to themselves and to other household members.

3.2.2 The Panel have only identified one occasion in 2003 when agencies had specific information about violence and aggression directed at S by J when he was 14. S took steps to remove him from her household at this time and subsequently when there were tensions. He returned however at regular intervals and even when not officially living there he was always a very frequent visitor, having his own room, and dependent on his mother in every day practical ways. Despite a range of incidents involving violence or threats towards non-family associates which were known to police and/or health professionals, no-one appears to have asked S directly about her experiences. Although she reported to the Community

Psychiatric Nurse that she was frightened at times, this did not result in any effective strategies to reduce the risks. Her daughter reported that at one stage S asked the mental health services not to discharge J but that this was ignored. S was reluctant to take any action that would restrict J's access to the family home if he was not in hospital. The Panel consider that professionals have a responsibility to make sure that close family members have had proper opportunity to understand the risks particularly where there are mental ill-health or criminal concerns. Professionals have a responsibility to explore strategies to reduce risks to family members whether or not they themselves appreciate those risks. S's reluctance to face these issues needed to be openly addressed with her on a regular basis.

3.2.3 The Panel have noted that the Probation Service, during its contacts and community supervision which concluded in 2009, could have made more rigorous enquiries about the family situation and the risks to S and her daughter from J's activities. Background information from the Youth Offending Service and the period of imprisonment could have prompted more rigorous risk assessment in respect of J's family. If S had had the opportunity to discuss this she may have been more alert to the specific risks subsequently. However the Panel noted that the situation at the time of her death was significantly different. J's offending involved more entrenched commitment to criminal activities and he was at this later stage associating with more dangerous individuals. It is not known if she was aware of this escalation as no professional approached her to discuss it. J's mental health problems are known to have been of considerable concern to her. This may have distracted her from his criminal activities at this time and the risks to her daughter and herself.

3.2.4 None of the agencies had a complete picture of the situation and the associated risks although the police and mental health services were exchanging partial information regularly through much of 2011. At no point did either agency identify any specific risks to S or her daughter although both made referrals in respect of her child minding activities.

3.2.5 S was a frequent attender at her GP practice. There is no evidence of unexplained injuries or other health matters that might have alerted professionals to incidents of physical violence or bullying towards S by J. However it is also possible that the incidents in 2003/2004 resulted in S using strategies to avoid provoking any repetition. It is also possible that J learned from this experience that it was not an effective strategy if he wanted his mother's support. This does not mean that there may not have been intimidation on occasions or that she was not fearful of what he might do. None of the agencies has any record of her reporting fears of direct victimisation by J. Her son's health records suggest that J appeared protective of his mother and the stress she experienced. Equally she was concerned, protective and supportive of him. There were opportunities for professionals to ask her about these matters when he was not present and to encourage her to consider her own safety even if she herself was inclined minimise those risks.

3.2.6 The Panel noted that the risk factors present in this situation of substance misuse and mental health concerns are common factors in domestic violence incidents between partners; they did not however trigger full inter-agency risk assessments for S as there was no recent incident prior to her death in which she was a victim to act as a focal point for such assessment. In addition the Panel observed that

even with such an event it would only have been considered by a Multi Agency Risk Assessment Conference (MARAC) if there were indicators of serious risk because of resource restrictions.

3.2.7 There is no evidence to suggest that signs were actively ignored in this case. However the Panel consider that there is a need to raise awareness of the risks to parents where adult children are known to be engaged in violence outside the domestic arena. It is more likely that violence outside the home will come to attention, and when it does, it is an opportunity for professionals to make enquiries about any unreported domestic incidents, threats or bullying. Such action is part of a wider strategy to raise awareness amongst parents of the risks to themselves from their children and to treat them with the same consideration as partners.

3.3 Risks presented by J through offending behaviour and mental health concerns.

3.3.1 There was a pattern of increasing complexity and seriousness in J's criminal involvements over a significant period of time from his early offending in 2003 to 2010/11. Interventions when he was at school and subject to community supervision appear to have had only temporary impacts for the better on his behaviour and may have helped him to be outwardly compliant while continuing his criminal activities. He does not seem to have had any significant treatment interventions during his periods of supervision for his own use of illegal substances despite good evidence of appropriate referrals and encouragement to engage, first by school and education services and then Youth Offending Team/Probation Supervisors. It is probable that much of his income has been derived from his criminal activities and it seems unlikely that his mother could have been completely unaware of such activities. Her friend noted the evidence of spending power when visiting S. When his behaviour changed in late 2010, his mother was diligent in persuading him to seek treatment and working with the mental health services during 2011 to support him.

3.3.2 Despite incidents of assault on his mother, an uncle and a prison officer, J was assessed as low risk of harm to others by Probation during and at the conclusion of his period of supervision. The Probation IMR recognises that these were optimistic risk assessments, that did not fully use previous records and that there was little contact with his family on which to base them. The Panel consider that changes in risk assessment practice that had already occurred before the death of S and the additional actions taken immediately these events came to light are appropriate. Some impact may have been achieved by his period of custody and community supervision as his offending was less frequently coming to the attention of the police in 2009 and early 2010 and it did not appear to merit arrest again until 2011.

3.3.3 The Care Programme Approach (CPA) is the national policy and practice framework used in mental health services for providing support in the community and in hospital settings. It has a strong multi-disciplinary and multi-agency focus and should have resulted in a comprehensive approach to J and the risks he presented both to himself and others. The SSSHFT IMR notes that it was not robustly implemented in respect of J, despite three compulsory admissions within a short time. The 'watch and wait' approach was active and involved considerable effort to understand J, but there was insufficient focus on the impact of his behaviour on others. The Panel consider that there is evidence of a lack of focus

in the service provision to J and in particular to the interaction of mental health, substance misuse and criminal activities. He received regular and frequent contact but it does not appear to address the consequences of his behaviour for others. Although there was some reference to forensic assessment, no such assessment took place. He was noted as being paranoid about threats from others at a time when police intelligence indicated serious conflict between different known offenders including J. The extent to which his fears were well grounded was not tested and the possibility of his activities having consequences for his family was not effectively evaluated by either the police or the mental health services.

3.3.4 Despite the extensive contact between the Community Psychiatric Nurse and S there is no evidence that she was offered any assistance in her own right as a 'carer' despite the legal obligation to offer such assessment, and to inform relatives of the right to assessment as a carer. R particularly commented that these contacts were not well focussed on J and that the Community Psychiatric Nurse shared personal issues with her mother. It should be normal practice in health and social care services to ensure that relatives who provide substantial support are themselves supported and able to carry such responsibility. The IMR from SSSHFT suggests a referral was made for such an assessment but does not explain why it did not take place. There is no explanation of the general arrangements with the local authority for ensuring that this is offered and completed and whether this case is unusual in this respect. R appears to have been largely ignored in these discussions and never asked about the impact of her brother's behaviour. Discussion in the Panel with the IMR author confirmed this omission. There is a legal obligation on local authorities to inform carers of their right to an assessment and the carer has a right to expect their work commitments to be respected (Carers (Equal Opportunities) Act 2004). The Panel consider that there is ample evidence of S's commitment to care for her son and a proper assessment of her needs and those of her daughter as a young carer, should have been offered although S had the right to decline. There may not have been any appropriate services to offer but that should not have prevented assessment before coming to that view. A full discussion about herself and her daughter may well have brought the risks into better focus too. Information about the right to a carer's assessment should be provided and recorded as part of the overall CPA and the failure of SSSHFT to robustly implement the CPA undoubtedly contributed to the inadequacies in this area.

3.3.5 The Panel are satisfied that S did recognise some of the dangers in the situation. She shared a great deal of information with mental health services about J's fascination with knives, their discovery in inappropriate places and his practice of carrying them and other potential weapons when not at home. It seems that this was a worry that he might hurt someone when out of the home rather than a concern that she or her daughter might be hurt. The Community Psychiatric Nurse did record her as being frightened but not what specifically she feared might happen nor what advice or support was offered in response other than to call the police. The threat J might present to professionals was recognised which makes the absence of explicit action focussed on the risks to his family inexplicable. Better liaison between the police and mental health services could have made better use of bail conditions to protect the family.

3.3.6 The Panel consider that there was a lack of focus on the risk of harm to others at the time of the compulsory admissions to hospital between January and March

2011. All these mental health assessments and admissions were triggered by police and courts, which reflects J's reluctance to engage when referred by his GP. It was not critical when during these processes this occurred but any assessment of J's mental state could only be made with full information about his criminal activities from the police. None of the professionals responsible for decisions in respect of J had the complete picture and health professionals were working from his and his mother's information rather than the wider picture known to the police. The SSSHFT IMR does not comment on the responsibility of mental health services to prevent crime and reduce risks to others but it cannot be in the best interests of patients to so ignore such matters that very serious crimes are subsequently committed by them. The Panel recognised that the lack of cooperation from J made it difficult to come to firm conclusions, but that very absence of motivation should have significantly raised the levels of concern. Neither the mental health services nor the criminal justice system engaged effectively with each other about J to contain or restrain his behaviour. His engagement in serious crime was known by criminal justice services and he presented a very considerable threat to the wider community through the supply of illegal substances and the associated criminal activity. Both agencies failed J, S, R, and the wider community in failing to use the powers available effectively to share information and agree joint action. Instead both agencies watched and waited and failed to evaluate the accumulating evidence of risk to others. The police IMR comments appropriately on these matters. SSSHFT offers the suggestion that there could have been a forensic assessment. This would have been a wise precaution.

3.3.7 The SSSHFT IMR does add some commentary on access to forensic services at the time of these events and makes proposals to improve that and clinical oversight following discussion with the Panel. The Panel were informed of different service requirements within different commissioning areas provided by the Trust and consider that the Staffordshire commissioning specification requires review to ensure better continuity of medical oversight, treatment and assessment of risk both to the patient and to others.

3.3.8 In August 2011, there was a further opportunity for both agencies to take stock when a review meeting was convened. While there was agreement to keep each other informed, there was no explicit management strategy developed to reduce the risks or restrict his liberty. J had been arrested twice during the previous week and was clearly equipped with bladed weapons. He was reporting to psychiatrists that he was well at this point although his mother had considerable doubts. It is possible that his reported fears were well founded at this time. It needed joint action to get to grips with the risks. At this time the police had substantial evidence of his activities; if the criminal matters had progressed to a successful prosecution it could have resulted in conviction and a prison sentence. He was continuing to offend while on bail but this did not result in action to restrict his liberty.

3.3.9 The police IMR reviews the missed opportunities throughout 2011 and proposes actions which should minimise such problems in the future within the scope of a single agency. It also considers carefully whether explicit risk management processes as a 'Potentially Dangerous Person' could have been applied and concludes that J did not meet the threshold criteria for such processes. The Panel agree with this assessment. The intelligence that he may have acquired a hand gun in 2010 was never confirmed and the weapon he used to kill his mother, which

was a shotgun, was probably acquired only hours before her death. The possibility that he had sought a firearm was not shared with mental health services by the police when they became involved. The information did not of itself have significance at the time in the volume of similar information emerging about J and a number of others. More robust arrangements for sharing information where there are multi-agency concerns might have enabled such focus before a weapon was used. There are no comments from SSSFT about these arrangements. The Panel consider that while cooperating with explicit requests from the police there is little evidence of any initiative by mental health services with a public protection concern as opposed to the immediate interests of J. The Panel were very concerned that treatment was not based on a full understanding of J's activities and behaviour.

3.3.10 The Panel also considered whether adult safeguarding procedures might have been relevant to these events. There is no indication that S should at any point have been considered a "vulnerable adult"[1] and therefore these procedures are not relevant. It is possible a carer's assessment might have indicated some need for services but the Panel thought it highly unlikely that they would have been in relation to her being a "vulnerable adult".

3.3.11 The Panel consider that joint action and joint protocols are required regardless of the level of dangerousness to encourage information sharing and effective joint decision-making. Without the complication of mental health concerns, it is likely that the criminal processes resulting from his offending would have resulted in significant restrictions of J's liberty earlier in 2011. His disturbed behaviour increased the risks of a serious incident while also leaving him free to commit further offences. The police recommendations are a good start but more is required of NHS agencies as a whole, including GP services. Without strong leadership from the police and NHS, it is unlikely other partners can make an effective contribution. This is such a substantial issue in terms of community safety that the Community Safety Partnership as a whole needs to ensure that adequate mechanisms are in place for effective information sharing to protect the community and reduce the risks of serious crime where mental health difficulties are also a feature.

3.4 Community Safety Strategies

3.4.1 J appears to have been using cannabis on a daily basis from about 14 and was excluded from school by the end of the autumn term of year 10 (2003). There are suggestions in the open way he was using in school at this time and the quantities involved, that he was beginning to be involved in supply as well, although this was not recognised at the time and there was insufficient evidence to trigger criminal enquiries. There is no evidence that any of the agencies attempted to identify his source of supply and its funding either then or subsequently. Young people do not access significant quantities of illegal substances without the assistance of others who may have a vested interest in encouraging them to engage their peers in the same activities. J's exclusion helped the school, but it is likely that he continued his activities unchecked. His suppliers experienced no inconvenience or disruption to their business. The grooming of young people to become involved in

[1] Defined as: A person aged 18 years or over, who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

criminal activities is a significant community safety concern and different types of activity are often inter-related. There is a need to ensure that in dealing with the individual young person appropriately that the opportunity to evaluate other evidence is not lost.

3.4.2 Conflict between neighbours and J first occurred in 2004/5 and may relate to his substance dealing activities in the immediate area. It seems that neighbours tried to disrupt S's child minding business by complaining to Ofsted and S complained of being harassed by neighbours. The responses to the neighbour disputes in 2009/10 were handled by the Borough Council within its own planning powers and responsibilities but did not engage with police intelligence about activity in the area. J appears to have been well established as a dealer and as his activities escalated, the neighbours may have had legitimate concerns for their own safety and that of their families. The Panel noted that these complaints were not of sufficient frequency or seriousness to be dealt with by legislation in respect of anti-social behaviour.

3.4.3 The Panel Chair and report author were offered an opportunity to review the intelligence material available to the police prior to S's death. J was just one individual in a large group and his activities were one thread in a complex web of only partially verified intelligence. J was moving in circles with more persistent, experienced, and dangerous individuals in respect of substance misuse and illegal weapons, who were the focus of the exercise. There were risks to the community associated with substance misuse and with the unpredictable, impulsive and violent behaviours associated with such misuse but much of it did not have sufficient corroboration to enable effective action. It is possible that a more robust response to the general problem may have reduced the likelihood of the risks to S becoming a reality. The Panel has been re-assured that following the death of S and the detention of J, the wider criminal issues also have been dealt with and there is a significant reduction in the risks to the community in consequence. The Community Safety Partnership has determined to keep these matters under review and consider how it can be informed of such difficulties should they arise again in the future.

3.5 Child protection matters and child-minding registration

3.5.1 There were 2 different aspects to the child protection issues

a) The safety of S's 14year old daughter;

b) The safety of children receiving a child-minding service:

The risks were different for each, the remedies available were different and each needed to be considered carefully and reviewed regularly. Opportunities to take protective action in respect of both were missed and action in one area did not routinely result in a review of the other. There were failures of communication and failures to recognise the seriousness of the risks when facts were shared.

3.5.2 Many situations where there are domestic violence concerns are also ones that generate concerns for children and systems to protect both adults and children need to work together well. This case does not meet the criteria for a serious case review within Working Together 2010, and the Panel have therefore carefully considered these issues within this DHR.

3.5.3 For the parents whose children were cared for on a daily basis by S the circumstances of her death must have been very distressing. The Panel consider

that if parents had been fully aware of the facts, they would have been unlikely to select S to provide this service. They will reasonably ask what measures were available to agencies to identify any risks to their children and advise them of the situation. Although in practice actions relating to both the minded children and S's daughter overlapped, for the purposes of this discussion the situation in respect of the daughter is taken separately.

3.5.4 At the time of J's assault on his mother in 2003, there is no indication that the police identified that there was another child in the household or considered if his behaviour had any child protection implications. As R was unaware of this event it is possible she was not present at the time. All referrals to children's social care in 2011 identified risks to the minded children but were less consistent about R. The GP records show that concerns were raised about the implications of J's behaviour for R but this was not recorded by social care. When the police made their referral in March 2011 social care considered without prompting the needs of R but the assessment was over-reliant on S as the source of information about the risks. The referral was managed as a 'child in need' (S17 Children Act 1989) referral and full interagency checks were not undertaken although this could have been undertaken following discussion with S. The police provided only a fraction of the information available to them which a S47 Children Act 1989 enquiry would have revealed. The Community Psychiatric Nurse referral in May 2011 did not prompt any review of the safety of S's daughter in the belief that the previous assessment was sufficient, although there had been no discussion with mental health services at that time. All of these referrals were undertaken with limited information available to the referrer and were not confirmed in writing and the complete picture was never developed by children's social care. Only one resulted in an assessment and that did not seek to verify S's assurances or ensure that R's father who lived elsewhere and with whom she had significant contact was fully aware of the situation. R states no-one ever spoke to her about how she felt about her brother's presence and this again suggests that the assessment was inadequate. The Panel believe that a more robust assessment initially, and subsequent review as the situation with J persisted, would have helped S to identify more realistically the risks he presented to her daughter and to herself. In particular the assessment needed to be alert to her need to deny or minimise the risks to protect her livelihood.

3.5.5 The social care IMR considers that more information should have been gathered and evaluated before decisions were made that no further intervention was needed. The Panel has been told that there have been changes since these events to local arrangements which facilitate better exchange between social care and police at the point of referral and throughout the management of allegations. However there is also a need for those making referrals to ensure referrals are properly presented and supported with relevant background information about the situation including other interested agencies. Confirmation of referrals with written information is also essential if risks are to be properly evaluated and thoroughly verified. These are matters which the Staffordshire Safeguarding Children Board is in a better position than the Panel to take forward in detail and these events were drawn to its attention at an early stage in the review process.

3.5.6 In respect of the children receiving child minding services the Panel consider that there were missed opportunities in 2011 to review the information available to agencies about J through the provisions of Working Together (2010) in respect of 'Allegations of abuse made against a person who works with children'. These

regulations provided the framework for considering the safety of these children. The registration and inspection processes provide opportunities to check on anyone living and or working on the premises as well as the person providing the child care service. Staffordshire Safeguarding Children Board procedures state

> "For the purposes of these procedures the definition of '*work*' is significantly widened and intended to include the following:
> - Those in paid employment, including temporary, casual, and agency staff.
> - Individuals undertaking unpaid voluntary work.
> - Individuals who are self-employed and work directly, or are contracted to work, in the provision of services to children."

3.5.7 S was such a person, and was alleged to be allowing her son, who was acknowledged to be unsuitable, contact with the children she cared for. Where such conditions are alleged there should be consultation with the Local Authority Designated Officer (LADO) (Working *Together to Safeguard Children* (2010), paragraphs 6.32 to 6.42 and Appendix 5). There does not need to be a specific allegation in relation to an individual child that reaches the threshold for S47 enquiries Children Act 1989 for the LADO to consult on an inter-agency basis. A strategy discussion within these procedures would have enabled a realistic and comprehensive risk assessment to be undertaken on an inter-agency basis. None of the agencies considered this route for sharing information although both the police and the GP identified the risks to the children being cared for as a concern. As a result despite clear professional concerns, the parents of the children were unaware of the full situation. The IMRs did not comment on this omission, however following Panel discussion, Ofsted and children's social care acknowledged the omission.

3.5.8 The agencies responsible for making such enquiries are now in agreement. If the full information made available to the Panel had been known to agencies at the time, it is likely more rigorous enquiries in respect of S's registration would have occurred and resulted in its suspension or cancellation. This did not happen because she consistently assured everyone that J was not in contact with the children. However police observations in particular indicate his presence at times when children might be present and the Community Psychiatric Nurse had reason to be concerned on this matter on the basis of her own observations.

3.5.9 The earliest opportunity to consider the impact J might have on children being cared for by S, or on his sister, was when he first committed offences in 2003/4/5. It is likely that he was at this time consuming illegal substances in the family home and he was known to have assaulted first his mother and subsequently his uncle. None of the agencies that worked with J at this time considered consultation with relevant children's agencies in respect of S's daughter or the minded children. LADO procedures were not in place then but there were sufficient powers within the Children Act 1989 to establish what the circumstances were and whether any child was placed at risk. He was under 16 at this time and there was no obligation for S to inform Ofsted of his conviction. Some of the facts did come to Ofsted's notice but the re-assurances given by S were accepted without corroboration.

3.5.10 A further opportunity to take stock should have occurred when J reached 16 years. Ofsted believed he was not resident in the family home and therefore did not need to be formally checked. While technically this was true, he was not in a secure tenancy and it was quite likely that he would return with little notice. Few 16 year

olds leave home for good and criminal justice agencies were in fact recording him as resident at his mother's address for much of the time. As a precautionary principle, family members should be subject to checks upon reaching 16 unless there is sufficient evidence of a secure alternative address not to do so. Verifying this fact with key agencies would have made the risks much clearer. This should have alerted Ofsted to the incidents of assault in respect of his mother and subsequently his uncle. Child minders should also be required to disclose information about a wide range of offending by family members or frequent visitors to the household and not wait until criminal records are due to be checked. Ofsted has taken steps to remedy these issues which will be of re-assurance to parents. However even if these matters had been dealt with, it would not have guaranteed that the particular circumstances that arose in 2011 would not have occurred.

3.5.11 In February 2011 J's GP initiated and recorded telephone contact with children's social care and also raised the risks to the minded children but as noted earlier this conversation was neither recorded nor actioned in social care. The police identified concerns about children grounded in events and observations in March 2011. It is unfortunate that the local beat police officer made the referral to children's social care without first consulting child protection specialists within the police who could have triggered the relevant procedures for disclosing a fuller picture. While children's social care accurately advised the officer to inform Ofsted, there was no consideration of involvement of the Local Authority Designated Officer and no evidence that they were alerted. Ofsted accepted the information as a complaint and did not trigger these procedures either. It is the Panel's considered view that the allegation from the police, if confirmed, was a child protection matter, rather than a complaint about standards and that all agencies involved should have managed the concern within Safeguarding Board procedures. The result of this failing was that while both children's social care and Ofsted discussed the concerns with S independently of each other, neither had access to all the details of the police and mental health services knowledge of the situation. Both organisations accepted S's assurances that the situation was safe. Neither organisation discussed the situation with the local child minder support service which might also have recognised the opportunity for information sharing through LADO procedures and undertaken an unannounced visit. The Panel considered that Ofsted in particular need to review the initial evaluation of complaints to screen for the child protection matters it is not authorised to investigate itself. This is not explicitly covered by their recommendations. Many professionals, as well as members of the public, referring to social care will defer to their decisions as the 'experts' and accept the outcome, as appears to have happened here. The Panel are concerned that most Community Safety Partnership agencies will regularly encounter the need to make referrals and care should be taken by those receiving the referral to guide referrers, particularly those not working within specialist child protection services, and secure all available information in determining actions.

3.5.12 When the Community Psychiatric Nurse contacted Children's Social Care in May 2011 the previous limited responses were exacerbated. Children's Social Care have reviewed the decisions and actions in relation to the referrals in 2011 and accept that this was a missed opportunity to obtain more information. The Panel are concerned that all the information exchanged occurred in telephone conversations without written confirmation. As these were not about immediately urgent situations, the Panel consider that these matters should have been confirmed in writing and this may have assisted a better appreciation of all the

ramifications including LADO responsibilities. This is a matter for the Local Safeguarding Children Board.

3.5.13 Ofsted in their IMR have provided robust information about the policies and procedures of the organisation. The Panel considered that in implementing these, the confidentiality of information about child minders appeared to take precedence over either their support needs or the needs of the children in their care. Any relevant complaint about a child minder, whether well-founded or malicious, is likely to generate consequences for the child minder, which might be ameliorated by contact with the available local support services. This is not only in respect of safeguarding matters, as complaints may not in the first instance fall clearly into any particular category. It should be a routine part of such enquiries that consultation will occur and child minders should be made aware of this as both a source of accurate local information and post complaint support. This reinforces the role of any available support services in helping child minders to achieve required standards and in helping resolve problems. Where complaints relate to criminal behaviour, the Panel were at a loss to understand how a complaint could be investigated without a full picture of those activities from the police. LADO responsibilities provide the vehicle for dealing with such concerns and would have ensured much fuller disclosure than the concerns expressed by the beat officer. LADO procedures also provide a vehicle for engaging information held by the mental health services where issues of patient confidentiality need considered management. The Panel suggest that any complaint investigation relating to suitability of individuals and their households by Ofsted should involve a strategy discussion with the LADO and local Early Years Service's before progressing enquiries. This will ensure there is robust verification of information on which decisions are made. While separation of registration responsibilities from support provides objectivity in judgements about standards, it should not be at the expense of sound verification of facts and access to local knowledge. Had such discussion occurred it would have provided an opportunity to engage S in a more realistic assessment of the risks presented by her son's behaviour.

3.5.14 The Panel have concluded that despite the missed opportunities to take action to protect children and to help S appreciate the risks from the consequences of her son's serious criminal activity, there is no reason to believe that the homicide would or could have been predicted or prevented by such action. However risks should have been managed better and it is fortuitous that no children were physically harmed.

4. Lessons to be learned

4.1 In reviewing the overview report for re-submission in 2014, the Community Safety Partnership has also reviewed progress in respect of the Action Plan. This progress is detailed separately in that document. The following matters are of particular note.

4.2 All partner agencies in Stafford Borough have signed up to the Staffordshire One information sharing protocol. The protocol has been produced by a working group made up of representatives from various public bodies whose remit has been to review existing information sharing protocols and replace them with 'One Staffordshire Information Sharing Protocol' which accurately reflects the current information sharing climate, legislative requirements and best practice. The aim is to enable partners to co-ordinate effort, collate and exchange information to

achieve joint objectives, co-ordinate resources, support one another in addressing common and locally set priorities and comply with the law. The protocol outlines the purposes for sharing information, the powers that organisations have to share information, the role of partners and what can be expected from them, the process for sharing and scheduled review dates.

4.3 A multi-agency Partnership HUB has been implemented as part on the on-going Community Safety arrangements in Stafford which is facilitated by Stafford Borough Council and the local policing team. Practitioners from all agencies attend the meetings to raise awareness of and discuss concerns and/or issues of safety, vulnerability, wellbeing and locality crime. This enables agencies to share information and to implement a co-ordinated approach to the issues that are highlighted.

4.4 The Panel endorses the learning identified by individual agencies in the IMRs. This learning is properly reflected in agency actions and recommendations and the Panel supports the recommendations made in their reports. Each agency was asked to provide a summary of their conclusions and these are set out below with the agency recommendations. The recommendations and the associated actions are further set out in the Action Plan. Where these have been completed this is made clear in the Action Plan and progress is reported to the Community Safety Partnership.

4.4.1 South Staffordshire and Shropshire Healthcare NHS Foundation Trust

The Trust has provided the additional information requested by the Panel on 15/11/2012, and its recommendations which were not available to the Panel until January 2013.

- Early Intervention(EI) Teams are small specialist teams who work with a defined age group of individuals who may be exhibiting early signs of psychotic illness or individuals who have been diagnosed as suffering with a psychotic illness namely schizophrenia. Some teams may have a dedicated Consultant Psychiatrist, this may be a whole time Consultant Psychiatrist or part time. Other teams may access the Consultant Psychiatrist working in the community mental health team linked to the area where the individual lives and on-going medical assessment and treatment will be provided by this Consultant Psychiatrist. In the case of the Staffordshire EI service the team members access and utilise the medical input from the relevant locality CMHT. A named clinical lead i.e. a senior clinician would provide the benefit of on-going supervision of complex or high risk patients and would strengthen multi-disciplinary discussion and decision making.
- It was identified that if J had resided in Shropshire it was likely that the EI service would have considered referring him to the Forensic Liaison Scheme that has been set up in Shropshire for some considerable time and which clinicians across community and inpatient services find supportive in the on-going formulation of risk and in the development of risk management.
- Risk assessment should remain a dynamic process as risks can increase or reduce during an individual's episode of care. The team had increased from one worker visiting to two as a safety measure. When this was reduced good practice would be for the risk assessment to be updated and for the rationale to be documented. It is to be noted that the Trust is moving to a paperless clinical system. The Trust is currently working on a combined system of paper

documents and electronic. The electronic system has an alert feature whereby clinicians are able to place a red alert for individuals with an identified risk and this had been completed in the case of J. Since July 2013 the Trust has begun roll out of a single electronic health record which ensures all Trust service user information is held on the system therefore all Trust staff have access 24/7 to clinical information including that related.

- The EI Team were familiar with safeguarding procedures and Trust policy and whilst the concerns regarding the potential risks to child minded children were recognised and discussed with the team leader and advice sought from the Trust's Safeguarding Team the telephone call that was made to First Response[2] did not constitute a referral.
- The potential of child on parent violence may not be initially viewed in the spectrum of domestic violence. There was evidence that there were times when S expressed some fear of her son.
- Although there is no record of discussions about risks to her daughter the Community Psychiatric Nurse was aware that S's daughter was being seen by the Child and Adolescent Mental Health Service (CAMHS) and it is known that CAMHS were also aware of the Community Psychiatric Nurse's involvement with the family. It is usual practice for each service to separate their engagements to ensure the individual needs of the service users are kept separated. It is however expected practice that contact is made between the services if either had any concerns.
- The EI Team documented comprehensive assessments and reviews and contemporaneous notes were recorded. However the use of professional meetings or multi-agency conferences within the CPA approach is required to ensure best practice of care plans and risk assessments remaining dynamic and ensuring that information from other agencies is captured in an overarching document available to clinical teams involved and shared with other agencies as appropriate.

Recommendations

1. The clinical leadership of the team is to be reviewed. This will include the pathways required to ensure that practitioners in EI are able to access medical consultation as required. This may result in there being a named EI clinical lead. (A paper regarding clinical engagement within teams was discussed at the Directorate Management Team in January 2013).
2. A high level risk management review group has been re-established and will enable clinical teams to present complex high risk cases to assist in formulation of clinical and risk management plans. It is recommended that an evaluation of this is undertaken in six months to establish whether there is a need for additional Forensic expertise to be available.
3. Risk assessment and management plans should include rationale for reduction in risk i.e. moving from two practitioners visiting to lone working in addition the transporting of individuals with a known history of criminal activity and assaultive behaviour including the possession of knives should be avoided until a comprehensive assessment is undertaken and a safety plan is in place.

[2] The First Response Service works in partnership with the Multi-Agency Safeguarding Hub (MASH) to make prompt decisions regarding referrals made by the public or by professionals to Children's Social Care.

4. In relation to safeguarding and welfare of all children any concerns relating to any child's safety or welfare must be referred to the Local Authority Children's Social Care without delay and not rely on waiting for advice from the Trust's Safeguarding Team. This will enable an initial assessment to be undertaken which may result in a multi-agency review. This is to be reiterated in team meetings and the safeguarding training.
5. The directorate is to consider in collaboration with the Safeguarding Team the need for supplementary training for teams in relation to domestic violence.
6. The application of the Care Programme Approach provides opportunity to hold multi-professional meetings to enable comprehensive assessment and review with input from a number of agencies in contact with the individual. Therefore clinical teams are advised to hold such reviews of individuals to ensure that appropriate information is shared across agencies involved.

4.4.2 Staffordshire County Council: Education Inclusion

There are no recommendations in view of changes in practice since the period under review.

4.4.3 Staffordshire County Council: Early Years Services

The IMR notes that this service could have made a better contribution had it been informed and consulted by Ofsted and children's social care. There are no recommendations.

4.4.4 Staffordshire County Council: Families First

- Whilst the actions taken by children's services were proportionate and in keeping with local and statutory procedures there is a clear theme about social workers and others demonstrating a lack of curiosity in verifying information they were being given.
- It is clear that Social Workers relied too much on the account S provided about her son which minimised and underplayed the potential threat that he posed. There was also evidence of social workers not going back to referrers to check the information gathered in assessments.
- There was also an acceptance of poor information being provided to the First Response service with a corresponding lack of challenge as to why professionals had been in contact. Referrers were not routinely being asked to write in to outline their concerns in non-urgent cases which would have allowed the opportunity for proper consideration of the facts and a more accurate assessment of risk.
- These factors have been remedied in the intervening period by the introduction of clear 'scripts' for call takers and extending the facility for referrers to be able to talk and discuss matters with a qualified social worker. The development of the MASH (multi agency safeguarding hub) has further facilitated the free flow of information between the Police and Children's Services and if similar circumstances arose in the future it is inconceivable that a full and relevant history would not have been shared at the point of referral.
- There was a rationale which considered the threshold for LADO not being met and this was largely based on S's own account of the situation. In retrospect

there were legitimate concerns from a number of agencies which, if LADO procedures had been implemented, would have allowed for an appropriate sharing of information through a joint evaluation meeting and could have opened up a helpful dialogue between Children's Services, Mental Health Services and the Police.

Recommendations

1. To continue to review the quality of referral information received and accepted by First Response and the appropriateness of any subsequent actions taken.
2. Where Emergency Duty Service receive referrals where an issue pertaining to adult services is the reason for the referral, checks should always be made regarding the safety and or welfare needs of any associated child.

4.4.5 Staffordshire Police

- J both sold and consumed controlled drugs; he was also someone experiencing mental ill health. Two police referrals were made to other agencies which taken together referenced J's unpredictability arising from mental illness, his displays of violence towards other people involved in drugs and his proximity to children being minded by S.
- There was a working relationship between J's Community Psychiatric Nurse and a local Detective Sergeant dealing with J for criminal matters. However unless criminal behaviour triggered a police power there were few, if any, other options available solely to the police to manage J's behaviour within the community.
- A wider professionals meeting was not initiated by any agency; therefore no joint risk assessment involving all relevant agencies took place. A more effective joint working approach was required involving full discussions and information exchange by relevant professionals with knowledge of S, J and S's daughter.

Recommendations

1. Where mental health concerns are involved processes and procedures should be made clear to enable the recognition of those occasions when a person should be the subject of:

    a) A meeting of professionals at the appropriate level or
    b) Consideration of being classed as a Potentially Dangerous Person

2. Staffordshire Police should have a clear understanding of intra-familial violence and a clearly documented statement of its approach to this category of violence based on a detailed analysis of reported incidents. That approach should be supported by written procedures.
3. The Staffordshire Police Mental Ill Health Steering Group to continue to monitor the completion of the Mental Ill Health and Learning Disabilities package by operational officers and to consider the extension of the training to the roles shown in recommendation 6 below.
4. All Senior Investigating Officers and Family Liaison Advisors who conduct risk assessments for FLO deployments to be reminded of the need to routinely check Guardian for the involvement of any other agencies, current or past involvement with any family member of the deceased, particularly where the person involved with another agency is a child or vulnerable adult. Depending on the outcome of such a check to ensure that that agency is notified of the

incident with the location of the person concerned and that there is an auditable record of that notification.

5. To ensure there are clear auditable processes between agencies within the Multi Agency Safeguarding Hub (MASH) for recording and acknowledging receipt of all information received or disseminated relating to threats and risks which includes notifying the agency who originated the information of the final outcome of any action taken as a result of that information.
6. To ensure that all intelligence staff including analysts receive child safeguarding training. To ensure members of the MASH receive training in recognising and recording mental ill health issues. To consider the suitability of all intelligence staff to receive training in recognising and recording mental ill health issues from within the material they handle.
7. Promote understanding of the mental ill health patient - offender within the community. To create written processes and procedures to identify and risk assess the balance of patient interests to risks posed by a patient who is also an active offender but not managed by Multi Agency Public Protection Arrangements (MAPPA) or Integrated Offender Management processes.
8. Consider the role and tasks of the Mental Health and Learning Disabilities Liaison Officer as described in paragraph 8.2.3 of the ACPO Guidance on Responding to People with Mental Ill Health and Learning Disabilities with a view to ensuring the tasks and functions are catered for within a single point of contact (SPOC) function or by some other equally effective means within the MASH.

4.4.6 Staffordshire Youth Offending Service

- Staff did not demonstrate sufficient understanding of domestic violence.
- Communication of risk factors when presenting/referring cases to First Response needed to be more explicit. Whilst there was evidence of a referral, it was not clear what the basis of the referral was about.
- Lack of synergy between work with young person and the family, denied the YOS the opportunity to make a holistic assessment.
- Managerial oversight was insufficiently robust.

Recommendations

1. To ensure that all relevant staff from Staffordshire Youth Offending Service attend the Domestic Violence Training provided by SSCB during the period 2012-2013. This will support an improved knowledge base specific to Domestic Violence and the correlation between other significant risk factors identified during assessment.
2. All SYOS staff who contact /refer to children's services will communicate clearly any risk factors. Staff will be expected to record outcomes/decisions and work in conjunction with other agencies.
3. All case managers will undertake Parenting assessments and provide interventions appropriate to the needs of the young people and their families.
4. To raise the importance, amongst line managers, of the need for staff to produce good quality holistic assessments in line with Service expectations and SYOS Recording policy.

4.4.7 Staffordshire and West Midlands Probation Trust

- In order for Probation assessments to be as accurate as possible, supervising staff need to approach all agencies that have had dealings with a case in the recent past to ascertain what they know. This is further supported by writing the need for such an exchange of information, even on closed cases, into YOS/Probation case transfer agreement.
- Domestic abuse is not confined to intimate relationships. When supervising young people there is always the possibility that there has been familial domestic abuse. So Probation staff must make a check with the Domestic Violence police.
- When young offenders are sent to Young Offender Institutions (YOI/prison) the YOI assumes ownership of the Probation Oasys assessment. Prison offender supervisors can update the Oasys with relevant information from the time spent in the YOI. When this happens and seemingly no evidence is recorded to support conclusions this must be checked out with the prison offender supervisor, when ownership of the assessment is returned to Probation.
- When offenders have assaulted staff members of other organisations/agencies, this should act as a trigger to the Probation supervising officer to record this in Probation's case record system as a warning to others, in a position of authority, who will work with this young person.

Recommendations

1. All Probation report writers to be reminded to contact YOS about previous contact by that agency, when dealing with young people for report or supervision purposes in their first contact.
2. To liaise with Staffordshire YOS re including exchange of information about previous cases known to YOS in the Transfer Document.
3. Email to staff when assessing risk when supervising young people on Probation to check with police, whether there is any history of domestic violence or call outs to the home.
4. When Prison Offender Supervisors change Risk of Serious Harm assessment, this should be followed up by community Offender Managers to check reasoning before returning the risk level to a previous assessment.
5. When offenders have assaulted members of staff, albeit of organisations other than Probation, the risk to staff flag should be triggered in CRAMS[3] with full explanation in the text.

[3] Staffordshire and West Midlands Probation Trust's electronic database.

4.4.8 Stafford Borough Council

The IMR concludes that policies and procedures were properly implemented and there are no recommendations.

4.4.9 Staffordshire NHS Cluster of PCTs

Recommendations

1. All referrals made to First Response must be followed up in writing in line with SSCB procedures.
2. That all health professionals are made aware of the SSCB Escalation Policy.

4.4.10 Ofsted

The IMR identifies that there is still room for improvement to ensure that Ofsted's risk assessment procedures take account of all the information received and includes:

- Consideration of the impact of wider issues such as the potential for child-on-parent violence, domestic violence and abuse, particularly when assessing risks to minded children; this is covered by recommendation 1 linked to training.
- Consideration of the wider implications of information received for minded children on other children, young people and vulnerable adults connected with a setting (recommendations 3 and 4)
- Taking account of all information about the wider household and improved liaison with other partner agencies to gauge the full extent of their involvement with registered providers. (recommendation 5)
- Over and above the lessons learnt and recommendations identified in Ofsted's IMR, which have helped Ofsted identify and act on areas for improvement, additional lessons learnt from participation in the DHR process include:
- The benefits of allocating sufficient protected time to read the IMR and chronology submissions of the other agencies. This provided opportunities to identify factual errors, for example, when one agency's submissions referred to contact with Ofsted that Ofsted's records did not corroborate, and for which the agency itself had not retained any written evidence. (Recommendation 2)
- Attendance at the review meetings added to Ofsted's knowledge and understanding of the DHR process, and provided valuable external professional scrutiny to the individual IMR and chronology submissions. The Chair created a blame-free environment which encouraged challenge and debate, which enabled organisations to correct some factual errors. At the same time the Chair was able to deliver difficult messages, for example around the quality and timeliness of individual agency submissions.
- The process provided an opportunity for representatives of contributing agencies to review the draft overview report, including opportunities to debate information and interim conclusions, which is especially important when agency representatives feel conclusions may not represent their information fully and fairly.

Recommendations

1. Amend the training for Regulatory Inspectors, Early Years Inspectors and CIE staff on safeguarding and child protection to include specific information on domestic violence and abuse, child-on- parent violence and other inter-familial violence to improve the way these potential risks are taken into consideration when responding to information received and to improve how investigation visits are planned and carried out.
2. Ensure staff record precise and up to date information on Ofsted's database to ensure a sufficiently detailed record of events including the reasons for decisions and accurate attribution of statements in accordance with Ofsted's existing guidance.
3. Revise Ofsted's guidance on referrals to include checking with other agencies that onward referrals have been made where those agencies identify potential risks not affecting minded children, and to make those referrals where appropriate.
4. Amend Ofsted's guidance to consider the impact of unsuitable people in a household at times when child minding does not take place.
5 Review existing guidance and protocols with statutory agencies to ensure that respective roles are understood, information is shared and the full range of risks is taken into account when considering what action to take.

4.5 Conclusions and Recommendations of the Panel

4.5.1 In addition to the above the Panel have considered whether there are recommendations that it should make. The Panel has considered the key issues discussed in the analysis to determine if there are matters that are not dealt with by individual agency recommendations.

4.5.2 The Panel has reflected on both the historical information which shows a persistent pattern of offending by J which presented risks to others around illegal substances, and the more recent information from 2010/11 which shows a significantly raised level of risk to those around him from his volatile and violent behaviour. His criminality became more serious and persistent during this time and this was exacerbated by concerns about his mental health which were less certain but sufficient to worry his mother greatly. The Panel believe that it was predictable that something untoward was likely to happen to someone, somewhere, sometime unless the situation was contained or disrupted. However what might happen, when and where it might happen and who might be hurt was quite uncertain. That it would result in the death of anyone, let alone the murder of S by her son was not something anyone had considered a possibility. Even with the benefit of hindsight, the Panel are uncertain about J's intentions in terms of using the shotgun although, as with knives, it seems likely that he was prepared to threaten to use it to intimidate others.

4.5.3 The Panel consider that more robust decision-making by all agencies to contain and disrupt the high risk behaviour might have reduced the risk of this death but it is not certain it could have been prevented. During the year before her death all the professionals could have taken greater care about the risks to S, her daughter and the minded children, presented by J's criminal activities and his beliefs, whether realistic or not, of being at risk himself.

4.5.4 There was a significant failure to evaluate jointly criminal and mental health concerns about J in March 2011 by police and mental health services. The Panel appreciate that issues of confidentiality and potential criminal proceedings make such sharing complex. However it is difficult to see how competent decisions on either count can be made without such information sharing. The Police IMR recognises this difficulty but a single agency cannot solve this problem. The complexity of NHS arrangements means that health information may well be spread across a number of different organisations and individuals with different accountabilities. The Panel considers that current arrangements do not facilitate routine exchange which will either enable risk to be identified accurately or responded to appropriately. While arrangements are good for the most severe and acknowledged risks through MARAC and MAPPA less acute concerns appear to have uncertain arrangements as demonstrated by these events. In particular, the assessment of mental health concerns introduced substantial delays to the criminal justice process, which might otherwise have restricted J's liberty more effectively. Although J is the perpetrator, it is recognised that this is also a tragedy for him as well as his victims, as he now faces a substantial period of detention and at the same time having to come to terms with the circumstances of the death of his mother.

4.5.5 This earlier failure might have been ameliorated in August 2011 when a meeting was held to share information but little is recorded either at the time or subsequently about how the information shared would be used. The Panel appreciate that each agency may have needed to make those decisions separately but neither the significance of the information shared, nor any effective actions in response, is made explicit by either. The opportunity to act on recent arrests was lost. These matters require attention together.

Recommendation 1

The Panel recommend that arrangements for routine information sharing between the police and NHS agencies are reviewed to ensure that they are robust and comprehensive to support effective and timely decisions by professionals to reduce risks to families, friends and the wider public from the consequences of criminal activity when exacerbated by mental health concerns.

Recommendation 2

The Panel recommend that whenever criminal activity is present and persistent in parallel with mental ill health, there should be regular forensic mental health led review to ensure that public protection is sufficiently considered.

4.5.6 The Panel are also concerned about the reporting of child protection concerns in March 2011. It is satisfied that the Families First IMR and its recommendations deal with the shortcomings in respect of the assessments of S's daughter. These are not matters that have direct relevance to the prevention of domestic homicide although these two issues may commonly occur together. However these assessments presented a significant opportunity for interagency exchange and the involvement of LADO procedures and would have alerted S more acutely to the risks associated with J's criminal activities to herself, her daughter and the children she cared for on a daily basis. These are primarily child protection matters beyond the remit of the Panel or the CSP and to which the Safeguarding Board is alert.

4.5.7 Similar issues occurred some two months later. The referral from the Community Psychiatric Nurse was dealt with as being 'for information only'. It was not passed on to Ofsted by social care on this occasion as it was interpreted as relating to S's daughter only although the social care record noted the minded children. The Panel are concerned that part of the import of the issues was missed because the referral was not made in writing and both parties seemed to be falsely re-assured. The Panel consider that SSSHFT failed to adequately inform social care or Ofsted of the risks to children from S's wish to support her son.

Recommendation 3

The Panel recommend that the Staffordshire Safeguarding Children Board should review this report and have access to any background details to assist them to consider the implications for the operations of child protection procedures and in particular Local Authority Designated Officers and the support that community safety arrangements may provide to those responsibilities.

4.5.8 In addition to responding to these concerns the Panel wish to draw the attention of CSP agencies to the wider issue of parents abused or threatened by their adolescent or adult children. None of the agencies had any specific services or strategies to address this concern but discussions in Panel suggest that there may be less serious incidents and scope to prevent them. The Panel are particularly pleased that some agencies responded very promptly to this issue and have already taken steps that will contribute to realisation of the following recommendation.

Recommendation 4

The Panel recommend that the CSP consult with all agencies and consider how the matter of violence and abuse of parents by their teenage and adult children can be identified and prevented.

4.5.9 In addition to the above considerations, the Panel are concerned that there have been substantial delays and omissions as a result of the minimal cooperation with these procedures by SSSHFT and a lack of clarity about what other processes may also be required. There appears to have been confusion about both the production of timely information and a lack of rigour in reviewing actions of key staff. Advice was sought at a late stage when it could have been made available earlier. There has been recognition at a very late stage in this process that more was required of the Trust and that measures are now being put in place that may remedy the failure. The Panel considers that it is critical that open and timely review is undertaken when incidents such as this occur.

Recommendation 5

The Panel recommend that the Chief Executive of the South Staffordshire and Shropshire Healthcare NHS Foundation Trust review these processes and provides a report to the CSP and Trust Board within 3 months on the arrangements in place to achieve compliance with DHR procedures in the future.

4.5.10 The Panel are pleased that SSSHFT has recognised in its recommendations the need to robustly implement CPA disciplines. The Trust recommendations do not however acknowledge the absence of a carer's assessment or support plan therefore:-

Recommendation 6

The Panel recommend that the South Staffordshire and Shropshire Healthcare NHS Foundation Trust ensure that legal obligations to relatives and friends of patients acting as carers are routinely met and robustly monitored.

4.5.11 The Panel remain concerned about the commissioning accountability for services provided by SSSHFT particularly in the light of NHS organisational change and therefore:-

Recommendation 7

The Panel recommend that the NHS commissioning body for the area consider what changes may be required to support effective accountability for managing risks presented by patients and ensure that these arrangements are subject to regular review.

References

Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' Home Office; London 2011.

Working Together to Safeguard Children, DCSF ,London. (2010), (https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf accessed 05/11/2012).

Appendix A

DOMESTIC HOMICIDE REVIEW TERMS OF REFERENCE

1 Introduction:

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

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

- **a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;**
- **a person to whom he was related or with whom he was or had been in an intimate personal relationship; or**
- **a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death:**

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

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

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

1.5 Paragraph 3.3 of the Guidance lays out that the purpose of undertaking a DHR is to:

- **Establish** what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- **Identify** clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- **Apply** these lessons to service responses including changes to policies and procedures as appropriate; and

- **Prevent** domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

2 Background:

2.1 The victim, S, is a 49 year old female who lived with her 14 year old daughter. She is divorced from the father of her child. The victim also has a 22 year old son J. The victim was a registered child minder.

2.2 At about 2200 hrs on an evening in October 2011 the victim called a friend and appeared fine. Her daughter was not at home at the time and was staying with her father.

2.3 At 0830 the following morning parents arrived at the premises with their children but failed to get a response. A concerned neighbour entered the house via the rear door and found the victim wearing a dressing gown on the hall floor. The ambulance service was summoned and confirmed that the victim was dead.

2.4 Post mortem indicates the victim died from a gunshot wound. The Police are treating the case as a homicide. J was arrested as a suspect for the homicide but has yet to be interviewed and is currently detained under Section 3 of the Mental Health Act.

3 Grounds for Commissioning a DHR:

3.1 A DHR Scoping Panel met on 21 November 2011 to consider the circumstances leading to S's death. The Panel were unanimous in the view that the following criteria for commissioning a Domestic Homicide Review had been met:

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

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

3.2 This recommendation was endorsed by the Chair of the Stafford Community Safety Partnership who was present at the meeting and minuted.

4 Scope of the DHR

4.1 The DHR should consider the period that commences from 1st January 2003 up to and including the events on the day the victim's death. The focus of the DHR should be maintained on the following family Members:

Name	**S**	**J**	**R**
Relationship	Subject of DHR	Son	Daughter
Date of Birth	Aged 49	28/12/1988	Aged 14
Ethnicity	White British	White British	White British
Address of Victim:	Stafford, Staffordshire		

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

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

5 Individual Management Reviews (IMR)

5.1 Key issues to be addressed within this Domestic Homicide Review are outlined below as agreed by the Scoping Panel. These issues should be considered in the context of the general areas for consideration listed at Appendix 6 of the Guidance.

- Were risks posed by J to his mother, his sister, children minded by S, professionals and the community as a whole appropriately understood/shared/acted upon?
- Were S's concerns for her personal safety recognised, appropriately risk assessed and responded to?
- Should J have been identified as a Potentially Dangerous Person?
- Agencies' and professionals' understanding of the impact of child on parent violence and whether S was seen as a victim of domestic abuse
- The nature and effectiveness of agency involvement with child minding services provided by S and adherence to regulatory guidance by agencies
- Provision of mental health services to J, S and S'S daughter
- Referral to children's safeguarding services in respect of S'S daughter

- Specific equality and diversity issues such as ethnicity, age, disability or vulnerability that require special consideration
- Was the homicide of S predictable and/or preventable?

5.2 Individual Management Reviews are required from the following agencies:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Staffordshire County Council: Education Inclusion
- Staffordshire County Council: Child minding Support Services
- Staffordshire County Council: Families First Safeguarding
- Staffordshire Police
- Staffordshire Youth Offending Service
- Staffordshire Probation Trust
- Stafford Borough Council
- Staffordshire NHS Cluster of Primary Care Trusts
- Ofsted

5.3 Where an agency has had involvement with the victim and both children a **single** Individual Management Report should be produced; which:

- discusses the circumstances and needs of each individual;
- discusses the relationship that existed between the family members;
- discusses the relationships with members of their immediate and extended family, which may have impacted upon them; and
- maximises learning from the circumstances leading up to the homicide.

5.4 In the event an agency identifies another organisation that had involvement with either the victim or her family, during the scope of the review; this should be notified immediately to the County Commissioner for Safer Communities, to facilitate the prompt commissioning of an IMR.

5.5 Integrated Health Chronology and Overview Report: The Designated Safeguarding professional will review and evaluate the practice of all involved health professionals (including GPs and providers commissioned in the area), in accordance with the Guidance.

5.6 Third Party information: Information held in relation to members of the victim's immediate family, should be disclosed where this is in the public interest, and record keepers should ensure that any information disclosed is both necessary and proportionate. All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

5.7 Staff Interviews: All staff who have had direct involvement with the victim or her children, within the scope of this review, should be interviewed for the purposes of the DHR. Interviews should not take place until the agency Commissioning Manager has received written consent from the Senior Investigating Officer. This is to ensure primacy of evidence for any parallel criminal proceedings that may result as a consequence of S's death. Participating agencies are asked to provide the names of staff who should be interviewed to the County Commissioner for Safer Communities who will facilitate this process. Interviews with staff should be conducted in accordance with paragraphs 11-120 of the Guidance.

5.8 Equally, where staff are the subject of other parallel investigations (Disciplinary, SUI, etc.) consideration should be given as to how interviews with staff should be managed. This will be agreed on a case by case basis with the DHR Independent Chair, supported by County Commissioner for Safer Communities.

6 Summary Reports

6.1 Where an agency has had no direct contact with the identified subjects within the period under review, but has had historic involvement with them or involvement with their extended family (outside of the scope of this Domestic Homicide Review), a Summary Report should be prepared.

6.2 Summary Reports are required from the following agencies:

- Mid Staffordshire NHS Foundation Trust
- Staffordshire and Stoke Partnership NHS Trust
- Staffordshire County Council – Targeted Services: Education Welfare
- University Hospital North Staffordshire

6.3 The Summary Report should commence from the point at which the agency first became involved with the family, until that involvement ceased. A chronology of **significant** events relating to family members should be attached to the report.

6.4 The purpose of the Summary Report is to provide the Independent Overview Author with relevant information which places each subject and the events prior to the incident that resulted in S's death into context.

6.5 The Summary Report should identify and discuss any significant life events, for example being the subject of a Child Protection Plan, offending behaviour etc.

6.6 Whilst the Individual Management Review or Summary Reports will not form a part of the submission to the Home Office, at the conclusion of this process; they should be authorised by the agency commissioning manager.

6.7 In the event that an agency identifies another organisation that had involvement with the victim or her family, outside of the scope of this review, this should be notified immediately to County Commissioner for Safer Communities, to facilitate the prompt commissioning of a Summary Report.

6.8 IMR Authors and Summary Report Authors should have <u>no line management responsibility</u> for either the service or the staff who had immediate contact with either the subject of the DHR or their family members. IMRs and Summary Reports should confirm the independence of the author, along with their experience and qualifications.

7 Parallel Investigations:

7.1 During the course of the Domestic Homicide Review, each agency should give consideration to whether they should initiate an Internal Review and/or take Disciplinary action (in respect of individual employees), in the event that policies and procedures have not been complied with. This information should be included in the agency's Individual Management Review.

7.2 The IMR need only identify that consideration has been given to disciplinary issues and if identified have been acted upon accordingly. IMRs should not include details which would breach the confidentiality of staff.

7.3 The County Commissioner for Safer Communities should be notified by the Commissioning Manager in writing where parallel investigations of practice etc are initiated during the course of the review.

7.4 The Senior Investigating Officer (SIO) for S will attend all Domestic Homicide Review Panel meetings, during the course of the review.

7.5 The SIO will act in the capacity of a Professional Advisor to the Panel, and ensure effective liaison is maintained with both the Coroner and Crown Prosecution Service, during the course of the DHR.

7.6 All communication with the SIO and County Commissioner for Safer Communities, between meetings, will be in writing to maintain a clear audit trail and accuracy of information shared.

8 Independent Chair and Overview Author

8.1 Both the Independent Author and Independent Chair are independent of Stafford Community Safety Partnership, Staffordshire Safeguarding Children Board and Staffordshire Vulnerable Adult Safeguarding Board, and are not employees of any of the agencies involved in this review.

9 Domestic Homicide Review Panel

9.1 The DHR Panel will comprise senior representatives of the following organisations:

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Staffordshire County Council: Education Inclusion
- Staffordshire County Council: Child Minding Support Services
- Staffordshire County Council: Families First Safeguarding
- Staffordshire Police
- Staffordshire Youth Offending Service
- Staffordshire Probation Trust
- Staffordshire NHS Cluster of Primary Care Trusts
- Ofsted
- Staffordshire Women's Aid (Independent member)

10 Legal and/or Expert Advice

10.1 The County Commissioner, in consultation with the DHR Independent Chair, will identify suitable experts who would be able to assist the Panel in regard to any issues that may arise.

10.2 However, the Individual Management Review Authors should ensure appropriate research relevant to their agency and the circumstances of the case is included within their report.

10.3 The Overview Author should include relevant lessons learnt from research, including making reference to any relevant learning from any previous DHRs and

Learning Reviews conducted locally and nationally.

11 Family Engagement

11.1 The DHR Panel will consider and keep under review arrangements for involving S's family and social network in the review process in accordance with section 11 of the Guidance. Any such engagement will be arranged in consultation with the Senior Investigating Officer.

11.2 The DHR Panel will ensure that at the conclusion of the DHR the victim's family will be informed of the findings of the review, prior to submission of the Overview Report to the Home Office. The DHR Panel will also give consideration to the support needs of family members in connection with publication of the Overview Report.

12 Media Issues

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

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

13.1 The DHR commenced with effect from the date of the decision of the Chair of the Community Safety Partnership: **21 November 2011 and should be completed and submitted to the Community Safety Partnership by 21 May 2012.**