Domestic Homicide Review

EXECUTIVE SUMMARY

Report into the death of Susan

Report produced by Peter Stride – Foundry Risk Management Consultancy

On behalf of Safer Somerset Partnership

May 2019

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1. THE REVIEW PROCESS

The pseudonyms Susan and Daniel were used in order to protect the identity of the victim and perpetrator.

The review was conducted in accordance with statutory guidance under s.9 (3) Domestic Violence, Crime and Victims Act (2004) and the expectation of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016.

There were no other reviews conducted contemporaneously that impacted upon this review.

The decision to hold a Domestic Homicide Review was made on 29th December 2017 and the initial review panel took place on 5th March 2018.

All agencies that may have dealt with Susan or Daniel prior to Susan's death were asked to check their records and confirm whether they had any contact or not. Nine agencies responded that they had had some contact and an Individual Management Review (IMR) and chronology was requested from each. Once received these were analysed.

Background information from the following was added in order to try to build up a picture of the context of the death:

- Multi Agency Safeguarding Adults Policy 2018
- Somerset Domestic Abuse Strategy 2017 -2020
- Safelives DASH Risk Assessment checklist
- Somerset Domestic 'Abuse MARAC guide for practitioners.
- Somerset Domestic Abuse 'Toolkit for Practitioners'.

2. CONTRIBUTORS TO THE REVIEW

IMRs were requested from the following agencies:

- Avon and Somerset Police Constabulary
- Somerset Clinical Commissioning Group
- Sedgemoor District Council, Housing Health and Wellbeing
- Somerset County Council Children's Social Care
- Somerset Integrated Domestic Abuse Service
- Somerset Partnership NHS Trust (Sompar)
- Bristol, Gloucestershire, Somerset and Wiltshire (BGSW) Community Rehabilitation Company
- Taunton and Somerset NHS Foundation Trust – Musgrove Hospital.

The chair and vice chair met with the victim's parents and discussed their engagement with the process. The parties are separated and whilst very happy to meet and discuss Susan's background and previous relationships, neither wished to meet the panel or engage with the review process, other than to inspect a draft copy of the Overview Report. Susan's mother 'Catherine' was identified as the point of contact for the couple and confirmed that she and 'Tom' had an amicable relationship and due to Tom's old age they had agreed that she was best placed to act as the conduit between the family and the process.

Catherine and the chair remained in regular contact throughout the period of the review and she was subsequently provided with access to the Overview Report which she discussed with all the family including Susan's daughters. They provided positive feedback and expressed their gratitude for the professionalism and dedication shown by the panel throughout the process.

3. THE REVIEW PANEL MEMBERS

The review panel consisted of:

Name	Job Title	Agency
Peter Stride	Independent chair	Foundry Risk Management
Mark Wolski	Vice chair	Foundry Risk Management
Peter Brandt	Assistant Chief Probation Officer	BGSW Community Rehabilitation Company
Kristy Blackwell	Community Safety Manager	Sedgemoor District Council
Lucy-Antoinette Duncombe	Governance and Quality Improvement Matron	Taunton & Somerset NHS Foundation Trust (Musgrove)

Saj Rizvi	Detective Inspector	Avon and Somerset Police
Punita Bassi	Safeguarding Review Author	Avon and Somerset Police
Julia Burrows	Associate Director	Somerset Partnership (SOMPAR) NHS Foundation Trust
Michael Hammond	Children's Service Manager	Barnardo's (SIDAS)
Mel Thomson	Strategic Business Manager	LiveWest (SIDAS)
Louise White	Adult Safeguarding Manager	Adult Social Care
Dr Andrew Tresidder	Patient Safety Lead	Somerset Clinical Commissioning Group
Christian Sweeney	Operations Manager	Somerset County Council Children Social Care
Suzanne Harris	Senior Commissioning Officer	Somerset County Council Public Health

4. AUTHOR OF THE OVERVIEW REPORT

The chair of the Review and Overview Report author was Peter Stride. Peter has completed his Home Office approved training and received subsequent training by Advocacy After Fatal Domestic Abuse. Peter has over 30 years detective experience in the field of Domestic Abuse, Public Protection and Safeguarding in the Metropolitan Police in London. He has no connection with Safer Somerset Partnership or any of the agencies involved in this review.

Mark Wolski also acted as co-chair with Peter Stride. Mark also worked at the Metropolitan Police, and has no connection with any of the Safer Somerset Partnership agencies.

5. TERMS OF REFERENCE FOR THE REVIEW

The terms of reference are summarised below

a) Domestic Homicide Reviews (DHR) place a statutory responsibility on organisations to share information. Information shared for the purpose of the DHR will remain confidential to the panel, until the panel agree what information should be shared in the final report when published.

b) To review the involvement of each individual agency, statutory and non-statutory, with Susan and Daniel during the relevant period of time: 1st January 2010 and the date of the homicide.
c) To summarise agency involvement between 1st January 2010 and 23rd of November 2017.
d) To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to identify and respond to disclosures of domestic abuse.
e) To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and as a consequence.
f) To improve inter-agency working and better safeguard adults experiencing domestic abuse and not to seek to apportion blame to individuals or agencies.
g) To commission a suitably experienced and independent person to:
    - chair the Domestic Homicide Review Panel;
    - co-ordinate the review process;
    - quality assure the approach and challenge agencies where necessary; and
    - Produce the Overview Report and Executive Summary by critically analysing each agency involvement in the context of the established terms of reference.
h) To conduct the process as swiftly as possible, to comply with any disclosure requirements, panel deadlines and timely responses to queries.
i) The review considered a variety of themes which developed throughout the process including Mental Health, Substance Misuse and Susan's pregnancy with couple's child (Baby A). Panel members and IMR authors were asked to consider these issues within the context of the reported domestic abuse, their engagement with partner agencies and decisions made during and following those engagements.
j) On completion present the full report to the Local Community Safety Partnership.

6. CHRONOLOGY SUMMARY

Initial contact during the reporting period was with regards to Susan and her previous partner John in 2010. John gained support from the GP surgery in gaining permanent custody of the couple's children.

In July 2013 Daniel and Debra separated, with Debra maintaining care of their children, this caused Daniel to become very low and he made several contacts with Debra suggesting self-harm and possible suicide as well as showing increasing levels of aggression towards Debra. Police were called on a number of occasions and Daniel began to receive support from the Somerset

Partnership NHS Foundation Trust's mental health Crisis Resolution and Home Treatment Team (CRHTT). The support lasted a week and included a psychiatric assessment which indicated that his mental health was continuing to deteriorate.

Daniel was admitted to a local hospital for acute mental health sufferers as an inpatient. Whilst there Debra made disclosures to hospital staff about the domestic abuse and coercive control which she was experiencing. Later in August 2013 Debra made further disclosures to both the mental health hospital and police that Daniel had made to threats to kill her, mistreated animals and she was scared of him. Daniel was discharged from the inpatient ward in September 2013.

There were two further reports of Daniel visiting Debra's home and making threats to kill himself. Police safeguarding activities were completed to support Debra.

In February 2014 a multi-agency meeting was held (not believed to be a MARAC) in which the risk to Debra was interpreted as 'medium' due to her unwillingness to pursue a formal charge.

Daniel had been sending messages to his children, which were often unwanted, with comments about self-harm and death. He was receiving Community Mental Health support however, in April 2014 Children B and C reported to school that Daniel intended to meet them there and would not let them see their mother. The children reported being scared of Daniel.

In December 2014 Susan's daughter was in contact with Children Social Care (CSC) about her mother's social activities and the fact that they were missing school due to lack of sleep. The CSC progressed matters via Child and Family Assessment, however this was closed in January 2015 as it was decided that the more pressing issue was the arrangements being pursued through the court. Following an incident where Child E called the ambulance service due to the fact that they couldn't wake Susan up, the 3 children (C, D &E) were taken into John's care.

Susan made several visits to the GP seeking support, confirming that her current medical conditions were improving, and that she no longer had any reliance on controlled drugs and that her child caring arrangements were appropriate. The GP surgery wrote to the Family Court stating that Susan's child care arrangements were adequate but that she had a long history of anxiety and depression and had struggled for many years with an opiate addiction.

In November 2015 Susan attended the surgery confirming that she was pregnant and homeless. At a similar time, Daniel visited Sompar due to his declining mental health problems and his need to support Susan. Both were offered an assessment but did not attend the appointments.

In December 2015 Susan had a midwife's appointment and acknowledged that she had a history of substance misuse and had smoked cannabis while pregnant, as well as low mood and anxiety issues.

In February 2016 Daniel requested a further psychiatric assessment and was referred to 'Talking Therapies'. Susan reported Daniel as being missing and this led to a pre-birth assessment being completed. Other issues raised was the fact Susan had been drinking, whilst 4 months pregnant, that both parents had mental health issues, the fact that Daniel carried knives and could be unpredictable and violent.

During March 2016 Susan missed two antenatal appointments and Daniel was arrested for a 'minor' assault during a domestic incident. Susan refused to support the allegation and no further was taken. A referral was made to the CSC. The Child and Family Assessment was concluded and the key issues raised were the Mental Health of both parents, Domestic Abuse and Substance Misuse. Considerations were given to a Child Protection Plan but not pursued due to the stage Susan had reached in her pregnancy.

Throughout May 2016, Susan did not attend any of her antenatal appointments. Nor was she present at the Children in Need meeting which occurred on the 9th. On the 25th the GP surgery raised concerns over Susan's diminishing mental health, particularly signs of alcohol abuse, lack of engagement with social services and not attending antenatal appointments.

On the 3rd June a Child Protection Conference was arranged due to both Daniel and Susan not engaging with social services and continuing concerns over their minimisation of mental health and substance misuse issues. Susan continued to miss antenatal appointments and eventually was admitted to Musgrove Hospital with reported bleeding. A subsequent scan confirmed that the baby was showing reduced growth but was clinically well. On the 16th an initial child protection plan was convened and Baby A was registered on a Child Protection Plan. Baby A was born in late June 2016.

In July, Susan and Baby A were entered onto a 4 week mother and baby placement, a subsequent interim care order was granted to Somerset County

Council and the placement was then extended to 9 weeks. Baby A's placement was moved to the CSC placement panel who decided to move matters to the legal threshold panel. In August the case was transferred to the 'Child Looked After' team and the decision was taken to allow Daniel to access Baby A and Susan at a parent and child foster placement.

In October a 'placement review' took place and the decision taken to deny Daniel and Susan time outside of the placement with the baby, due to the fact that neither parent was addressing concerns raised by the local authority and that the nature of their relationship was too inconsistent. Throughout November Susan continued to pursue her application for a larger home, this request was supported by the GP surgery.

On the 7th December the matter of Baby A returned to the Taunton Family Court as part of the case management process. On that evening, Daniel and Susan were involved in a domestic incident, in the presence of Baby A and consequently Susan and Baby A were moved to emergency accommodation. Daniel was provided with supervised access. The following day Susan met Housing officials and discussed mental health, domestic abuse and Daniel controlling her. Susan was moved to emergency housing and a report was requested about the relationship between the two by the Housing department. By the 19th December Susan had moved out of the accommodation and back in with Daniel. The CSC were granted an emergency protection order to safeguard Baby A who was then paced into confidential foster care with a plan to seek adoption. On the 28th December Susan contacted police and made allegations of assault and malicious communications, for which Daniel was subsequently convicted.

Susan become homeless having left the emergency accommodation and Baby A continued in foster care. Both Daniel and Susan registered with the Talking Therapies support group but neither completed the course. Susan began to seek support for a private property let and Daniel was referred by the CSC to the local Somerset Integrated Domestic Abuse Service Voluntary Perpetrator Programme, (called Lifeline and delivered by Barnardo's). However, as Daniel was unwilling to accept that what he had done was wrong, along with his mental health history it was deemed that he wasn't suitable to enter the programme.

In March 2017, as part of the Initial Sentence Plan Daniel met with his Probation Officer. No plan was created to address his risk of offending, access to Baby A or a reconciliation with Susan.

In April Daniel was referred for an Asperger's Assessment and an initial report suggested that this wasn't the case. Daniel told social workers of his intention to move closer to his parents. Susan appears to begin a relationship with Sam and he assaults Daniel after he and Susan had been to see the CSC.

Susan contacted the police to complain that Sam was hacking into her social media account however was not willing to support an investigation. Daniel raised concern with the Community Rehabilitation Company that Sam was stalking Susan.

In May 2017 Daniel contacts the police and expresses concern about bruising on Susan's arm and that fact the Sam has assaulted her. Officers attempted to speak with Susan but were unable to. Daniel expressed his anxiety that Sam was encouraging Susan to take drugs and that she was at risk of suicide, particularly as the date was approaching for the couple to return to the Family Court.

On the 23rd May the Care and Adoption Order was granted. On the 1st June Daniel contacted the Sompar mental health Crisis and Resolution Home Treatment Team and expressed concern that Susan was not coping well since the 'loss' of Baby A and that she was expressing suicidal thoughts. The Sompar team agreed that no further action was required as Susan had been staying with Daniel.

On the 20th June Daniel called the police to inform them that Susan had visited screaming and shouting demanding to be taken to the local mental health hospital. He has told her that the police and Mental Health Crisis team had been informed. The following the day SIDAS called and sent text messages to Susan but received no reply.

In July Sam and Susan were arrested for theft. Each admitted the offence. Sam claimed that Susan had encouraged him to start taking drugs and Susan claimed that Sam was obsessed and had a hold over her as he had paid the rent on her flat. Daniel continued to have meetings with his probation officer and remained anxious about the loss of Baby A.

In July and August SIDAS continued to try and contact Susan, without success and the case was closed.

In November 2017 Police received a call from Daniel reporting that Susan had stabbed herself several times and was dead. Police officers visited the address and discovered Susan on the floor of the bedroom, where she was pronounced dead and Daniel was arrested for her murder. The subsequent police

investigation led to Daniel being charged with Susan's murder and in 2018 he was convicted at Bristol Crown Court.

A post mortem examination was carried out and the pathologist concluded that the cause of death was: "Multiple stab wounds to the neck and chest".

7. KEY ISSUES

The key issues identified through analysing collated information and panel discussions were:

The value and use of DASH Risk Assessments and MARAC referrals

The author felt that throughout the analysis the management of risk has been inconsistent, and this view was supported by the panel. There has been a regular absence of the use of DASH risk assessments and professional curiosity. These may have improved the care and support provided to Susan and enhanced the likelihood of the perpetrator being managed/prosecuted more successfully. Subsequently various recommendations have been made to improve this and ensure a more streamlined approach to this subject.

Multi Agency engagement

It was felt that often agencies were working in isolation and that, in general terms, information sharing could have been better. Frontline staff, from across the Safer Somerset Partnership agencies, needed to be as well informed as possible when meeting, supporting and managing families similar to Susan and Daniel. The panel has recognised that there are plans to improve the current situation however the analysis of this review has generated various recommendations which could support and possibly enhance future planning.

Mental Health Assessments

Mental Health as well as Hidden Harm[1] issues has been a constant theme throughout the lives of both Susan and Daniel and the analysis process was focused upon identifying areas of learning to improve the services offered to those who fall outside the definition of Section 42 of the Care Act 2014. The panel agreed that neither Daniel nor Susan qualified under this criterion.

[1] Hidden harm is parental problem drug or alcohol use, that actually or potentially affects their child

Substance Abuse and impact upon the removal of Baby A

Daniel was a concern to the Children's Social Care staff from the initial point of contact. He demonstrated a complete lack of responsibility for his actions and a refusal to acknowledge his mental health issues and dependence on alcohol. He presented as minimising concerns over his relationship with Susan, blaming her or her friends for any physical or emotional abuse. He was unable to comprehend that what he was doing was wrong or abusive.

In his interactions with Baby A Daniel built an attachment and this was reciprocated by Baby A. However, Daniel often presented in a low mood with poor mental health. Where a child's primary carer is unresponsive or attuned to their needs, this can cause the child to become harmed (emotionally or otherwise). Daniel's history shows a cycle of being withdrawn and depressed, often linked to an unwillingness to take his prescribed medication. His depressive moods resulted in suicidal tendencies or incidents self-harm.

Children Social Care (CSC) had significant involvement with Susan and her three children from her previous relationship. There were reported incidents of Susan leaving the children home alone, that they had witnessed domestic incidents involving Susan and John and of the children missing school due to lack of sleep. In 2015 concerns were again raised over Susan's mental health and suicidal feelings, this was during the time of John taking the children into his full-time care.

In February 2016 the CSC received a referral due to Susan being pregnant. A Pre-birth assessment was completed due to Susan having been reportedly drunk at the 4-month period. Further reports (from the police) raised concerns about Daniel and his abuse of drugs and alcohol, that he had displayed aggressive behaviour and complex mantel health issues. Susan reported that Daniel's behaviour had become violent and unpredictable, that he often carried weapons. All of these factors raised significant concerns for the welfare of Baby A.

The assessment was completed in March with anxiety being raised about the mental health of both parents, the unstable nature of their relationship and the potential impact upon Baby A. Neither Susan nor Daniel demonstrated sufficient ability to 'parent' either separately or as a couple. Baby A was registered on a Child Protection Plan in June and once born, an Interim Care Order was granted to Somerset County Council. Susan and Baby A were moved into a mother and baby placement for 9 weeks and in September they were

joined by Daniel and the three of them moved to a FAST (parent/child fostering) family placement.

Despite regular support during the pregnancy of Baby A there was repeated abstention, by the couple, to attend hospital and ante natal appointments and refusal to acknowledge the issues that they faced, both individually and separately. There was a recorded history of Susan's addiction to opiates, and Daniel's use of cannabis. Both had a large amount of contact with local agencies regarding the mental health challenges and sought to minimise or deflect away their effects whenever the subject was raised.

This lack of acknowledgement must uplift the real and potential risks presented to Baby A and these were constant themes throughout the various multi agency meetings. The review recognised that all reasonable and proportionate efforts were made to support both parents during the pregnancy period, and the developing picture left Somerset County Council with no alternative but to take the legal route that it did.

Coercive Control

Coercive control is defined as:

> "an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour."[2]

Inextricably linked to Domestic Abuse is the issue of Coercive Control and throughout this review it has been forefront of the panels thinking and whether Susan was ever the victim of this type of behaviour. This is particularly relevant as Daniel's previous partner (Debra) had referred to this. Debra explained that Daniel's behaviour was coercive and controlling when she spoke with police and hospital staff before the break up of their relationship.

The review can find no evidence that this was the case in his relationship with Susan. During Susan's many engagements with local agencies there was no disclosure that Daniel was exhibiting these tendencies and practitioners didn't report any incidents or themes. For example, there are number of incidents

[2]https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/coercive-control/

where one or the other would go missing or make threats to self-harm and the other party would contact the police or other agency to help find them. Despite their issues there was an element of devotion between Susan and Daniel, for a large period of their relationship, particularly during Susan's pregnancy with Baby A and this gives the review good cause to believe that Coercive Control was not a factor in this review.

Review of Housing Department's Domestic Abuse Policy

As the result of this review and circumstances surrounding it, the Sedgemoor District Council, Housing department has reviewed its procedures regarding domestic abuse. New procedures confirm that when dealing with cases of reported or apparent domestic abuse the victim is the focus of immediate and subsequent activity including the need for a sensitive and supportive approach. All to ensure that there are suitable and safe lines of communication and specific pathways for information sharing.

Housing Officers are directed to complete ACPO DASH Risk Assessments and to use professional curiosity when completing this assessment. In terms of referrals Housing officers are directed to consider the potential escalation of domestic abuse including the volume of calls made by victims.

All cases that are discussed at MARAC will have an alert placed on their Homefinder file. Housing Advisers will provide support to victims, in order that they can remain in the home, however where they feel that they have to leave, victims will be given support with finding other routes for accommodation. Housing Officers are able to discuss individual cases at the weekly 'Together Team Meetings and cases involving children should be reviewed by Senior Case Officers.

In terms of monitoring, the process will be subject to an annual review by the Senior Case Officer.

Housing Officers are also provided with a list of 'Things to Consider' i.e.

- Domestic Violence and Prevention Orders
- Benefit Advice
- Support for those with no recourse to public Funds
- They are making themselves homeless.
- Home Safety Improvements

- Immediate and Longer-term accommodation issues
- Emergency injunctions

8. CONCLUSIONS

Susan and Daniel had both been in a long-standing relationship, prior to beginning their own in 2015. Both were parents, their previous relationships were abusive and neither had any ties to their children. They appear to have had very few friends, little or no family involvement and no apparent community engagement.

Despite having a large volume of contacts with agencies from across the local partnership these engagements were often brief with very little subsequent activity. This made the role of agencies pivotal in supporting Susan, as she was particularly vulnerable however, due to her regular but fleeting involvement this support was extremely difficult to provide.

With regards to Daniel he appears to have presented a risk to both Susan and his previous partner Debra. However, on many occasions there has been very little risk assessing or information sharing to bring Susan and Daniel to the attention of ALL partner agencies. It is for this reason the first two themes of the analysis in the review were:

- Risk Assessment
- Information Sharing

Consultation with subject experts and panel members has recognised the issue of mental health and the problems faced by those who do not fall under the definition of Section 42 of the Care Act 2014. The chair recognised the efforts being made across the partnership to support those experiencing mental health problems and feels that this is reflected in the third theme of the analysis:

- Mental Health

Hindsight may indicate that there were opportunities for health care professionals to assess both parties and potentially introduce processes to mitigate any identified stress triggers. However, whether such an early intervention would have prevented this tragedy is unclear.

It appears that the death was neither preventable nor predictable. However, all circumstances such as these present opportunities to consider current methods, policies and working practices. The Chair of this review feels it is the

role of the review panel to identify these opportunities to improve services provided to residents, families and the wider community.

The recommendations arising from this DHR are therefore aimed at enhancing current local and national provision. It is hoped that they will further reduce risks of domestic abuse and increase safety to those suffering in similar circumstances.

9. RECOMMENDATIONS

During the Individual Management Review process authors were encouraged to identify recommendations for improvement within their own environment. These have been recorded together with the recommendations prepared by the chair and is based upon both the IMR's and Chronologies provide by panel members but also drawn from the analysis and research carried out by the chair.

For ease of reference, these are consolidated below:

Arising from panel and independent chair

1. All panel members to review their own response and activities with regards to the 3 themes. I.e. Risk Assessing, Multi Agency Engagement and Mental Health (Safer Somerset Partnership's Domestic Abuse Board)
2. Embed the principles of the ACPO DASH Risk Assessment process throughout all CSP agencies. (Safer Somerset Partnership's Domestic Abuse Board)
3. Review the systems, policies and procedures that ensure the completion of DASH Risk Assessments and ensure that MARAC referrals are completed when required (Safer Somerset Partnership's Domestic Abuse Board)
4. Develop a culture of 'Professional Curiosity' of frontline practitioners through on-going training and internal publicity (Safer Somerset Partnership's Domestic Abuse Board)
5. Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions (Safer Somerset Partnership's Domestic Abuse Board)
6. The development of a robust quality assurance process for managing risk reports within the Lighthouse/Police Safeguarding Unit. (Avon and Somerset Police)
7. The down grading of all DASH Risk assessments must be reviewed and agreed by those supervising frontline practitioners. (Safer Somerset Partnership's Domestic Abuse Board)
8. All CSP practitioners and line managers to receive training regarding risk management in domestic abuse cases and subsequent information sharing (Somerset County Council / Safer Somerset Partnership)
9. The South West Ambulance Service should enhance their training programme to encourage frontline practitioners to demonstrate more professional curiosity when receiving disclosures of domestic abuse from patients and their families (Southwest Ambulance Service NHS Foundation Trust)
10. LSCB to review their approach to Child Protection Conferences to ensure that the learning, from this review, regarding trigger points for escalated risk of Domestic Abuse in the family environment are recognised and acted upon. (Somerset Safeguarding Children Partnership)
11. The Home Office Quality Assurance panel should direct police forces across the country to confirm that a Mental Health pathway of referral exists, allowing officers to refer those

exhibiting symptoms to a framework of support including statutory, volunteer and charities service providers. (Home Office)

12. All self-harm matters should be considered for vulnerability assessment and followed up with a referral to MASH if appropriate (Safer Somerset Partnership's Domestic Abuse Board)
13. Somerset Local Safeguarding Children Board to improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption. (Somerset Safeguarding Children Partnership)

Arising from IMRs

14. ASC to improve management of high risk perpetrators to increase the safety of high risk victims (Avon and Somerset Constabulary)
15. ASC to ensure management of DA offenders is in accordance with best practice (Avon and Somerset Constabulary)
16. Compliance by officers of policy to refer domestic abuse cases to Lighthouse Safeguarding Unit (LSU) to be reviewed (Avon and Somerset Constabulary)
17. Probation Officers to ensure they are aware of the definition of a 'significant event' linked to reoffending and harm (BGSW CRC)
18. Probation Officers to ensure that risk management prioritise victim safety (BGSW CRC)
19. Ensure that information provided by service user is checked with partner agencies (BGSW CRC)
20. Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions (Clinical Commissioning Group)
21. Access policy and children's DNA policy to be revised to clearly describe process for maternity users. (Musgrove Hospital)
22. Improve staff awareness of domestic abuse within organisation (Sedgemoor District Council)
23. Publicise help/support available for all forms of domestic violence within organisation (Sedgemoor District Council)
24. Devise a robust approach to risk assessment and management (Sedgemoor District Council)
25. Professionals are confident about sharing information and making informed decisions about actions (Sedgemoor District Council)
26. Ensure that the decision not to accept any referral (for voluntary perpetrator programme) is shared with key partners (SIDAS Barnardo's)
27. Ensure timely closure of client files (SIDAS Barnardo's)
28. Caseworkers to Intensify and record all methods of attempts to engage both client and other professionals during 1st month following allocation (SIDAS Livewest)
29. CW to update other professionals and record in case notes this has happened following significant event during client engagement. (SIDAS Livewest)
30. Effective Information sharing (SCC Adult Social Care)
31. Disseminate learning from DHR across Adult Social Care (SCC Adult Social Care)
32. Improve confidence of professionals in accessing all relevant support for clients (SCC Adult Social Care)
33. SCC Adult Social Care to review, alongside the SSAB Manager, engagement with future DHR and the cross over between other review mechanisms (SCC Adult Social Care)
34. Ensure completion of DASH Risk Assessments when 'in-custody' DA victims disclose abuse, and refer as appropriate(Avon and Somerset Police)
35. CAAS to consult with police officers once a prisoner presents as a domestic abuse victim. Discuss risk management plan and confirm actions required (Somerset Partnership NHS FT)
36. All frontline community mental health service professionals are aware of the 'Hidden Harm' protocol, and use it (Somerset Partnership NHS FT)
37. Ensure compliance with the statutory child protection process obligations (Somerset Partnership NHS Foundation Trust)

The action plan is attached as appendix A.

Appendix A Somerset Domestic Homicide Review 022 Action Plan

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
Avon and Somerset Constabulary	ASC to improve management of high risk perpetrators to increase the safety of high risk victims	Local	Review systems and ensure high risk domestic abuse perpetrators are flagged routinely on Niche Annual review to ensure the system is working correctly	• Criteria for review determined • Review completed • Report compiled with actions	30.6.2020	
Avon and Somerset Constabulary	ASC to ensure management of DA offenders is in accordance with best practice	Local	ASC to continue to review the management of DA offenders	• Identification of different methods of DA offender management in use • Review effectiveness and create action plan • Any proposed changes to be implemented	30.6.2020	Complete (September 2018) BRAG process and MARAC used
Avon and Somerset Constabulary	Compliance by officers of policy to refer domestic abuse cases to	Local	Operational procedures to be reviewed and audit	• Audit use of current procedure	30.6.2020	Complete (September 2018). Procedure

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	Lighthouse Safeguarding Unit (LSU) to be reviewed			• Review current procedure and revise if appropriate • Train officers in use of procedure		implemented with training of officers.
Avon and Somerset Constabulary	All self-harm matters should be considered for vulnerability assessment and followed up with a referral to MASH if appropriate	Local	Remind partner agencies of their responsibilities of safeguarding policies, with particular focus self-harm cases	• Promote safeguarding policy	30.6.2020	Complete (August 2019)
Avon and Somerset Constabulary	The development of a robust quality assurance process for managing risk reports within the Lighthouse Safeguarding Unit.	Local	Define minimum standards for both Ensure adherence is reported to CSP and safeguarding boards.	• Oversight / governance of this to be set • Create quality assurance process • Implement process • Review process	30.6.2020	Complete (June 2019) Force-wide procedure reviewed and updated

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
BGSW CRC	Probation Officers to ensure they are aware of the definition of a 'significant event' linked to reoffending and harm	Local	BGSW CRC has delivered 2 workshops in February and March 2018 for all offender managers which covered our risk assessments and significant events. This has been followed up by a quality assurance process.	• Training to be designed and implemented	31.3.2018	Completed March 2018
BGSW CRC	Probation Officers to ensure that risk management prioritise victim safety	Local	BGSW CRC has delivered 2 workshops in February and March 2018 for all offender managers which covered our risk assessments and significant events. This has been followed up by a quality assurance process.	• Training to be designed and implemented	31.3.2018	Completed March 2018

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
BGSW CRC	Ensure that information provided by service user is checked with partner agencies	Local	Middle Managers to discuss in supervision and review through case audits	• Procedures to be reviewed • Audit of middle managers approach and identification of an gaps. Action plan to be created if required for management / officer compliance	30.6.2018	Completed June 2018 and ongoing
Clinical Commissioning Group	Make training available to all Primary Care staff, to embed a higher understanding of Domestic Abuse and an awareness of available resources within the Somerset Trust	Local	Ongoing education in Somerset for Primary Care with Somerset CCG to liaise with education and to use Safeguarding Lead communications to spread learning	• Training to be designed • Training to be delivered	31.06.2020	Complete (December 2019) Training organised and promoted
Clinical Commissioning Group	Encourage those who work within GP practices to ask Domestic Abuse screening/safety questions	Local	Training for CCG staff including ALL front-line staff GP's and other practice staff. Ensure that Somerset Domestic Abuse	• Training to be designed • Training to be delivered	31.6.2020	Complete (December 2019) Training completed

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
			Board monitors and supports the uptake of training by professionals.	• Reporting to Somerset DA Board		
Home Office Quality Assurance Group	The Home Office Quality Assurance panel should direct police forces across the country to confirm that a Mental Health pathway of referral exists, allowing officers to refer those exhibiting symptoms to a framework of support including statutory, volunteer and charities service providers.	National	Clarify routes for police referrals into community mental health services Work with NHS England and ACPO to issue national guidelines for police, community mental health services and GPs to enable people to be referred direct into appropriate mental health service provision.	• Review current routes • Liaison with NHS England and ACPO • Publish new routes and promote this	31.6.2020	
Musgrove Hospital	Access policy and children's DNA policy to be revised to clearly describe process for maternity users.	Local	Locate and Cascade the 'Access Policy Refresh and reinforce the 1st Did Not Attend Policy Enhance Mother engagement	• Review the policy • Revise policy • Promote policy	31.6.2020	Completed (March 2019)

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
			including their responsibilities should they miss appointments Refer all vulnerable mothers and families to 'Talking Families Complete DASH referrals on all vulnerable mothers			
All Panel Agency's	Review their own response and activities with regards to the 3 themes. I.e. Risk Assessing, Multi Agency Engagement and Mental Health	Local	Complete formal Assessment. Forward outcomes to the Domestic Abuse Board for subsequent and then onward reporting to the Community Safety Partnership Board	• Assessment circulated • Responses collated as part of DA Board Self-Assessment 2019	30.05.2020	
All Panel Agency's	Embed the principles of the ACPO DASH Risk Assessment process throughout all CSP agencies.	Local	Ensure that the Somerset Domestic Abuse Board monitors and supports the uptake of training, by professionals in respect of the ACPO	• 2018 DA Board Self-Assessment Action Plan produced and presented to board • Board members to take the action to their	30.6.2018	Completed (February 2019) Somerset Domestic Abuse Board Self-

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
			DASH Risk Assessment	agencies to implement by target date		Assessment Audit
Safer Somerset Partnership	Review the systems, policies and procedures that ensure the completion of DASH Risk Assessments and ensure that MARAC referrals are completed when required	Local	Ensure that the Somerset Domestic Abuse Board encourages supports and monitors the completion of DASH reports throughout partnership agencies	• Domestic Abuse Board members to complete 2018 Self-Assessment • DA Board Self-Assessment to be produced and presented to February 2019 meeting • DA Board members to feed back to their agency to implement	30.6.2020	Completed (February 2019) Evidenced through self-assessment. To be monitored through continued self-assessment
Safer Somerset Partnership	Develop a culture of 'Professional Curiosity' of frontline practitioners through on-going training and internal publicity		Ensure that the Somerset Domestic Abuse Board monitors and supports the uptake of training by professionals	• Inclusion in Somerset DA newsletters • SCC organised DA training content reviewed and updated (if required)	30.06.2020	In progress Included in July 2019 newsletter and reminders in subsequent editions

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
Safer Somerset Partnership	The down grading of all DASH Risk assessments must be reviewed and agreed by those supervising frontline practitioners.	Local	The new MARAC process has SIDAS in the role of Quality Assessor. No DASH down grading should be agreed without their independent review and sign off.	• Audit by Somerset Domestic Abuse Board as part of 2019 Self-Assessment	30.11.2019	Complete Audit in 2019 self assessment
Safer Somerset Partnership	All CSP practitioners and line managers to receive training regarding risk management in domestic abuse cases and subsequent information sharing	Local	The new MARAC Operating protocol sets expectations in this area and therefore reflects the spirit of this recommendation. The promotion of this protocol should be highlighted to all relevant staff. SSP/SCC provide training within this area and staff should attend this training as part of their career development process.	• MARAC Operating Protocol to be finalized and promoted via Somerset DA Board and Somerset DA newsletter • Review SCC organised DA training to ensure includes sufficient focus on risk	31.05.2020	
Sedgemoor District Council	Improve staff awareness of	Local	Safeguarding lead to ensure domestic	• Training to be organised	30.11.2018	Complete

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	domestic abuse within organisation		abuse training is included in generic training to all staff. Frontline service areas to access Somerset training on domestic abuse for key staff	• Training delivered	31.12.2018	21.1.2019 Training completed
Sedgemoor District Council	Publicise help/support available for all forms of domestic violence within organisation	Local	Update staff website and key information platforms with relevant internal communication. Promote awareness of support to the general public through SDC buildings and outreach points.	• Materials sourced • Materials promoted	31.7.2020	Complete (June 2019) Information obtained and promoted
Sedgemoor District Council	Devise a robust approach to risk assessment and management	Local	Review current procedures for undertaking risk assessments and management review of cases.	• Review procedure and amend as required • Implement new procedure so all relevant staff are aware	31.7.2020	Complete (January 2019), new procedure
Sedgemoor District Council	Professionals are confident about sharing	Local	Review information sharing protocols	• Audit current awareness of information	31.7.2020	Complete

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	information and making informed decisions about actions			sharing protocols • Review protocols • Promote protocols		
SIDAS (Barnardo's)	Ensure that the decision not to accept any referral (for voluntary perpetrator programme) is shared with key partners	Local	Although SIDAS Lifeline programme has now closed, ensure learning from this review is shared with any future perpetrator programmes delivered by SIDAS	• Review current process • Revise process and audit its implementation and compliance	30.9.2020	Complete
SIDAS (Barnardo's)	Ensure timely closure of client files	Local	Review processes and revise as required	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.9.2018	Complete
SIDAS (Livewest)	Caseworkers to Intensify and record all methods of attempts to engage both client and other	Local	Audit by Team Leaders in Case Management Review for all Case Workers to ensure intensity and all methods attempted	• Procedures are reviewed • Procedures revised • Compliance is audited by	30.6.2020	Complete (case management reviews audited)

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	professionals during 1st month following allocation			senior managers		
SIDAS (Livewest)	CW to update other professionals and record in case notes this has happened following significant event during client engagement.	Local	Refresh standards with Case Workers using this case as example. Refresh expectations of practice with all Case Workers as learning point.	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.6.2020	Complete (case management guidelines reviewed and updated)
SCC Adult Social Care	Effective Information sharing	Local	SCC Adult Social Care to review all avenues of referrals into the service to ensure that our responses are proportionate.	• Procedures are reviewed • Procedures revised • Compliance is audited by senior managers	30.06.2020	
SCC Adult Social Care	Disseminate learning from DHR across Adult Social Care	Local	To review content of social care "recognising adult abuse" training and ensure DHR learning is evident.	• Current training reviewed • Training revised • Training implemented	30.06.2020	
SCC Adult Social Care	Improve confidence of professionals in accessing all	Local	Ensure appropriate SG leads for other agencies are	• Review existing multi-agency referrers	30.06.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	relevant support for clients		included in Somerset Regional SG lead forum	• Invite their safeguarding leads to attend forum		
SCC Adult Social Care	SCC Adult Social Care to review, alongside the SSAB Manager, engagement with future DHR and the cross over between other review mechanisms	Local	Adult Social Care Safeguarding Service Manager to meet with Somerset Safeguarding Adults Board Manager	• Meeting to be organised and held	30.06.2020	Completed (June 2019)
Avon & Somerset Police	Ensure completion of DASH Risk Assessments when 'in-custody' DA victims disclose abuse, and refer as appropriate	Local	Feedback learning point to CAAS team (now LADS) via Team safeguarding supervision	• Review existing procedures and revise as appropriate • Promote and train staff in new procedure including on completing DASH	30.06.2020	Complete
Somerset Partnership	CAAS to consult with police officers once a prisoner presents as a domestic abuse victim. Discuss risk management plan	Local	Feedback learning point to CAAS team (now LADS) via Team safeguarding supervision	• Review existing procedures and revise as required • Implement and review	30.06.2020	Completed

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	and confirm actions required			compliance by officers		
Somerset NHS Partnership Trust	All frontline community mental health service professionals are aware of the 'Hidden Harm' protocol, and use it	Local	Send out memo to all relevant teams; support ongoing audit programme of shared SDAS / SIDAS and Sompar mental health cases to ascertain adherence to shared protocol	• Location of protocol reviewed and ensure placed where staff can see • Promote the protocol and how to use • Review and audit compliance by frontline professionals in its use	31.03.2020	Completed (May 2019)
Somerset Safeguarding Children Board (LSCB)	LSCB to review their approach to Child Protection Conferences to ensure that the learning, from this review, regarding trigger points for escalated risk of Domestic Abuse in the family environment are	Local	• Adult and Children's Safeguarding Boards to have oversight of this review. • All CPC chairs are to be made aware of the potential escalation in risk and document considerations and actions to mitigate this possibility. • A review of the current Safety Plan processes	• Report (when available to be published) to be shared with local Safeguarding Adults and Children's Boards • Review child protection procedures and	30.06.2020	Complete

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	recognised and acted upon.		including policies and procedures. • Based on any subsequent policy changes ensure that training is delivered to all frontline practitioners.	deliver training if/as required		
Somerset Safeguarding Children Board (LSCB)	Improve knowledge amongst Children's Services professionals of the available support for parents whose children have or are going through the process of formal adoption.	Local	• CSC staff to be reminded of the Adopt SW pathways for referral and information sharing process	• Determine methods of promoting this information • Implement promotion of information • Audit the effectiveness of the promotion		
South West Ambulance Service	Enhance their training programme to encourage frontline practitioners to demonstrate more professional curiosity when receiving disclosures of domestic abuse	Regional	Training content and policies should be updated so that staff can be encouraged to be proactive in referring information, relating to domestic abuse to the police and relevant agencies	• Review current training programme and amend as required • Implement new training • Audit impact	30.6.2020	

Lead Agency	Recommendation	Scope (local/ national)	Action	Milestones	Target Date	Completion Date and Outcome
	from patients and their families					
Somerset Partnership Mental Health Trust	Ensure compliance with the statutory child protection process obligations	Local	Review the performance from the previous reporting year Identify reasons as to why any compliance was missed. Circulate expectations and provide appropriate training, as applicable	• Review and audit compliance • Create action plan for change • Promote this within staff teams	30.06.2020	

Appendix B - Glossary

ACPO	- Association of Chief Police Officers
CMHT	- Community Mental Health Team
CPC	- Child Protection Conference
CRC	- Community Rehabilitation Company (probation)
CRHTT	- Crisis Resolution and Home Treatment Team
CSC	- Children Social Care
CSP	- Community Safety Partnership
DASH RIC Checklist	- Domestic Abuse Stalking and Honour Based Violence Risk Identification
GP	– General Practitioner
IDVA	- Independent Domestic Violence Advisor
IMR	- Individual Management Review
LSCB	- Local Safeguarding Children's Board
MARAC	- Multi Agency Risk Assessment Conference
MASH	- Multi Agency Safeguarding Hub
SIDAS	- Somerset Integrated Domestic Abuse Service
Sompar	- Somerset Partnership NHS Foundation Trust