SAFER SOMERSET PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

Into the death of Graham (Pseudonym)

In April 2022

EXECUTIVE SUMMARY

Independent Review Chair and Report Author: Michelle Baird MBA, BA.
Review Completed: 12th April 2023

CONTENTS

1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by the Domestic Homicide Review Panel during the Review into the death of Graham[1] who was a resident in a town in Somerset at the time of his death.

1.2. To protect the identity of the deceased, the perpetrator, their family and friends, pseudonyms have been used throughout this report.

1.3 In April 2022 at 23:43 hours, Police received a phone call from the Ambulance Service advising that they were attending an address in a town in Somerset where a male, confirmed as being Graham had been stabbed. Debra his friend/landlady had made a call to the Ambulance Service stating that she had been stabbed in the leg and that she had then stabbed Graham.

Upon arrival at the address, Officers found Debra with Graham. He was lying at the bottom of the stairs, unresponsive and unconscious. Officers immediately started CPR on Graham and administered first aid to Debra who had 3 stab wounds to her upper thigh. Paramedics arrived and Graham was pronounced deceased at 00:25 hours. Officers arrested Debra for Graham's death.

1.4 A post-mortem was conducted, and the cause of death was stated as 'Stab wounds to the chest and abdomen'.

1.5 Debra was found guilty of Graham's murder and sentenced to 20 years in prison.

1.6 A decision to undertake a Domestic Homicide Review was taken by the Chair of the Safer Somerset Partnership on the 10th June 2022. The Home Office was informed of this decision, with a further update provided on the 21st July 2022 regarding timescales. The Independent Domestic Homicide Review (DHR) Chair was appointed on the 17th June 2022, and the first meeting of the DHR was held on the 25th July 2022. During this meeting, the Panel Members were requested to secure their records and appoint an IMR author.

1.7 Seven of the organisations involved with the Review have completed Individual Management Reviews (IMRs) as they had relevant previous contacts with Graham and Debra.

2. CONTRIBUTORS TO THE REVIEW

2.1. The following eighteen organisations were contacted, seven completed Individual Management Reports (IMRs).

- **Advocacy After Fatal Domestic Abuse (AAFDA):** This specialist Charity is providing an Advocacy service for Graham's son Jack (pseudonym). They had no previous involvement with either Graham or Jack.

[1] Pseudonym chosen for the deceased.

- **Avon and Somerset Police:** This Police Force had relevant contacts with Graham and Debra and an IMR was completed. A Senior Member of this organisation who is independent of any contact with Graham and Debra is a Panel Member.

- **Hampshire and Isle of Wight Constabulary:** This Police Force had contact with both Graham and Debra prior to the timeframe of the Review and an Individual Management Review (IMR) was completed. An independent Member of this Force is a Panel Member.

- **NHS Somerset Integrated Care Board (ICB):** This organisation had contact with Graham and Debra, and an Individual Management Review (IMR) was completed. A Senior Member who is independent of any contact with Graham and Debra is a Panel Member

- **Somerset Drug and Alcohol Services:** Although this service had no contact with Graham, Debra self-referred via email. A Senior Member is a Panel Member, and an Individual Management Review (IMR) was completed.

- **Somerset NHS Foundation Trust:** This Trust had contact with both Graham and Debra and an Individual Management Review (IMR) was completed. A Senior Member of this Trust is a Panel Member.

- **Probation Service:** This service provided an Individual Management Review (IMR) and had regular contact with Graham. A Senior Manager is a Panel Member.

- **South Western Ambulance Service NHS Trust:** The only contact they had with Graham and Debra was on arrival at the property on the date of Graham's death.

- **Surrey Police & Sussex Police:** This Police Force had contact with Debra on 2 occasions and an Individual Management Review was completed. A Senior Member of this Force is a Panel Member.

- **The You Trust (Somerset Integrated Domestic Abuse Service):** This service had no previous involvement with Graham or Debra. A Senior Member of the Trust is a Panel Member.

- **Yeovil District Hospital:** Graham was not known to them. They did however have contact with Debra on 3 occasions, the last contact being in April 2022. No representative from the Hospital was on the Panel and no IMR was completed.

2.2. The following organisations/trusts were contacted and reported having no contact with either Graham or Debra:

- Mendip District Council

- Safe Link (ISVA)
- Somerset and Avon Rape and Sexual Abuse Support
- Somerset Council Adult Social Care
- Somerset Safeguarding Adults Board
- The Nelson Trust
- Victim Support

2.3. The following family members and friends provided relevant information which has been included in the Overview Report of this Review:

- "Jack (deceased's son)
- "Lisa" (deceased's sister)
- "Debra" (perpetrator)
- "Paul" (perpetrator's friend)
- "Clare" (perpetrator's ex-partner)

3. THE REVIEW PANEL MEMBERS

3.1. The DHR Panel consists of Senior Officers, from statutory and non-statutory agencies who are able to identify lessons learned and to commit their organisations to setting and implementing action plans to address those lessons. None of the Members of the Panel have had any contact direct or indirect with Graham or Debra.

3.2. The Panel Members:

Michelle Baird	Independent Domestic Homicide Review Chair
Suzanne Harris	Senior Commissioning Officer (Interpersonal Violence) SCC Public Health (SSP)
Emma Read	Deputy Nurse for Adult Safeguarding - NHS Somerset Integrated Care Board
Louise Smailes	Deputy Named Professional for Safeguarding Adults/Modern Slavery Lead - Somerset NHS Foundation Trust
Jane Harvey Hill	Safeguarding Manager - Somerset Drug & Alcohol Services
Liz Spencer	Head of Somerset Probation Delivery Unit
Su Parker	Detective Inspector - Avon and Somerset Police
James Dore	Area Manager - The You Trust (Somerset Integrated Domestic Abuse Service)
Grace Mason	Serious Case Reviewer - Hampshire and Isle of Wight Constabulary
Jane Lord	Manager - Surrey Police & Sussex Police Major Crime Review Team

3.3. The DHR Panel met formally four times. (Due to COVID restrictions, all meetings were held on 'Teams').

- 25th July 2022
- 14th December 2022
- 26th January 2023
- 4th April 2023

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of this Domestic Homicide Review is a legally qualified Independent Chair of Statutory Reviews.

4.2 She has no connection with the Safer Somerset Partnership and is independent of all the agencies involved in the Review. She has had no previous dealings with Graham or Debra.

Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Effective Freedom Therapy (EFT).

5. TERMS OF REFERENCE

5.1 This Domestic Homicide Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant Statutory Guidance for the Conduct for Domestic Homicide Reviews (DHRs).

5.2 The full Terms of Reference can be found in the main Overview Report. The key lines of enquiries for the Domestic Homicide Review were as follows:

5.3 The Review will identify agencies that had or should have had contact with Graham and Debra between February 2017 and the date of Graham's death in April 2022 or any relevant contact prior to that period.

5.4 Agencies that have had contact with the Graham and Debra should:

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts.
- Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews.[2]

[2] The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance 14.62 and 14.63

The Review will consider:

- Each agency's involvement from February 2017 until April 2022 subject to any significant information emerging that prompts a Review of any earlier or subsequent incidents or events that are relevant which may be relevant to domestic abuse, violence, controlling behaviour, self-harm or other mental health issues.

- Establish the facts that led to the death in April 2022, and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- Produce a report which summarises concisely the relevant chronology of events including:

    - the action of all the involved agencies
    - the observations (and any actions) of relatives, friends and workplace colleagues relevant to the review
    - analysis and comments on the appropriateness of actions taken
    - make recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they've experienced
    - apply these lessons to service responses including changes to policies, procedures, and awareness-raising as appropriate

6. SUMMARY CHRONOLOGY

6.1 The synopsis of the case has been informed by chronologies of the contact agencies in Somerset, Hampshire and Surrey had with Graham and Debra. Both Graham and Debra were of White British origin. At the time of death, Graham was 61 years of age and Debra was 53 years of age.

6.2 Graham occupied a bedsit in Debra's property, she was his friend/landlady and they had known each other for 12 years. Graham and Debra were not in a relationship, Debra was in a same-sex relationship at the time of Graham's death.

Graham

6.3 Graham had a history of mental health issues dating back to 1982. In November 1999, he took a drug overdose and was section under s37 of the Mental Health Act in June 2000 after he attempted suicide. He had attempted to take his life on a number of occasions and was prescribed lithium, a mood stabiliser.

6.4 Graham was previously a serving Police Sergeant for 18 years. He had been involved in two long-term relationships which involved domestic abuse, and in both relationships, Graham displayed controlling, possessive, manipulative and jealous behaviour. When his relationships ended, he turned to alcohol which impacted significantly on his mental health state.

6.5 In 2001, after the break-up of his second marriage, (with the mother of his two children), Graham was medically retired from the Police Service due to his mental health.

6.6 Graham had a history of violence against women and was convicted of the manslaughter (on the grounds of diminished responsibility) of his wife in 2001, serving 10 years in prison. He was released from prison in 2011 on Life Licence and assessed by the Probation Service as posing a risk of serious harm to known adult females with whom he was in a relationship with and any children within the relationship. After his release from prison, Graham moved to Hampshire and took up fulltime employment at a Charity Shop which is where he met Debra.

6.7 In January 2017, Graham was dismissed from his job for making racial and sexual comments to female members of staff. He moved to a town in Somerset in March 2017 without notifying his Probation Practitioner. His reason for moving was to be closer to his best friend Debra, who had moved to the area. Graham was located by Somerset Probation Service in May 2017.

6.8. Whilst working with the Probation Service in the community, Graham discussed repeated feelings of shame, sadness - linked to ongoing guilt he still felt with regards to the breakdown of his marriage. He acknowledged that he was incapable of dealing with the breakdown which led him on the path to committing his offence. Graham made it clear that one of the reasons he had not pursued an intimate relationship with someone else was because he couldn't trust himself. He also recognised alcohol as a trigger for him and was open in his discussions with Probation Service around this.

6.9 On the 21st February 2020, Graham attended a physical and mental health review with his GP. Graham mentioned that his mood was low and that he "had to pull away from his best friend as she had started taking drugs and becoming aggressive towards him". It is suspected that he was referring to Debra, but he did not specifically name her. He declined further change in medication or mental health support.

6.10 In October 2021, Debra asked Graham if he would like to rent the bedsit within her property as it had become vacant. Graham felt that this would really be a positive move for him, as it would improve his quality of life. He would have his own space, company and be able to help Debra in the garden and walk her dog.

6.11 On the 19th October 2021, appropriate checks were undertaken through Police Force Intelligence in relation to the new proposed address. There were no concerns, and the address was found to be suitable. Graham moved into

the property towards the end of November 2021. No information was received about Debra from the Police prior to Graham moving into the property.

6.12 On the 10th February 2022, a home visit was carried out by 2 Probation Practitioners. Graham showed them around his section of the house. His mental health was discussed, and he reported that he was managing well and taking his medication. A stockpile of medication was seen in the corner of his room, but Graham was not questioned about this.

6.13 In March 2022, five years after receiving a letter from a Solicitor informing Graham that his sons wanted to meet him, a meeting was confirmed for him to meet his two sons. There were long unexplained delays with the Restorative Justice process, and unfortunately, Graham did not get to meet his sons as the meeting was scheduled for the week following his death.

Debra

6.14 Debra had a history of mental health issues and perpetrated domestic abuse/ violence towards two of her same-sex ex-partners, "Sue" and "Jenny". She also perpetrated violence towards her teenage daughter.

6.15 On the 15th November 2011, during an incident between Debra and Sue, Police were contacted. Threats were made by Debra to kill Sue, her partner. A significant comment was made by Sue to Police stating, "she would hate to have an illness or in the worst-case scenario pass away and that Debra be investigated", but this was not explored further.

6.16 On the 22nd December 2011, Sue contacted the Police advising that the 8 month relation between her and Debra had come to an end. Debra was upset and came into the bathroom whilst Sue was in the bath and assaulted her.

6.17 On the 26th September 2012, Sue contacted Police to report that she was receiving an excessive amount, of unwanted calls and texts from her ex-partner. She received over 80 text messages from Debra in one day. Sue did not support any Police action and the matter was filed.

A CA12[3] was completed and shared with Adult Services and a CYPR[4] was completed and shared with Children's Services. An AD232R (Safeguarding Officer Worksheet) was completed and risk assessed as medium but lowered to standard by the Central Referral Unit (CRU) on the 29th September 2021.

6.18 On the 29th January 2013, Debra's teenage daughter contacted the Police to report that her mother had assaulted her. She also reported that her mother consumes large amounts of alcohol and smokes cannabis daily.

[3] A CA12 form is used by Police to notify partnership agencies about adults at risk. These have since been replaced by PPN1s.

[4] A CYPR form is used by Police to notify partnership agencies about children at risk. These have since been replaced by PPN1s.

The call to 999 made by the daughter records a slapping sound followed by a scream. A female is also heard to shout “you’re dead”. A CA12 (notifying partnership agencies about adults at risk) was completed and shared with Adult Services and a CYPR (notify partnership agencies about children at risk) was completed and shared with Children’s Services.

Debra was arrested, and during her interview she gave a prepared statement indicating that she used reasonable force, as her daughter was “out of control”. She recorded in her statement that her daughter has a high functioning of Asperger’s[5]. Debra was charged with assaulting her daughter but was found not guilty in Court.

6.19 On the 12th February 2013, Debra’s daughter was made subject to a Child Protection Plan under the category of neglect and in May 2013, she was removed from a Child Protection Plan and placed on a voluntary Child in Need Plan.

6.20 On the 15th December 2013, Debra breached a restraining order against Sue. Sue reported feeling very frightened as she believed this would escalate in severity. Attempts to arrest Debra were unsuccessful, but she made contact with the Police on the 17th December 2013, to advise she had been at her address but was looking after a toddler who was asleep so did not answer the door. She informed the Police she was a child minder.

6.21 Debra was arrested and interviewed on the 19th December 2013. She was charged with harassment and released on unconditional bail to attend court in January 2014. At court, she was sentenced to a 12 month Conditional Discharge.

6.22 On the 18th January 2017, Jenny called her ex-husband and shouted, ‘get here now’. He could hear screaming in the background and Jenny shouted that she had been assaulted by Debra. Police attended and Debra was found sitting in her car, outside in the grounds of the large detached property. She was arrested for assault and criminal damage. Jenny stated that the relationship had now ended, and that Debra had assaulted her on 3 previous occasions, but this incident was the worst. She did not wish to make a statement or support a Police prosecution.

A DASH was completed and a VAAR (Vulnerable Adult at Risk form) for Jenny was submitted. Jenny gave information that Debra had no money and had been financially dependent on her. She was aware that she had mental health issues, and that she had previously had an injunction against her (no further details known). Jenny did not consent to this information being shared with partner agencies and opted out of victim contact. The DASH was graded as standard risk, no further action was taken against Debra.

[5] Asperger’s is a diagnosis that refers to a person that meets the criteria for autism and does not have an intellectual disability or a language delay.

6.23 On the 14th February 2017, a referral was made by Debra's GP to mental health services after an overdose in January 2017. An appointment was offered with Talking Therapies Service. Debra attended a telephone triage appointment on the 1st March 2017 and during the appointment she disclosed childhood abuse. Debra was referred into an Emotional Skills Group and attended one session on the 9th June 2017 and did not return for any further sessions. She was discharged from the service on the 16th June 2017.

6.24 On the 23rd September 2019, Debra attended the Minor Injuries Unit (MIU). She reported that she fell whilst out walking with a friend, but the friend's details were not given. She had abrasions and swelling to the left side of her head, plus swelling to her elbow. An x-ray revealed a fracture to the intra-articular radial, head and elbow. There was no disclosure of domestic abuse or apparent challenge to the rationale for the injuries. Whilst a fall could result in the injuries sustained, a professionally curious approach may have revealed greater detail and given 'permission' for Debra to disclose an assault if this had occurred.

6.25 On the 22nd March 2020, Debra attended Minor Injuries Unit (MIU) and reported that she woke that morning with a bruised finger and pain in her ribs (said she had taken Ketamine for pain relief that morning). The explanation she gave for the bruising was that she thought someone was breaking in at night and assaulting her and that she was planning to report this to the Police. Bruising was noted to the back upper right arm, red/purple bruising to right thoracic area and blue bruising to the left lower lumber area. No professional curiosity around further exploration/challenge regarding the reason was given for the bruising.

6.26 On the 28th September 2021, Debra made a self-referral via email to Somerset Drug and Alcohol Service (SDAS) for support around her alcohol use. She stated in her referral that she was referring in "Because of my lifestyle drinking is not sustainable". Debra stated that she was drinking almost daily and smoked cannabis monthly. There was no mention of domestic abuse or any relationship.

6.27 On the day of Graham's death in April 2022, Debra reported that he was sitting in a dark space in the hallway upstairs. His whole demeanour and body language had changed which scared her. Debra sent him a text message from downstairs asking him to leave.

6.28 In April 2022, the day of Graham's death, a witness account from a friend details that Debra came to her house around 13:00 hours. She was really anxious and worried and repeatedly stated that she was "scared' and said, "he's so dangerous".

6.29 Whilst Debra was still at her neighbour's house, she made a video call to her friend Paul. She stated, "Do you see why I'm scared now and running around with a knife". She went on to say, "Should I just go up to his bedroom, stab him, and then stab myself a little bit and I can tell them that he attacked me?".

7. KEY ISSUES AND CONCLUSIONS

7.1 The Review Panel has formed the following conclusions after considering all of the evidence presented in the reports from those agencies that had contacts with Graham and Debra, as well as information gathered from Graham's family and Debra's friends.

7.2. The Panel commends the agencies that had contact with either Graham or Debra for the thoroughness and transparency of their reports. Whilst all of the lessons identified will be addressed by the action plans set during this Review, many would not have had a significant bearing on the circumstances surrounding Graham's death.

The Panel has however, recognised the following as being key issues, albeit some with the benefit of hindsight:

7.2.1 Graham's son has questioned why background checks were not considered on Debra, before consent was given for Graham to move into the property. Such a check may have revealed her mental health problems and her history of domestic abuse, coercive control and violent behaviour towards previous partners. If Debra's background had been known to the Probation Practitioner who inspected the premises, and who warned her about the reason Graham was under supervision, the Practitioner may have been more circumspect in what information was given to Debra.

7.2.2 The length of time (5 years) taken to conduct the Restorative Justice process, caused Graham distress and his sons a lasting feeling of being unable to find closure. The Panel questions why this process was so prolonged, and why expert advice was not sought from his GP or a mental health professional during and before this process.

7.2.3 The Panel noted the lack of clarity regarding follow up appointments by the GP, and that there was no follow up consideration of comments made by Graham at previous reviews.

7.2.4 A lack of professional curiosity during Graham's review visit with his GP in February 2022, was considered by the Panel and IMR Author to be a missed opportunity to signpost him to appropriate specialist support. Graham had reported that he was feeling low and had to "pull away from his best friend who had started taking drugs and become aggressive towards him". It was presumed that he was talking about Debra. There is no evidence to indicate that it was considered that Graham may have been at risk, or a victim of domestic abuse.

7.2.5 At Graham's last home visit before his death in February 2022, a stockpile of medication was seen by the Probation Practitioners. No questions were asked as to whether he had stopped his medication. Could this have been a contributing factor towards his behaviour to Debra, bearing in mind that she

told her friend on the day of Graham's death, that his behaviour was erratic as he had not taken his lithium for four days?

8. LESSONS TO BE LEARNED

8.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the action plan template in Section 9 of this report.

Hampshire and Isle of Wight Constabulary

8.2 A missed opportunity was identified regarding the incident on the 15th November 2011, whereby threats made by Debra to kill Sue, her ex-partner could have been assessed in a domestic abuse context. The significant comment made by Sue to the Police was also not explored further.

8.3 The continuing risk to Sue relating to the incident on the 22nd December 2011, which was after their relationship ended was also not fully recognised by the Officers dealing and not in accord with the Force Policy. (Para.6.16)

8.4 In 2020, Hampshire and Isle of Wight Constabulary took a recommendation from a Domestic Homicide Review, that all frontline and Multi-Agency Safeguarding Hub (MASH) Officers and staff understand factors that are widely known to increase or minimise risk. This recommendation is covered under Hampshire and Isle of Wight Constabulary's Domestic Abuse Strategy and Tactical Plan and was signed off as complete in November 2021.

8.5 There were a number of areas of identified improvement for Hampshire and Isle of Wight Constabulary, including risk grading in domestic abuse incidents, recognising the factors that may increase risk in relationships, ensuring professional curiosity and the importance of holistic risk assessments. However due to the length of time passed, (10 years) much of the training has already been identified in other Reviews and acted upon accordingly. Therefore, no further recommendations are being made.

NHS Somerset Integrated Care Board (ICB)

8.6 The GP practice should have been aware that Graham had not had a lithium blood test for some time as this will show up as an alert on the system. This should have been chased, as it is not safe to continue prescribing lithium if it is not monitored. Each prescription is an opportunity to review the latest blood test.

8.7 During Graham's medical review on the 9th February 2018, consideration should have been given towards his mental as well as physical health. Graham reported that he had started smoking again, questions regarding stress and his wellbeing would have been appropriate given his mental health history.

8.8 Given Graham's deterioration in his health during his consultation on the 20th March 2019, it would have been helpful to arrange a time to follow up with the

GP, as his increased smoking would have a negative impact on his cardiovascular risk. Clear follow up arrangements should be made when referring for tests or when health is declining.

8.9 No professional curiosity was explored on the 21st February 2020 when Graham mentioned experiencing aggression from his best friend. When a patient discloses that they may be at risk of harm, this should be explored in greater detail and consideration given to whether this constitutes domestic abuse or a safeguarding risk.

8.10 When a patient declines care, discuss and document why someone may be declining care and ensure that they are clear of the purpose of any interventions and the risks involved, so that they can make an informed decision.

8.11 Each consultation should make reference to what is known from previous information and not be considered in isolation.

Somerset Drug and Alcohol Services (SDAS)

8.12 When Debra referred herself into the service in September 2021, the service was not using the contact and screening tool, it was a generic referral form which didn't detail specific risk, apart from a tick box which asked, 'do you feel at risk'. Debra's referral mentioned no risks. Where risks are identified and contact is made, an appointment is booked within 5 working days rather than 10.

Somerset NHS Foundation Trust (SFT)

8.13 The IMR Author highlighted two occasions of potentially missed opportunities, the incident on the 23rd September 2019, when Debra attended the Minor Injuries Unit (MIU) after a fall and on the 22nd March 2020 when she explained someone breaking into her house and assaulting her.

8.14 It is the Author's view that staff potentially missed an opportunity on these two occasions to be professionally curious about how the injuries were attained, particularly Debra's explanation of someone getting into her house at night to attack her.

Probation Service

8.15 There are key points where entries should have been made by Management, for example at the full transfer of the case and at each point when Graham was allocated to a Probation Practitioner and why this action was taken.

8.16 The transferring of cases from one area to another area was governed by a Probation Policy, but this was acknowledged not to be consistent as it was open to interpretation from the receiving area. This related to expectations, timescales and actions to be completed prior to the transfer being completed.

8.17 The frequency of transfer of Probation Practitioners was also not best practice, and it is clear that some of these changes were due to staff leaving, moving roles, caseload adjustments and the COVID pandemic.

8.18 The Probation Service was working under the Exceptional Delivery Model (EDM) from March 2020. This was a blended approach of face-to-face and telephone contacts. The concern this raised was that information could get lost if clear handovers do not happen and records on nDelius are not updated by the previous Probation Practitioners (PPs). Whilst the PPs were asked to complete a handover with the new PP, this was completed as a verbal discussion and the receiving PP may have made notes of their own, these notes did not get recorded onto nDelius.

8.19 Frequency of reporting should have been increased after Graham received the Assistant Chief Officer warning letter. He was new to the area and the new Probation Practitioner needed to establish a positive, purposeful working relationship with him. Given Graham's history to ruminate on issues that took him to bad places, it would have been helpful to see additional contact to touch base with him as to his thoughts and feelings. These could have been telephone calls or face-to-face.

8.20 The IMR Author highlighted inconsistencies in terms of entries made on nDelius. Some contacts had limited details recorded, some had not been updated with any information and other contacts were missing all information which presented problems in the continuity of information.

8.21 There was no professional curiosity displayed, for example during Graham's last home visit on the 10th February 2022. There was a stockpile of medication in his room, and no record of questions being asked about this or if he was attending his blood tests in relation to his use of lithium.

8.22 No expert advice was sought from Graham's GP or a Mental Health Professional in relation to the impact the Restorative Justice process would have had on his mental health.

Surrey Police and Sussex Police

8.23 The Police response to the incident on the 18th January 2017 was appropriate. Parties were spoken to separately, an early arrest made, photos taken of the damage, DASH completed and VAAR (Vulnerable Adult at Risk) for Debra submitted. (Para.6.22)

While the IMR Author identified some practice learning points for this contact, specifically, procedural confusion around the issuing of a DVPN[6]; no enquiries being made with Avon & Somerset Police regarding information provided separately by Jenny and Debra that there had been previous domestic abuse incidents in their relationship, and that the 39/24 (referral

[6] Domestic Violence Protection Notice.

form) for Debra should have been shared with Hampshire agencies (where Debra was residing).

8.24 It was felt, that due to the time that has elapsed since the incident and the significant team structural changes that have taken place with Public Protection Command since 2021, as well as changes to domestic abuse policy and procedure, these learning points have now been addressed. No recommendations have therefore been raised.

9. RECOMMENDATIONS AND ACTION PLANS FROM THE REVIEW

9.1. The DHR Panel's recommendation and up to date action plan at the time of concluding the Review on 12th April 2023 are detailed in the template below. After publication of this report, Safer Somerset Partnership will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

SOMERSET DRUG & ALCOHOL SERVICES (SDAS)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) To develop a contact and screening tool to include risk criteria for online referrals.	Local	Risk criteria to be developed by Senior Operation Managers and approved by the Senior Clinical Governance Team. The risk criteria increased priority/risk referrals to 65% of all referral demand. The criteria were revised and changed.	SDAS/Turning Point	To capture any additional risks. If Contact Point is unable to get hold of a client and risks have been highlighted, they can escalate this to the Hub Manager who will try and make further contact.		**December 2021** **August 2022**

SOMERSET INTEGRATED CARE BOARD (ICB)

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) Patients on Lithium should have a regular (3 monthly) blood test to ensure it is being prescribed safely and effectively.	Local	GP Surgery to ensure they have a robust system in place to ensure appropriate monitoring has been undertaken before prescribing.	GP Surgery	NICE guidelines on Lithium prescribing.	May 2023	
2) Follow up arrangements should be discussed with patient and clearly documented.		GP Surgery to consider how they arrange, and document follow up consultations.	GP Surgery	Good practice to ensure ongoing care of chronic, physical & mental conditions.	May 2023	

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
3) Where a patient discloses that they may be at risk of harm, this should be explored in greater detail and consideration given to whether this constitutes domestic abuse or a safeguarding risk.	Local	GP Surgery to ensure that all staff are aware of how to assess risk and possible domestic abuse through appropriate training.	GP Surgery	Good practice to understand risk.	May 2023	

SOMERSET NHS FOUNDATION TRUST

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) To remind MIU staff of the importance of being professionally curious when patients are presenting with injuries for which the explanation given seems/could be questionable.	Local	This will be addressed via MIU safeguarding supervision and dissemination of the 'professional curiosity' 7-minute briefing.	Deputy Named Professional Safeguarding Adults/Matron West Mendip MIU/ Operations Manager SFT MIUs (oversight by NPSA)	To help identify potential instances of domestic abuse in order to be able to take appropriate action to help mitigate further risk of harm.	March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
2) To consider how domestic abuse routine enquiry (DARE) can be embedded across MIU's.	Local	To develop and deliver DARE workshop. To explore how DARE can be prompted/recorded within MIU records.	Domestic Abuse Lead/Deputy Named Professional Safeguarding Adults (oversight by NPSA)	To help identify potential instances of domestic abuse in order to be able to take appropriate action to help mitigate further risk of harm.	September 2023	

SOMERSET PROBATION SERVICE

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
1) Recording of Management Oversights	Local	Introduction of the Touchpoint Model for Probation Practitioners to record key points during sentence.	Senior Probation Practitioner for each team in Somerset	There is now a performance report generated which highlights when Management oversights are added and when they are not. This also introduced clear contact choices in nDelius in relation to enforcement.		**November 2021**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
2) Transferring of cases from one area to another.	Local	Introduction of a new Transfer Policy and the requirement to complete a Non-Statutory Intervention (NSI).	Senior Probation Practitioner for each team in Somerset	The NSI provides a National, Regional PDU (Probation Delivery Unit) a view of case transfers and temporary moves. These are tracked and are now escalated at the 20-day, 30-day and 40-day point. The safeguarding checks and address checks are also linked to this NSI to ensure checks have been completed.		**August 2022**
3) Recording of case handover notes between previous Probation Practitioner and the new Probation Practitioner.	Local	SPP request to Probation Practitioners when cases are transferred between team members	Senior Probation Practitioner for each team in Somerset	This would ensure no information is missed and any ongoing concerns/situations could be tracked. The new PP would have one place to check and get an overview refresh for the case.	31 March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
4) To monitor the frequency of contact with people on Probation and Licence.	Local	SPP to discuss case discussions, supervision and team meetings. SPPs to monitor using the data set now provided on face-to -ace contact.	Senior Probation Practitioner for each team in Somerset	SPPs can highlight to PPs that whilst the recommendation of minimum contact is 28 days, if they have concerns about their cases, they can offer additional appointments either over the phone or face-to-face. This can be used to monitor and self-reporting of active risk factors.	31 March 2023	**March 2023**
5) To monitor nDelius Recording (Probation Database)	Local	For SPPs as part of the supervision process with the Probation Practitioners to undertake dip sampling of nDelius records and use this as one of the reflective discussions which form part of the Competency Based Framework (staff appraisals).	Senior Probation Practitioner for each team in Somerset	The use of CRISS (Check in, Review, Intervention, Summary, Set Tasks) makes it clear what work is undertaken and how risk factors are being explored.	31 March 2023	**March 2023**
6) To implement Professional Curiosity Guidance 2022.	Local	This is a supportive tool for SPPs to use in supervision and team meetings to encourage and support staff in using professional curiosity. This is something that could easily be added to any Team Meeting Agenda and worked through over time to refresh	Senior Probation Practitioner for each team in Somerset	The Probation Service recently launched the Professional Curiosity Guides, these were released in October 2022.This guide is based on information, sourced from HM Inspectorate of Probation's core	March 2023	**March 2023**

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
		people's knowledge about professional curiosity and empower trainee Probation Officers and newly qualified Practitioners with these skills.		programme, thematic inspections carried out between 2020 and 2022 serious further offence (SFO) reviews and independent case reviews.		
7) To consider referral for Mental Health Assessments during any Restorative Justice process.	Local	SPPs to be aware of the need to consider this if any supervised person becomes involved with this process.	Senior Probation Practitioner for each team in Somerset	Explore whether the Probation Service should reach out to Mental Health Specialists for assessments to be completed prior to referring individuals onto programmes or processes which could have an impact on their mental health. Particularly if this is linked to risk of reoffending or serious harm or there have been previous psychiatric reports.	31 March 2023	**March 2023**