Derby & Derbyshire Coroner's Area

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	THIS REPORT IS BEING SENT TO: **1. [redacted], Chief Constable, Derbyshire Constabulary** **2. [redacted] Chief Executive, Mental Health Trust** **3. Rt Hon Theresa May, Secretary of State for the Home Department** **4. Rt Hon Jeremy Hunt, Secretary of State for Health** **5. [redacted] Association of Chief Police Officers – Chief Constable with responsibility for Information Management**
1	**CORONER** I am **Dr Robert Hunter**, Senior Coroner, for the Coroner Area of **Derby & Derbyshire**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10th June 2010 I commenced an investigation into the deaths of Rachael Claire Slack, Aged 38, Auden George Slack, Aged 22 months and Andrew David Cairns, Aged 44. The investigations concluded at the end of the inquest on 22nd October 2013. The conclusions of the Jury were as follows : **Rachael Claire Slack** 1(a) Multiple Stab Wounds **Conclusion of the Jury :** Unlawfully killed – in part her death was more than minimally contributed to by a failure to impress upon her that she was at high risk of serious injury or homicide from her ex-partner. **Auden George Slack** 1(a) Multiple Stab Wounds **Conclusion of the Jury :** Unlawfully killed – in part his death was more than minimally contributed to by a failure to impress upon his mother that he was assessed as high risk of serious injury or homicide by his father and by a failure to discuss with his mother adequate steps that could be taken to address the risks to him.

	Andrew David Cairns 1(a) Multiple Stab Wounds **Conclusion of the Jury :** Andrew Cairns took his own life
4	**CIRCUMSTANCES OF THE DEATH** 1. Andrew Cairns was the ex-partner of Rachael Slack and the father of their two-year-old son, Auden Slack. 2. Mr Cairns had been known to Mental Health Services for a number of years and had been assessed under the Mental Health Act on a number of occasions and also had voluntary hospital admissions for a depressive illness. 3. Prior to the deaths of Andrew Cairns, Rachael Slack and Auden Slack, Mental Health Services were reconsidering the diagnosis to be one of a potential personality disorder. 4. Miss Slack had been estranged from Andrew for 18 months and was in a new relationship with a new partner and was carrying her new partner's child. 5. On the 26th of May during an access visit to Auden, Mr Cairns refused to get out of Rachael's car. She drove to a Police Station. Mr Cairns was assessed by the Police and detained under Section 136 of the Mental Health Act. He was assessed by the Mental Health Team, who deemed there was no major mental illness and was released from Section. 6. On the 27th of May 2010, Mr Cairns made threats to kill Rachael; this was reported to the Police. Rachael and Auden were assessed by the Police as being at high risk of homicide by Mr Cairns. Mr Cairns was arrested. He was questioned by the Police on the 28th of May 2010 and released on Police bail. 7. The Jury at the Inquest heard evidence that Mr Cairns had breached his Police bail on at least two occasions by approaching Rachael's house, Rachael was unaware of this however her neighbours were aware of the approach but were unaware of any bail conditions on Mr Cairns. He had also contacted her by telephone and text. 8. On the 2nd of June 2010 Mr Cairns went to Rachael's house, gained entry and he first stabbed Auden, their two-year-old son to death then turning his attack on Rachael he stabbed Rachael to death and then stabbed himself to death.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. At the time of arrest of Mr Cairns, the Police were aware of his assessment under Section 136 of the Mental Health Act the previous day. The Custody Nurse had contacted the Crisis Team to obtain information regarding the 136 assessment which was duly given by the Mental Health Team. However, there was no reciprocal exchange of information and the Mental Health Team were not informed that Mr Cairns had been arrested with regards to Threats to Kill his partner. 2. At the conclusion of the Inquest and after all the evidence was heard, it came to light that there was in existence a policy for mutual sharing of information between the Police and Mental Health Services if each respective organisation requested information from the other. 3. This document was not disclosed prior to the Inquest or during the Inquest itself and it would have been critical to ask witnesses from the Police and Mental Health Services about their knowledge of this document.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. Derbyshire Police and Derbyshire Healthcare NHS Foundation Trust should give consideration to developing a policy of mutual disclosure of information regarding mental health patients who have been arrested by the Police, when the reason for the arrest is one of a purported serious violent or sexual nature. Consideration should be given to making the policy one of voluntary disclosure between the agencies as opposed to an agency having to request information. 2. I consider this to be a National issue and therefore the Home Secretary and the Secretary of State for Health should give consideration to a joint National policy. 3. In regard to this, issues of medical confidentiality were raised during the course of the Inquest. For your information I enclose the General Medical Council's guidance to Doctors on breaching confidentiality. In particular paragraphs 53 to 55 are important. In essence, disclosure of personal information to an authority can be done without the patient's consent if it is in the public interest to do so, particularly when it is a violent crime in relation to domestic violence, or where children or others may be at risk. The GMC stipulates it is best practice to inform the patient of the disclosure even if the Doctor does not have the patient's consent for disclosure. The GMC continues by stating that the patient should be informed before disclosing information if it is practical and safe to do so.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **27th December 2013**. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons : [redacted] Independent Police Complaints Commission [redacted], Children and Young Adults Department, Derbyshire County Council [redacted], Derbyshire County Council [redacted] Derbyshire Health United [redacted], Amber Trust [redacted] Local Safeguarding Board I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**01 November 2013** **Dr Robert Hunter** **HM Senior Coroner** **Derby and Derbyshire Coroner's Area**