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warwickshire

**DOMESTIC HOMICIDE REVIEW
EXECUTIVE SUMMARY OF REPORT
INTO THE DEATH OF “Mary”**

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RESTRICTED

EXECUTIVE SUMMARY REPORT

PART ONE:

DOMESTIC HOMICIDE REVIEW BACKGROUND AND PROCESS

1.1 Purpose of the Review:

The key purpose for undertaking DHRs is to enable lessons to be learned from when the death of a person has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were or had been in an intimate personal relationship with or a person who they shared the same household with. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

1.2 Who the report is about:

This DHR examines agency responses and support given to “Mary”¹, a resident of Warwickshire prior to her death in 2014. Mary was the wife of “Peter” and the mother of two children, now living independently as adults. She was in her late 70s when she died from a single stab wound. Peter, who was also in his late 70’s when his wife died, was arrested on suspicion of murder. He subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility and received a suspended prison sentence.

In the last six years of her life, Mary had a complex medical history. In August 2008 she had elective surgery, as a day patient at George Eliot Hospital (GEH). This relatively minor and routine procedure was completed with no apparent complications and she was discharged on the same day. However, eight days later Mary presented at the George Eliot Hospital (GEH) Accident & Emergency Department with abdominal pain, a urinary tract infection and other symptoms. Over the following six years, she continued to have serious physical and mental health problems.

¹ Pseudonyms of Mary and Peter are used, in place of the actual names of the deceased and her husband.

1.3 Events leading up to the homicide incident

The following descriptions of events and of Mary's behaviours are based on information from multiple sources, including Independent Management Reviews (IMRs) provided by health provider services who were involved in the period leading up to the homicide and disclosures by Peter in the course of a psychiatric assessment carried out after the homicide.

From April 2014 onwards, Mary's physical, mental and emotional condition became progressively worse. It appears that Peter was under extreme physical and emotional stress, as a result of his caring responsibilities for Mary. This pressure stemmed from Mary's emotional and physical care needs which she expressed through constantly distressing and demanding behaviours, including:

- Prolonged bouts of wailing, described by Peter as "incessant and horrendous".
- Repeatedly saying "you promised me", which Peter (following the homicide) said he understood to mean that he had promised that he would not let her suffer.
- Needing to be taken to the toilet repeatedly, requiring Peter to stay and comfort her, sometimes for several hours at a time.
- Waking up through the night, resulting in Peter never sleeping for more than two or three hours at a time.
- Refusing to comply with nursing care procedures and interventions which were intended to ease her condition.

The extreme emotional and physical pressures on Peter were graphically evidenced in the psychiatric report requested by the Crown Prosecution Service, for the purposes of the criminal proceedings against Peter. For example, the report describes some quite extraordinary measures taken by Peter, to ensure that he would be woken, should his wife need any assistance during the night.

Unfortunately, none of the professionals in contact with Mary and Peter at the time were aware of the extreme levels of stress that Peter described following the homicide incident. In summary, it now appears that he was '*putting on a brave face*' to the outside world, but was in fact finding it increasingly impossible to cope with what he experienced as a desperate situation.

1.4 The homicide incident

In the early hours of the morning, Warwickshire Police were telephoned by Peter, stating that he had killed his wife. Police attended the property, where they found Mary, deceased. She had been stabbed once in the chest. A subsequent post mortem confirmed that the cause of death was a single stab wound to the heart.

1.5 Individual Management Reviews and Chronologies

Each of the following organisations provided a chronology of their involvement, together with an Individual Management Review (IMR) addressing the questions set out in the Terms of Reference:

- General Practitioners (IMR author provided by NHS England)
- Warwickshire County Council Adult Social Care
- Warwickshire Police
- George Eliot Hospital NHS Trust (GEH)
- Coventry & Warwickshire Partnership NHS Trust (CWPT)
- South Warwickshire NHS Foundation Trust (SWFT)

Additionally, West Midlands Ambulance Service (WMAS) provided a chronology which recorded some brief contacts, but no IMR was required from this service.

1.6 DHR Panel membership

| Job title | Organisation ² |
|--|--|
| Richard Corkhill ³ Independent Consultant | Independent Chair / Overview Report Author |
| CSP Chair | A Warwickshire CSP |
| Communities Manager | A Warwickshire Council |
| Violence Against Women & Girls Strategy Development Manager | Warwickshire County Council |
| Operations Manager, Safeguarding Adults Team | Warwickshire County Council |
| DHR Officer | Warwickshire County Council |
| Detective Chief Inspector | Warwickshire Police |
| Designated Lead for Safeguarding Children and Adults | Coventry & Warwickshire Partnership NHS Trust |
| Lead Nurse Safeguarding Adults | A Warwickshire CCG |

1.7 Contact with Peter and other family members

Peter and his adult children were informed of the DHR process and its purpose was explained. They were invited to contribute to the DHR, but politely declined.

² There was no voluntary sector representation on the Panel. This is now recognised as a process shortfall. A Warwickshire CSP will seek to establish relevant non-statutory Panel membership for all future DHRs.

³ **Independence statement:** Richard Corkhill (richardcorkhill.org.uk) is a self-employed Consultant, with extensive experience of leading DHRs and similar multi-agency review processes. He has never been employed by any of the agencies which were involved with Mary and her husband.

PART 2:

COMMENTARY, ANALYSIS AND KEY LEARNING

2.1 Introduction

The full overview report provides a detailed chronological history of events for the full period specified in the DHR Terms of Reference, which was from 1/6/2008 until Mary's death in June 2014. The view of the DHR Panel is that the key lessons for the future arise from events and agencies' responses in the last weeks of Mary's life. Specifically, hospital discharge planning appears to have been the most significant factor. The following is a summary of the main DHR findings and key learning points, structured in line with the questions which were set out in the Terms of Reference:

2.2 Did agencies have any previous knowledge or concerns that Mary could have been a victim of domestic abuse as defined in Home Office Guidance for DHRs, perpetrated by her husband or any other household or family member?

All of the evidence presented to the DHR (i.e. agency IMRs, chronologies and the forensic psychiatric report on Peter) shows that there had been no previous knowledge or concerns of this nature, and no reason to suggest that any of the agencies could have identified such concerns.

On the contrary, there was very solid evidence from what was documented by agencies that Mary and Peter had a caring and loving relationship. This was confirmed by observations from the family GP and by family background information collated for the psychiatric report for criminal proceedings against Peter. It was also evident from GEH records which showed that, during periods when Mary was an in-patient, Peter spent many hours on the ward, sitting with Mary, reassuring her and helping to manage her physical discomfort, pain and anxiety. Two days before the homicide, a referral letter from the family GP referred to an "*excellent and supportive family network*".

2.3 Did primary and secondary healthcare services effectively meet Mary’s healthcare needs?

As already outlined, it is not within the DHR’s terms of reference to review or evaluate clinical diagnoses and treatments provided. However, there appear to have been some major failures of communication between GEH and SWFT, resulting in Mary being discharged from hospital twice in the weeks immediately preceding the homicide, without effective discharge planning having taken place. The following table summarises conflicting information⁴ between the GEH and SWFT IMRs and chronologies, which highlight these communication failures:

| GEH | SWFT |
|--|--|
| <p>Mary’s inpatient stay at GEH on 7/5/14 to 20/5/14: The GEH chronology states that, during this inpatient stay, referrals were made to Mental Health Team, dementia screen & Intermediate Care Team.</p> <p>Mary’s discharge from GEH on 20/5/14: <i>“On reviewing the discharge planning booklet it would appear that the Ward Manager and the OT mentioned the Intermediate Care Team (ICT) to support the discharge. There is no documentation to state whether or not the ICT assessed Mary or whether this was discussed with Mary and her husband.</i></p> <p><i>Ward Manager remembers asking Peter about help at home and he appeared very confident in his ability to manage, stating he did not require any help, had a good network of support with his daughters and he would ask for help if needed.”</i></p> | <p>SWFT IMR and chronology make no reference to receiving a referral for ICT, or any other SWFT service, on or before Mary’s discharge on 20/5/14.</p> |
| <p>Mary’s discharge from GEH on 11/6/14: <i>“Plan was for home that day, with support from the Intermediate Care Team (IMC). Documented in the discharge booklet that IMC referral had been done and faxed and they were informed of the referral.”</i></p> <p>The GEH analysis concludes; <i>“Ward Manager also identified the staff nurses who had referred Mary to IMC and district nurses, both nurses</i></p> | <p>SWFT IMR and chronology make no reference to receiving a referral for ICT or District Nurses on or before Mary’s discharge on 11/6/14.</p> |

⁴ In the light of conflicting information, both agencies were asked by the DHR to re-check their records. Both agencies have confirmed that their records are as summarised in the table.

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| <p><i>are experienced, competent and are dementia friends. They both engage with the dementia link nurse meetings and after some discussion with Ward Manager there is no doubt these nurses would have made the referrals as per their documentation.”</i></p> | |
|---|--|

GEH's record of the discharge on 20/5/14 does not make it clear that a referral was made to SWFT, only stating that *'it would appear that the Ward Manager and OT mentioned the ICT service'*. However, a GEH chronology entry does state that such a referral was made, during the course of this in-patient stay (i.e. at some point between 7/5/14 and 20/5/14). GEH appear to have no documentary record of the referral itself. They also have no record of such a referral having been discussed with Mary and Peter, or confirmation of receipt by SWFT.

For the subsequent hospital discharge on 11/6/14, there is a similar conflict between the records of GEH and SWFT. The GEH discharge booklet recorded that there had been a referral to ICT and that this was part of the discharge plan. On the other hand, SWFT have no record of receiving a referral. The GEH IMR author expresses confidence that the members of GEH staff involved *'would have made the referrals, as per their documentation'*. The documentation referred to is an entry in the discharge booklet stating a referral had been made. But there appears to be no confirmed record of the referral itself or any other communication between GEH and SWFT in relation to Mary's discharge arrangements. The evidence from both agencies' IMRs indicates a lack of jointly agreed or implemented procedures for making and recording referrals of this nature.

The picture is further confused by the WMAS records from 12/6/14 when they received a 999 call. WMAS records relating to the call state *"that the virtual ward (GEH) had attempted to arrange a District Nursing visit, but this had not been possible"* It is unclear precisely what attempts had been made to arrange a District Nursing visit, when the attempts were made, or why the attempts had been unsuccessful. The only point of clarity is that SWFT can find no record of receiving a referral from GEH.

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As Mary was re-admitted to GEH on 12/6/14, the discharge on 11/6/14 was described by GEH as having been a 'failed discharge'. It is significant that, when she was discharged again on 13/6/14, Peter required a lot of reassurance about the referrals made by GEH, with his main concern being about Mary's restlessness and frequency of going to the toilet. Whilst GEH records again confirm that a referral had been made for District Nursing services, SWFT continue to state that they received no such referral from GEH. They state that their first visit to Mary was on 14/6/14, in response to a telephone call from Peter, earlier that day.

SWFT records do mention that the nurse was handed a 'community nursing letter' when she made the home visit on 14/6/14. As SWFT have not retained a copy of this letter, it is unclear whether or not the letter originated from GEH, but this is the most probable explanation. If GEH gave Peter a letter to be handed to the District Nurse, this is an indication that GEH believed a referral for this service had been made, even though SWFT have no record of such a referral. However, there is still further confusion, as SWFT's original IMR refers to '*the referral that was sent to the Community Nursing Team*' but the SWFT addendum refers to the nurse being *handed* a community nursing letter by Peter. It is unclear whether the IMR and addendum are alluding to the same letter, but this appears to be the case. This raises further questions about whether or not a referral letter was in fact sent by GEH to SWFT.

On the basis of the evidence made available to the DHR, it is not possible to say with complete certainty whether or not referrals were made by GEH and / or received by SWFT.

On the other hand, it is reasonable to observe that GEH, as the referring agency, should have retained a copy (paper or electronic) of the referral documentation and should also have sought confirmation that the referral had been received by SWFT and was to be actioned, within an agreed time frame. GEH have not presented the DHR with any evidence to show that this occurred. Similarly, SWFT should have retained a copy of the letter which they report was handed to the District Nurse on 14/6/14.

In summary, there were clear failures of communication, referral procedures and record keeping. Consequently, Mary was being discharged from hospital without any effective plan being implemented for care and support at home. On the last of these discharges, one week before Mary's death, Peter had been anxious and had sought re-assurance that relevant referrals had been made. He may have received this re-assurance, but the reality was that a district nursing service was only provided in response to him making a referral himself, on the day following discharge. The more intensive support which could have been offered by the ICT service was not provided, even though GEH records suggest an ICT referral was made.

Either no referrals were made, or they were made then 'lost', at some point in the processes between the two NHS Trusts. It is not within the remit or resources of the DHR process to further investigate the exact causes of (or responsibilities for) these communication failures. This requires urgent review by GEH and SWFT, to establish exactly what took place and to ensure that the lessons from this are learned. (See recommendation 1).

Key learning point 1

Failures in discharge planning and inter-agency communication resulted in Mary being left without adequate support, and Peter with increased caring responsibilities as a result of this shortfall, in what were extremely distressing circumstances. The DHR has concluded that this was a significant factor in the circumstances leading to the homicide incident.

Whilst Peter's extreme reaction on 20/6/14 could not have been predicted by any of the agencies involved, the fact that he was left to care for his wife without an effective hospital discharge plan is likely to have contributed to the personal distress he was experiencing. Had there been a discharge plan including daily inputs from District Nurses and the Intermediate Care Team, this could have reduced the levels of stress that Peter was experiencing at this extremely difficult time.

Whether this could have prevented the homicide is unknown. However, it is reasonable to observe that, if such services had been in place, this would have provided opportunities for Peter and Mary's levels of distress as carer and cared for, to be better understood and for additional services (for example longer term carer support services) to be discussed with him.

A further area of key learning is that of joint working between the Medical Ward at GEH and Mental Health Services provided by CWPT. It is clear that referrals were made to AMHAT and that these were responded to. Even though the predominant view of CWPT mental health professionals was that the primary root causes of Mary's distress were physical in nature, they still provided psychological and ongoing psychiatric review. This is recognised as having been good practice.

However, it is also clear that there was not a mutually agreed or coordinated treatment plan in place. This appears to be mainly due to the differences of professional opinion as to whether Mary's problems were primarily psychological / mental health related, or were primarily physical health problems.

Whilst GEH clinicians placed a strong emphasis on psychological and mental health causes, mental health assessments generally concluded that Mary's anxiety states were secondary to underlying physical conditions. It is recognised that differences of opinion between medical professionals are sometimes unavoidable. However, in this case this seemed to result in an 'impasse', which is reflected in CWPT's IMR:

..'There is little evidence to suggest that information between medical and mental health staff was shared in a meaningful way regarding decisions made regarding Mary's care, particularly during the most recent admissions to hospital.....her needs may have been better met if communication between medical and mental health staff was improved and a more holistic approach adopted'.

2.4 Did adult social care services effectively assess and meet Mary's eligible social care needs, in line with recognised best practice?

ASC did not assess and meet Mary's eligible social care needs, because at no stage did they receive a referral to request such an assessment. That no referral was made could be seen as a criticism of the health care services which were involved and they could possibly also have observed that a carer's assessment would be appropriate. However, it is understood that Peter was very independent by nature and it is doubtful whether he would have agreed to such a referral being made.

As the only direct contact which Peter made with ASC was the phone call on the day preceding the homicide, this has been closely scrutinised by the DHR Panel, who have listened to an audio recording of that telephone conversation. The firm conclusion of the Panel was that the contents of this call gave no clue whatsoever of a potential risk of Peter causing harm to Mary. The Panel also concluded that the Warwickshire County Council Customer Service Centre staff member who took this call communicated with Peter in a very courteous and professional manner and ended the call, having clarified Peter's request for an OT assessment. This was then followed up with appropriate recording and the information was logged with the ASC OT team, to be actioned. The DHR Panel's positive conclusions about how this call was handled have been communicated to the relevant ASC Manager and passed on to the staff member concerned.

2.5 Were Peter's needs as a carer properly assessed and reviewed at appropriate intervals and what services were provided to meet assessed needs?

There is no record of Peter having had a carer's assessment at any stage. As with the previous question, there were no referrals received by ASC to indicate that a carer's assessment was required, so there was no opportunity when this could have been carried out.

There is some evidence to show that doctors at GEH had discussions with Peter about his possible needs as a carer, but that he stated that he did not want any assistance in this area. Again, it appears that he presented as being highly

independent and the extent of his needs as a carer were not easily recognisable. However, this further highlights the importance of learning point 1. If there had been a package of post discharge support in place, this would have significantly increased opportunities for recognition of Peter's needs as a carer and to have engaged with Peter about his needs. It may then have been possible to persuade him to have a carer's assessment, with a view to a longer term package of carer support services.

Key learning point 2

The evidence from this DHR suggests that Peter was very reluctant to disclose the extent of the distress he had been experiencing, which only became clear after the homicide incident, in the course of his psychiatric assessment.

Peter's ability to present as a person who was managing the situation without undue levels of stress was particularly evident from the audio recording of the phone call to ASC, on the day before the homicide. His request for an Occupational Therapy assessment for Mary gave a clear picture of a routine and non-urgent request, with no indication (in content or in tone) that he was unable to cope with his caring role. Given this background, it would be entirely incorrect (and unfair) to suggest that anybody could have had reasonable cause for concern that such a tragic outcome may follow.

On the other hand, this case can act as a reminder of the extreme stresses that carers may be under, and that many people (and older carers in particular) are highly skilled at presenting as coping quite well, and/or are perhaps uncomfortable seeking outside support or assistance, when in reality they may be in urgent need of help. It is important that all agencies involved in assessing and meeting carers needs should maintain an awareness of this learning point and to continually develop strategies and professional skills for engaging with such 'hard to reach' carers.

2.6 What information (if any) did agencies have about Mary's views and wishes around end of life care?

The DHR has seen no evidence that any agencies held information about Mary's views and wishes in this respect. However, as Mary's health conditions were not

diagnosed as life threatening, there would not have been an expectation of medical professionals pro-actively discussing her options for end of life care. On this basis, the DHR has concluded that there is no significant learning in relation to this question.

2.7 Was the Mental Capacity Act (MCA) applied appropriately, in line with the MCA Code of Practice and Deprivation of Liberty Safeguards (DoLS)?

The evidence reviewed by the DHR has raised some questions and concerns in relation to this question. The DHR has concluded that, during her GEH admissions in May and June 2014, there was evidence to suggest Mary may have lacked capacity to consent to treatment. However, there is no record to show that the need for an MCA assessment or DoLS was ever considered.

In particular, Peter's report (in the course of the psychiatric assessment after the homicide) of events on 14/6/14, when he states he was asked to hold Mary down whilst a medical procedure was carried out, is a very disturbing account. If she needed to be held down, this may have indicated that she was not consenting to treatment. If this was the case, the opinion of the DHR Panel is that treatment should only have been given if she was assessed as lacking capacity and the treatment was then confirmed as being in her best interests. But it is difficult to envisage that such a decision would have included asking her husband to assist in this manner.

The DHR Panel requested an IMR addendum from GEH, as this A&E attendance was not discussed in the original report. The addendum confirms that the procedure was documented as being 'traumatic', but GEH have been unable to comment on Peter's report that he was asked to hold his wife down, as the doctor who carried out the assessment has since left the employ of GEH. Similarly, the GEH addendum does not comment on whether potential issues of consent and mental capacity were considered by the staff involved with this A&E attendance.

The conclusion reached by the DHR is that the events at A&E as described by Peter raise some important questions for GEH, including:

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- Was the procedure carried out with Mary' consent?
- If there was no consent (or indeed implicit or explicit refusal) was there any consideration given to the need for an assessment of Mary's capacity to give / withhold consent for this procedure?
- If she was assessed as lacking consent, was the procedure carried out following a best interests decision, in line with the MCA?

The DHR has not seen evidence of any specific causal relationship between these events at A&E and the homicide, some six days later. However, by Peter's own account, this was an extremely upsetting incident, for his wife and for himself. It is reasonable to observe that this would have been an additional stress factor, adding to numerous other sources of emotional and physical distress affecting Peter during that period.

2.8 What are the views of Peter and other family members about the quality of care and treatment services provided to the victim and alleged perpetrator? In particular, what (if anything) might have been done differently - within existing legal frameworks - which could have prevented the homicide from taking place?

As Peter and his daughters have chosen not to directly engage with the DHR, their general opinions about the quality of care and treatment services are not known. However, it is known that Peter and Mary were firmly of the view that Mary's health problems stemmed directly from the surgical procedure in August 2008.

The DHR conclusion about what might have been done differently which could possibly have prevented the homicide, is addressed above. (See learning point 1).

PART 3 RECOMMENDATIONS

3.1 DHR Overview recommendations

Overview Recommendation 1:

GEH and SWFT should jointly review the issues about discharge planning, referral systems and failures of inter-agency communication, which have been highlighted by this DHR. The Review should aim to:

- Establish the facts of what actually occurred, including whether or not the referrals to SWFT (as stated in GEH's IMR and chronology) were in fact sent by GEH and / or received by SWFT.
- Having established the facts, to identify the root causes of no ICT service (now known as Community Emergency Response Team) being provided and the District Nursing Service only commencing as a result of a direct request by Peter, following Mary's last discharge.
- Establish a multi-agency action plan (for implementation by GEH, SWFT and any other relevant parties) to address the root causes. This is likely to include work to ensure that future hospital discharge plans are clearly recorded and agreed between GEH and partner health and social care providers, for services to be delivered within time frames specified in the discharge plan.

This recommendation should be overseen by the relevant Warwickshire Clinical Commissioning Group, who should report to Warwickshire Safeguarding Adults Board (SAB) on the findings of the GEH/SWFT Review and on implementation of the resulting action plan. Lead involvement by the SAB is indicated, as the issue of discharge planning is recognised as a wider safeguarding adults concern, rather than being specific to issues of domestic abuse or homicide, which would have indicated a lead role for the Community Safety Partnership (CSP).

Overview recommendation 2:

GEH should further review the questions raised by this DHR (see section 3.6) about Mary's mental capacity to consent to treatment, during her admissions in May and June 2014 and the A&E attendance on 14 June. This review should consider whether or not clinicians worked appropriately and in line with the MCA Code of

Conduct and Deprivation of Liberty Safeguards. GEH should advise A Warwickshire CCG of the findings from this Review and any action plan which may follow.

Overview Recommendation 3:

Key learning from this case should be shared and utilised within the A Warwickshire CSP area and more widely, with a specific reference to the key learning points relating to:

- Hospital discharge planning
- Raising awareness about the needs of older and 'hard to reach' carers who may refuse help and / or go to considerable lengths to conceal the need for carer support services.

Overview Recommendation 4:

The CSP Chair should write to the Care Quality Commission (copied to the Warwickshire CCG) drawing their attention to the findings of this DHR, with specific reference recommendations 1 and 2.

3.2 Individual agency recommendations:

The following recommendations are reproduced from agency IMRs:

George Eliot Hospital NHS Trust:

MCA training and regular updates for all decision makers.

Coventry & Warwickshire Partnership NHS Trust:

To re-iterate within care planning training and via a learning alert across the Trust the importance of effective communication between professionals, services and agencies and the need for the patient and their experience to be at the centre of this where agencies hold differing views as to the source of the ill health.

South Warwickshire NHS Foundation Trust:

As a response to this Review, awareness will be highlighted in the Safeguarding Adults training when it is reviewed in April 2015.

General Practitioners, Adult Social Care and Warwickshire Police:

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No recommendations.

APPENDIX 1: GLOSSARY

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| A&E | Accident and Emergency |
| AMHAT | Arden Mental Health Acute Team (part of CWPT) |
| AMT | Abbreviated Mental Test |
| ASC | Adult Social Care (Warwickshire County Council) |
| BPSD | Behavioural and Psychological Symptoms of Dementia (Medical diagnosis) |
| CERT* | Community Emergency Response Team provided by SWPT (Previously known as Intermediate Care Team / ICT) |
| CSP | Community Safety Partnership |
| CWPT | Coventry and Warwickshire NHS Partnership Trust (Providers of mental health services) |
| DHR | Domestic Homicide Review |
| DoLS | Deprivation of Liberties Safeguards |
| GEH | George Eliot Hospital NHS Trust |
| ICT* | Intermediate Care Team (provided by SWPT, now known as Community Emergency Response Team) |
| IMC* | Intermediate Care |
| IMR | Individual Management Review |
| ISPA | Integrated Single Point of Access (at SWFT) |
| MCA | Mental Capacity Act |
| MHLP | Mental Health Liaison Practitioner (within AMHAT) |
| SWFT | South Warwickshire NHS Foundation Trust (providers of District Nursing services and ICT / CERT) |
| WMAS | West Midlands Ambulance Service |

*CERT, IMC and ICT all refer to the same service provided by SWFT. They were used interchangeably in some IMRs. The correct name for this service (which has undergone name changes in the recent past) is CERT.