DORSET COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of Jane

June 2022

Independent Chair and Author: Simon Steel

Date of Completion: 30 November 2023

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Dorset Community Safety Partnership (CSP), Domestic Homicide Review panel in reviewing the circumstances of the death of Jane who lived with her husband David both were local residents.

1.2 The following pseudonyms have been in used in this review to protect their identities.

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
Jane	Deceased	76	White British
David	Deceased (Husband)	79	White British
Peter	Davids's brother	78	White British

1.3 On the morning of their deaths in June 2022 Jane and David were discovered deceased at their home address, nobody else lived at that address. Emergency services attended the address and Jane and David were pronounced dead at the scene. It was clear they had both died of gunshot wounds. From the CCTV at 06:02hrs that day a single shot can be heard on the rear camera. The time shown on the screen is 06:02:50. At 06.03hrs David called the police on 999 to report that Jane had died of a suspected heart attack and asked for police to attend straightaway. Police have the call received at 06:03:51. At 06:07hrs from the CCTV a further single shot can be heard on the front garden camera. The time shown on the screen is 06:07:07.

1.4 The Police investigated and concluded no third-party involvement, and the case was passed to HM Coroner. The coronial hearing in this case took place on the 19th of June 2023. It recorded that Jane died by a gunshot wound inflicted by another, and that David died by suicide.

1.5 Dorset police referred this matter to the Dorset Community Safety Partnership (CSP) on the 6th of July 2022. Following an initial scoping of the referral contact was made with the Home Office on the 5th of August 2022. For a number of months there was ongoing contact with the Home Office, who wrote to the Leader of the Council in February 2023. On the 6th of March 2023 the leader of the council responded confirming the Partnership would carry out a Domestic Homicide Review into this matter.

1.6 Agencies that potentially had contact with Jane and David prior to the point of the deaths were contacted and asked to confirm whether they had involvement with them.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact directly or indirectly with Jane and David with the exception of the ambulance service, where a short report was requested.

2.2 The following agencies who had contact and their contributions are shown below.

Agency	Nature of the contribution

Dorset Police	IMR and Chronology
NHS Dorset Integrated Care Board (on behalf of the GP)	IMR and Chronology
Dorset County Hospital NHS Foundation Trust.	IMR and Chronology
South West Ambulance Service	Short report and Chronology

2.3 IMRs were completed by authors who were independent of any prior involvement with Jane and David.

2.4 The authors and panel members assisted the panel further, with one-to-one meetings and answering follow up questions as necessary.

3. THE REVIEW PANEL MEMBERS

3.1 The review panel members included the following agency representatives.

Name	Agency	Job Title
Simon Steel	Perse Perspective Consultancy Ltd	Independent Chair and Author
Stewart Balmer	Dorset Police	Force Review Officer
Kirsten Bland	NHS Dorset	Designated Professional for Adult Safeguarding
Sarah Cake	**Dorset County Hospital NHS Foundation Trust**	Head of Safeguarding / Directorate of Nursing and Quality
Alison Clark	Dorset Healthcare University NHS Foundation Trust	Head of Safeguarding
Joe Ennis	Probation Services	Deputy Head of Service for Dorset, Devon and Torbay
Diane Evans	Community Safety Partnership, Dorset	Community Safety Business Manager
Karen Maher	Adult Safeguarding, Dorset Council	Strategic & Operational Lead
Tonia Redvers	The YOU Trust	Director of Paragon, Young Lives and Counselling
Jane Stuart	Children Social Care, Dorset Council	Principal Social Worker
Neil Wright	Dorset Police	Chief Inspector - Safeguarding Hub
Andrea Breen (August 2023 panel)	Adult Social Care, Dorset Council	Head of Specialist Services

3.2 The review panel met on 4 occasions.

3.3 Agency representatives were of appropriate level of expertise and were independent of the case.

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Simon Steel. Simon has completed his Home Office approved training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 20 years-service with Thames Valley Police retiring at the rank of Detective Superintendent. During his service he gained significant experience in response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Simon has no connection with the Dorset Community Safety Partnership, or any agencies involved in this case.

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 The primary aim of the DHR was defined as examining how effectively Dorset's statutory agencies and Non-Government Organisations worked together in their dealings with Jane and David.

5.2 The purpose of the review is specific in relation to patterns of Domestic Abuse and/or Coercive Control, and will:

- Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.
- Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Contribute to the Prevention of Homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Highlight any fast-track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

5.3 Case specific key lines of enquiry included the following:

- Were there any concerns or reports made by family, friends, or neighbours about the vulnerability of the victim to abuse. Were opportunities missed to explore these?
- Were there any barriers to services experienced by the victim or her family and friends, in reporting concerns, specifically any relating to abuse? How could these have been reduced?
- Did Covid-19 impact on the ability of the hospital to satisfactorily engage with, understand and respond to the victim when assessing her vulnerability and any potential abuse. Could more have been done with the information available?

- Did Covid-19 impact on the ability of the GP to satisfactorily engage with, understand and respond to the victim specifically in respect to the potential for identifying vulnerability and abuse. Could more have been done with the information available?
- The shotgun license and process around assessing vulnerability and that of wider family.

6. SUMMARY CHRONOLOGY

Family Perspective

6.1 Following the decision to conduct a DHR the Partnership along with the chair wrote to Jane's sister and David's brother. Jane's sister however decided she did not wish to take part in this review. David's brother Peter decided to engage with the review.

6.2 The chair engaged with Peter, David's brother, and Jane's brother-in-law. The chair met Peter along with his wife on 2 occasions at a location requested by Peter. Advocacy after Fatal Domestic Abuse (AAFDA) supported Peter and were present at the second in person meeting. The TOR were discussed with the family, and they were in agreement that the panel had addressed all the concerns they wished to explore. When the draft overview was ready the chair delivered it in person along with AAFDA on the 21st of November 2023. The draft was left with the family who then had time to consider the contents. Subsequently they confirmed with AAFDA that they were content with the draft overview.

6.3 Peter explained to the chair that David was his older brother and that they had grown up together on the family farm. Later in life David had run a butcher's shop. He described how David and Jane had a good marriage and did many things together, albeit both had their separate interests. Around 20 years ago they took early retirement and moved to Dorset to retire their together. He was not aware of any issues within the marriage and described them as a loving couple. Throughout his life he described David as having had access to firearms, whether this was on the farm, or when he was involved with working dogs on shoots. Understandably this tragic incident has had a profound impact on Peter, and he cannot understand why this has happened. He raised a concern around the shotgun that David had, stating that he thought he had given up shooting as he had a bad knee and did not keep the gundogs anymore.

6.4 2 friends of Jane and David spoke with the chair by their preferred method of telephone communication. The chair did offer in person visits but both where content with telephone contact and email. The first friend spoken to stated she had known Jane and David for around 15-20 years. She described them as a loving happy couple. She last saw both of them the day before their deaths. When she saw Jane on that day she described her as looking grey and she still looked very poorly, and she believed that Jane should still have been in hospital and not discharged.

6.5 She stated that when she saw David on the Saturday when Jane was in Hospital (the day before her discharge.) David was still unsure when Jane was coming home. She describes David as having to do everything for 3 weeks leading up to their deaths and he was struggling. David always wore shirts which were ironed by Jane, and she then took over ironing his shirts to help out. She describes when Jane initially went to the GP with concerns for her health, Jane told her that she was told it was muscular.

6.6 She was aware that David used to be a gamekeeper but raised the question on why he still had the shotgun, and why was his license renewed around a year before the deaths when he was no longer shooting. However, she did say he was still going out on the odd shoot just not very often. She considered whether David could live without Jane.

6.7 Another friend said that she had known Jane and David for 23 years. She knew Jane better as David was not as social as Jane. She also stated that Jane should not have been discharged from the hospital. She also saw both of them on the Monday and concluded that Jane did not look well at all. She also raised concerns around the shotgun that David had stating that he had given up shooting some years before.

6.8 She described an incident in the month before the deaths when David went round her house and showed her his tongue. She described it looking like a yellow ulcer. She told him he should see his GP. She also told Jane he should see a GP about it.

Dorset Police

6.9 The only involvement of the police relates to David as a shotgun licence holder and Dorset Police have applications for shotgun certificates dating back to 2006. David kept his shotgun in a gun cabinet bolted to a solid wall in the upstairs office at his address. The 2006 application details that he had been shooting all his life and he had been asked to assist on two estates, and that he was almost a part-time gamekeeper.

6.10 The most recent application was completed by him on the 2nd of September 2021, and it was for one shotgun which was kept at his address within the cabinet. The referee he listed was a gamekeeper. The Medical Information Proforma was completed by his surgery Dr, and they had no information that they thought relevant to the application. A risk matrix was used, and the risk level assessed as low. This was further reviewed by the Firearms Licensing Inspector, and they confirmed the decision to renew the licence and the application was approved by Dorset Police on the 18th of February 2022.

6.11 Dorset Police have a firearms licensing policy. To ensure consistency the Firearms and Explosives Licensing Manager is responsible for developing local working practices in accordance with the Authorised Professional Practice for Firearms Licensing[1] and the Home Office Statutory Guidance to Chief Officers 2021, Home Office Guidance on Firearms Licensing Law[2].

NHS Dorset Integrated Care Board (on behalf of the GP)

6.12 The GP services for both Jane and David were within the same practice. They presented with usual chronic conditions for a couple of their stage in life. Jane had a myocardial infarction

[1] Firearms licensing | College of Policing
[2] Statutory guidance for police on firearms licensing - GOV.UK (www.gov.uk)

(heart issue) in June 2022 requiring stent operation and according to records more intervention was required.

6.13 During their appointments it was noted that they would attend separately and at times together. Annual checks where completed, and it is noted that there appeared to be no barriers for either of them to present and have various conditions managed by the surgery.

6.14 The GP received the letter from police regarding application for a shotgun certificate and there is evidence that the GP reviewed the records, and no concerns were identified. Once the licence was granted the GP practice followed protocol and added the correct flag and patient alert to the records. Guidance for firearms licensing GP's is now available from the British Medical Association (BMA)[3].This guidance takes into account the published Home Office Statutory Guidance for chief officers of police which came into effect in Nov 2021 (therefore this guidance was released after David applied for the licence).

6.15 From 1 April 2016, information sharing processes between GPs and police was introduced to ensure that people licensed to possess firearm and shotgun certificates are medically fit. In July 2019 the Home Office, the police and the British Medical Association agreed a Memorandum of Understanding which sets out the roles and responsibilities of police and doctors regarding the medical assessment of firearms applicants and the ongoing monitoring of those in possession of a firearms. These agreements are clear that the responsibility for deciding whether to grant or renew a firearm or shotgun certificate is entirely a matter for the Chief Officer of Police. In carrying out this function it is appropriate for the police to consider wider evidence relating to suitability, including medical evidence. Information provided by the applicant's GP or other suitably qualified doctor will help to inform the police decision, but it does not alter that the decision whether to grant is made solely by the police.

6.16 In this case the GP received the correct template available at the time and acted appropriately by reviewing the records, stating no concerns and adding a code, however at that time it was not required for GPs to complete a form unless there were concerns. NHS Dorset guidance has changed and there is a template that needs to be completed with the relevant medical information. Current guidance produced by Wessex LMC to support the GP/Doctors responsibilities on firearms licensing[4].

6.17 There was appropriate management of correspondence about firearm application and prompt coding once this was granted. There is nothing noted in the medical presentation of either Jane or David that had any indicators of domestic abuse.

6.18 Paragon PARAGON - Domestic abuse - sexual abuse - stalking - counselling (paragonteam.org.uk) is the provider for DA services and are well known by the practice. However, the practice does not have leaflets in the waiting room, and the panel felt this would be beneficial. As a result, Paragon is sending new resources to all Dorset practices.

[3] Guidance for GPs on the firearms licensing process (bma.org.uk)

[4] Wessex LMCs: Firearms - requests from police for medical information in relation to Firearms Certification.

6.19 Jane attended hospital via ambulance in June 2022 after experiencing central chest pain. She was directed straight to cardiac catheter laboratory due to confirmed inferior myocardial infarction (heart issue) that required cardiac catheter and cardiac stent insertion.

6.20 Jane was considered to have recovered well and was deemed medically fit 3 days later. She had the required review through echocardiogram post procedure and would require further treatment in 6 weeks' time for percutaneous coronary intervention[5] (stent procedure). Jane was referred to the heart failure nursing team as she was found to have severe left ventricular dysfunction.

6.21 She was discharged with new medication as per inferior myocardial infarction primary medication provision. The ongoing treatment plan was for a consultant heart failure clinic in 4 months for complex device therapy and Jane required a repeat echocardiogram in 6 weeks' time.

6.22 Jane's stay in hospital was uneventful and she recovered well. She was mobilising, mentally orientated, and no concerns were voiced to staff. Safety netting[6] was completed regarding rehabilitation, post stent insertion, leaflets were given, and advice not to have no alcohol for 6 weeks. Information shared by Jane to staff about her personal circumstances, indicated that she lived with husband, she had no care or support needs & was fully independent.

6.23 Ward staff identified that David could collect her from the hospital for discharge home. David attended to collect Jane and when they were leaving, they tried to give the staff £40 cash for the care Jane had received, staff tried to explain that they could not accept it. Both Jane and David stated the care was excellent. David threw the money to the nurse's station and said, "pretend you found it". Staff safely stored the cash to discuss with the ward leader the next day. Jane left her mobile charger at the hospital she was contacted later on that evening; she asked if the staff could please post it to her home address.

6.24 No concerns were voiced in respect of DA or issues with returning home to cardiac care staff whilst she was under the care of Dorset County Hospital NHS Foundation Trust. Simple discharge planning was utilised as she did not require on going care and support. Support would be through outpatients/ heart failure team. She was fully independent prior to discharge.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Tragically it has not been possible to build a picture from Jane's perspective. The review has had to rely on anecdotal reports collated by involved agencies. However, the review has been fortunate that Peter has participated, and 2 friends of both Jane and David have provided information.

[5] Percutaneous coronary intervention - Wikipedia
[6] Safety-netting in the consultation | The BMJ

Were there any concerns or reports made by family, friends, or neighbours about the vulnerability of the victim to abuse. Were opportunities missed to explore these?

7.2 There were not any concerns reported by family friends or neighbours regarding anything that would indicate anything other than a happy marriage. There was no indication from anyone spoken to by this review or the coronial process that indicated any form of DA.

Were there any barriers to services experienced by the victim or her family and friends, in reporting concerns, specifically any relating to abuse? How could these have been reduced?

7.3 There is no evidence that there were any barriers to services for both Jane and David. They both accessed their doctor's surgery for conditions that would be entirely normal given their stage in life. In fact, there is good evidence of support from the GP Surgery. The continued care for David's knee problems and annual health checks where undertaken and are examples of excellent care. Whilst the CSP cover a large rural area, in this case the GP surgery was only just under 3 miles from their house, a 10-minute drive. They both had access to a vehicle (they were a 2-car family) and were able to get themselves, whether together or individually, to the surgery. It's also important to note that whilst Jane and David lived the later years of their lives in Dorset, they spent the earlier parts of their marriage together in a similar rural area and in the words of the family "their life was countryside". Its therefore of note that the family believe they were able to navigate the lifestyle of rural Dorset.

Did Covid-19 impact on the ability of the hospital to satisfactorily engage with, understand and respond to the victim when assessing her vulnerability and any potential abuse. Could more have been done with the information available?

7.4 There is nothing in this review or panel discussions that has indicated COVID 19 had an impact on Jane's final hospital stay and the ability of the hospital staff to assess her vulnerability. Whilst of course it must be accepted that COVID-19 has had an impact across access to services for a great number of people and in particular those who are vulnerable there is no evidence that has been presented to this review that would indicate it was a factor in this case. Whilst it is noted that the 2 friends in this review had concerns on whether Jane should have been discharged there has been no evidence seen by the panel that suggest this was the case. At the time of her discharge Jane did not have any ongoing care and support needs identified, under the Care and Support Regulations 2014[7].

Did Covid-19 impact on the ability of the GP to satisfactorily engage with, understand and respond to the victim specifically in respect to the potential for identifying vulnerability and abuse. Could more have been done with the information available?

7.5 There is much commentary about the effects of COVID-19 and GP services. The panel are of the view that it has to be accepted that COVID-19 must have had a disproportionate impact on the vulnerable when GP services were remote. However, in this case there is no evidence that this was a factor.

[7] The Care and Support (Eligibility Criteria) Regulations 2014 (legislation.gov.uk)

The firearms license and process around assessing vulnerability and that of wider family.

7.6 There is clear evidence that the shotgun renewal was lawful and followed the appropriate legislation. The Police and the GP as stated previously in this report followed all the appropriate guidance. Whilst it is noted from friends and Peter that they thought David had given up shooting, for a shotgun renewal, unlike a firearms licence, the usage does not have to be established. However, one friend who raised the concern did state that he "shoots now and again". It would be perfectly normal to be able to partake less as illness occurs. The review is clear the shotgun was lawfully held and the whole process including vulnerability was dealt with correctly.

Pattern of Abuse

7.7 Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was able to determine there was no evidence of a history of domestic abuse. This conclusion is based on all the information provided to this review.

Predictability versus Preventability

7.8 The review panel considered how likely it was that Jane's death could have been predicted and therefore what opportunities there were to prevent it from happening. The panel concluded that there was no information that could have predicted the death of Jane.

Rural communities

7.9 The panel whilst agreeing there is no evidence of any DA in this review are all alert to and conscious of the under reporting within rural communities. The national rural crime network reports[8] that there are hidden victims, isolated, unsupported, and unprotected. Victims are being failed by services, systems and those around them. In response to this the CSP are committed to their rural community.

7.10 Dorset is largely a rural area. In 2021 Dorset Police reorganised in line with local authority areas meaning that within the Dorset Local Policing Area (LPA) there is a policing area policing rural crime, including domestic abuse. Dorset Police is currently undergoing a review of its operating model following an independent review with an aim to improve performance of Grade 3 response times for calls. These are call for service which do not require an immediate response but do require a police officer's attendance (such as some domestic abuse incidents). This will impact the rural area where travel times can be significant, and victims can be isolated.

7.11 Following uplift Dorset Police has now reopened Wareham patrol police station to improve response times and patrol coverage and reduce travel times to incidents. The force has also

[8] Captive & Controlled - Domestic Abuse in Rural Areas - National Rural Crime Network

reopened a number of front counters to enable connectivity. Dorset Police has implemented community contact points for areas where there is no police station footprint. These dates are advertised on Facebook and members of the public can report crime at this site. In the near future the force has plans to invest further in an engagement vehicle to support connectivity. The LPA has targeted rural engagement for all crime including 40 engagement opportunities across the area over the summer of 2023. Neighbourhood engagement officers ensure that messaging including domestic abuse messaging is passed to its 115k followers.

7.12 Dorset Police undertook a programme of DA Matters training delivered by safelives. This was for all front-line officers in line with college of policing best practice and is considering a renewal of this training in the future. Dorset Police undertakes yearly vulnerability training for all front-line staff. All front-line constables receive training in domestic abuse upon recruitment as part of initial training to ensure staff are able to recognise signs of abuse.

7.13 There is a good and varied offer across Dorset, supporting people affected by domestic abuse. This includes services for anyone affected by domestic abuse, including those who live in rural areas. More information on the services can be found at www.dorsetcouncil.gov.uk/dvahelp.

7.14 In addition, PARAGON (specialist domestic abuse provider) delivers the Dragonfly Project. The Dragonfly Project develops community-based support for people affected by domestic abuse. Dragonfly champions are trained to provide a listening ear and a link to domestic abuse support agencies so that isolated people can access help. PARAGON developed the Dragonfly Project with people in the communities in mind. Those not supported by mainstream services can be signposted to help if they are affected by domestic abuse.

7.15 For many years the CSP has been working hard to tackle issues related to domestic abuse. The CSP believes domestic abuse, in all forms, is completely unacceptable and not to be tolerated. It is committed to tackling it by preventing abuse from happening, supporting victims, and prosecuting offenders.

1. prevention: we want to stop domestic abuse from happening altogether. To do that we will focus on actions and initiatives that are preventative so that fewer people become victims.
2. victims: victims of domestic abuse, whoever they are, will have access to services that keep them safe and prevent further harm.
3. offenders: offenders will be held to account for their actions.

7.16 Dorset Council, in consultation with the Dorset CSP published its Dorset Domestic Abuse Strategy 2021-2024. Dorset Domestic Abuse Strategy - Dorset Council The Strategy sets out how partners will work together to tackle domestic abuse. Ultimately it is an opportunity to ensure partners are putting in place a system that not only prevents abuse from happening in the first place, but also ensures that anyone affected by domestic abuse, has access to support, regardless of where they are on their journey. Since the Strategy was published the CSP has undertaken further research to help build partners understanding of domestic abuse. This has included work to understand the levels and impact of domestic abuse in rural communities.

7.17 Commissioning partners have also recently come together and agreed an approach to the co-design of future service provision and explore opportunities to align commissioning activity for services post March 2025. The aim of this work is to improve the journey of people experiencing domestic abuse, from initial referral through to recovery, creating a seamless pathway across all risk levels. This is to ensure continuity of care, maximise accessibility, and to enable a consistent service is offered across Dorset. This approach creates an exciting opportunity for partners and is focused on providing the best possible service to all people experiencing domestic abuse. Integral to this work will be to ensure the local offer meets the community needs including those who live in rural areas.

7.18 In addition, local partners continue to link in with central government departments to help shape national policy and have good links directly into the Domestic Abuse Commissioner's office. Partners across Dorset continue to raise awareness of domestic abuse in a variety of ways, with the aim of raising awareness amongst those communities who may find it harder to access services (including those living in rural areas). Examples of this work includes displaying awareness material in GP surgeries, community areas, supermarkets, on council vehicles, as well as through the work of the Dragonfly Project, radio messages and social media.

7.19 The panel recognises all of the excellent work that has been undertaken or is in the pipeline. However, the panel are not complaisant and are recommending that all agencies are to commit to a review of DA polices and training, to ensure those in the rural community understand more about DA, how to report, and the professionals know how to identify DA and signpost clients accordingly.

8. LESSONS LEARNED

8.1 Whilst the review did not identify any evidence of a history of DA within Jane and David's relationship the panel where open to any learning that could be identified. As a result, the panel have recommended that there is an opportunity to review policies and training around the specific needs of a rural community.

Learning Consideration – All agencies to review DA policies and training to ensure that their rural communities understand more about DA and how to report, and that professionals know how to identify and signpost those in rural communities.

8.2 The review has shown us that there can be a sudden change in dynamic within a relationship. In this case with older persons due to health deteriorating, potential carer responsibilities, and the possible fear of losing your life partner, all could have been factors, however sadly the review will never know the full facts.

8.3 The review also identified whilst not a factor in this case the process of shotgun and firearm licensing does not take into account partners health conditions. It is recommended that nationally this is considered as an action and when GP checks are carried out partners health conditions are considered.

National Learning Consideration – Shotgun and firearms licensing GP checks should also consider partners health conditions.

8.4 The were no themes identified.

9 GOOD PRACTICE

9.1 The work underway by the CSP which has been identified in 7.10 – 7.19 recognising the needs of the rural communities is an area of good practice along with the ongoing commitment to evolve this work.

10. RECOMMENDATIONS

Local IMR Recommendations

Recommendation LR1 – All agencies to review DA policies and training to ensure that their rural communities understand more about DA and how to report, and that professionals know how to identify and signpost those in rural communities.

National Recommendations

National Recommendation NR1 – Shotgun and firearms licensing GP checks should also consider partners health conditions.