



SAFER SOMERSET PARTNERSHIP DOMESTIC HOMICIDE REVIEW EXECUTIVE SUMMARY

Report into the death of John April 2017

Independent Chair and Author: Mark Wolski

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1. THE REVIEW PROCESS

1.1 This summary outlines the process undertaken by Safer Somerset Partnership, Domestic Homicide Review panel in reviewing the circumstances of the death of John who was a resident in their area in April 2017.

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

Pseudonym	Relationship	Age at the time of the incident	Ethnicity
John	Deceased	Adult	White British
Susan	Former Partner	Adult	White British
Anne	Mother of John	Adult	White British
Mary	Community Advocate	Not relevant	White British

1.3 No criminal trial took place.

1.4 In October 2017 an Inquest into the death of John was concluded. It was found that the cause of death was hanging, and the narrative conclusion was that in April 2017 at his home address, John suspended himself by the neck but his intentions at the time have not been established.

1.3 The process began when Somerset County Council Public Health Team completed a routine audit of suicides in September 2017 and having noted that John was reported to have been a victim of domestic abuse, his death was notified to the Safer Somerset Partnership for consideration as a DHR. Following correspondence with the Home Office, it was agreed by the Safer Somerset Partnership in July 2018 that a DHR must be undertaken.

1.6 All agencies that potentially had contact with John and Susan prior to the point of death were contacted and asked to confirm whether they had involvement with them. A total of eleven agencies were contacted and following enquiries during the review process a former employer was contacted by the chair. This employer has not been named as this information could be used to identify the subjects of the review.

2. CONTRIBUTORS TO THE REVIEW

2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with John and Susan.

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

Agency	Nature of Contribution
Avon and Somerset Police	IMR
Somerset County Council Adult Social Care	IMR
Somerset Partnership NHS Foundation Trust	IMR

Taunton & Somerset NHS Foundation Trust	IMR
Somerset Clinical Commissioning Group on behalf of GP services	IMR
Somerset Integrated Domestic Abuse Service (Live West)	IMR
Yeovil District Hospital NHS Foundation Trust	IMR
Yarlington Housing	IMR
Somerset Drug and Alcohol Service (SDAS)	IMR
South Somerset District Council	IMR
One Team	Summary Report

Independence and Quality of IMRs

- 2.3 The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the panel to analyse the contact with John and Susan and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Six IMRs made recommendations of their own. The IMRs have informed the recommendations in this report. The IMRs and subsequent contributions of panel members have identified changes in practice and policies over time.

3. THE REVIEW PANEL MEMBERS

- 3.1 The review panel members included the following agency representatives.

Agency	Name	Job Title
Somerset County Council Adult Social Care	Louise White	Service Manager
Somerset County Council Adult Social Care	Emma Lawton	Locality Lead
Somerset Partnership NHS Foundation Trust	Julia Burrows	Associate Director of Safeguarding
Taunton & Somerset NHS Foundation Trust	Heather Sparks	Named Professional for Safeguarding Adults / Domestic Abuse Lead
Avon and Somerset Police	Deb Congram	Detective Inspector - Intelligence Leader
Somerset Clinical Commissioning Group	Charlotte Brown	Designated Nurse for Safeguarding Adults
Somerset Clinical Commissioning Group	Dr Andrew Tresidder	GP Patient Safety Lead
Somerset Integrated Domestic Abuse Service	Leanne Tasker	Team Leader
Yeovil District Hospital NHS Foundation Trust	Glen Salisbury	Head of Safeguarding Team
Yarlington Housing	Nadia Hockley	Tenancy Compliance Specialist
Somerset Drug and Alcohol Service	Vikki Lake	Senior Operations Manager

South Somerset District Council	Paul Huntington	Specialist Compliance and Enforcement
Somerset County Council	Suzanne Harris	Senior Commissioning Officer
Foundry Risk Management	Mark Wolski	Independent Chair and Overview Report Author
Foundry Risk Management	Peter Stride	Independent Chair (Deputy)

3.2 The review panel met on five occasions.

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

4. AUTHOR OF THE OVERVIEW REPORT

4.1 The Chair of the Review was Mark Wolski. Mark has completed his Home Office approved Training and has attended training by Advocacy After Fatal Domestic Abuse. He completed 30 years-service with the Metropolitan Police Service retiring at the rank of Superintendent. During his service he gained significant experience leading the response to Domestic Abuse, Public Protection and Safeguarding.

4.2 Mark has no connection with Somerset or any agencies involved in this case

5. TERMS OF REFERENCE FOR THE REVIEW

5.1 Overarching 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 establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work individually and together to safeguard victims.
- c) To 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 and as a consequence.

5.2 Scope of the Review determined by Safer Somerset Partnership and DHR Panel

- To review events up to the death of John in April 2017. This is to include any information known about his previous relationships where domestic abuse may have occurred.
- Events should be reviewed by all agencies during the relevant period of time from 1st January 2014 to April 2017. However, if agencies have any information prior to that they feel is relevant, then this should be included in any chronology/IMR.
- To seek to involve the family, friends and wider community within the review process.
- Consider how (and if knowledge of) all forms of domestic abuse (including non-physical types) are understood by the local community at large - including family, friends and statutory and voluntary organisations. This is to also ensure that the dynamics of coercion and control are also fully explored.

- To consider how (and if knowledge of) the risk factors surrounding domestic abuse are fully understood by professionals, and the local community - including family and friends, and how to maximise opportunities to intervene and signpost to support.
- Determine if there were barriers John faced in both reporting domestic abuse and accessing services. This should also be explored against the Equality Act 2010's protected characteristics.
- Review relevant research and previous domestic homicide reviews (including those in Somerset) to help ensure that the review and Overview Report is able to maximise opportunities for learning to help avoid similar deaths occurring in the future.

6. SUMMARY CHRONOLOGY

- 6.1 John had a long medical history of substance misuse problems and mental health illness. It was also reported he had previously attempted suicide and there were a number of incidents of self-harming.
- 6.2. John and Susan had been in a relationship for 3 years, and it is understood that Susan would stay at John's address intermittently. [REDACTED]
[REDACTED]
- 6.3 During this period of three years, there were numerous contacts with police many of which related to allegations of Domestic Abuse. It is the nature of the relationship and Domestic Incident calls that ultimately resulted in this DHR being commissioned.

Family and Friends Perspective

- 6.4 John was described by his mother as having problems with illegal drugs and alcohol from his early teens. Having moved to Somerset around twenty years prior to his death, he struggled with his mental health and substance misuse, his life punctuated with periods of self-harming.
- 6.5 He was described as a kind and loving man, though vulnerable and to an extent gullible.
- 6.6 On meeting Susan, the relationship was remembered for frequent incidents of assault against John.
- 6.7 There were periods of calm, as he was supported in his efforts by a community organisation [REDACTED] to help him with his substance issues and provide stability. [REDACTED]
[REDACTED] The community organisation also helped to secure him a permanent job in a local factory.
- 6.8 Notwithstanding, her memories of John's troubled life, she does recall periods of stability where he was able to maintain his own flat, was relatively sober and content. These coincided with John's friendships such as during an online relationship, [REDACTED]
[REDACTED] when he was helped to find permanent employment [REDACTED] through his involvement with a community group.
- 6.9 John's mother spoke well of the police, being very patient and caring to John. However, she did say that John's confidence in the authorities was knocked badly on a number of occasions including when an allegation of assault by Susan and her brother that resulted in a trial at court. She said the 'not guilty' verdict severely impacted his self-confidence, as

well as that in the authorities. On another occasion, she recalls that John alleged that Susan had assaulted him and that this was not pursued by the police, even though they had appealed that it should be.

Avon and Somerset Police

- 6.10 There are thirty-eight (38) incidents/contacts with the police recorded during the period 1st January 2014 until John's death in April 2017. The types of incident are summarised as; Twenty (20) domestic abuse related incidents with Susan; Seven (7) non-domestic abuse incidents where John is identified as vulnerable and most relate to drug related crime; Nine (9) incidents of him being under the influence of drugs/alcohol; Two (2) intelligence reports related to drugs.
- 6.11 It is a matter of recorded fact, that of the eight crime allegations between John and Susan, he featured as the victim on seven occasions. There are also cross allegations and where a cross allegation was not investigated, the IMR author raised the potential for gender bias, in believing a female victim over a man.
- 6.12 The chronology showed clusters of incidents, that did not result in automatic referrals to Multi-Agency Risk Assessment Conference (MARAC); one cluster of four incidents in July and October 2015; one cluster of five incidents January to April 2016; one further cluster of five incidents July to September 2016.
- 6.13 The chronology shows over the relevant period, improving standards of investigation, including use of body worn video, neighbour enquiries and consideration of evidence-based prosecutions. The noticeable development in the standards of investigation was also matched by improvements in Domestic Abuse, Stalking and Honour-Based Violence Risk Identification Checklist (DASH) completion rates, though there were incidents of downgrading the initial investigators DASH assessments.
- 6.14 Notwithstanding the observation around automatic referrals to MARAC, there were three MARAC discussions about John and Susan that do not document the consideration of judicial restraints, do not consider John's broader vulnerability (health and well-being needs), his mental capacity nor his suicidal ideation.
- 6.15 The MARAC is well represented, though opportunities to seek information from agencies not represented such as the GP were not apparent.

Somerset Adult Social Care

- 6.16 Adult Social Care had limited contact with John, two alerts having been made regarding his address having been 'cuckooed' by drug dealers and one in relation to his relationship with Susan.
- 6.17 With regard to the 'cuckooing' alerts, the first resulted in an initial contact confirming his engagement with SDAS, and the second by police was not deemed to meet the threshold for contact.
- 6.18 The third alert resulted from the mental health nurse referring Susan as vulnerable to John's coercion and control. Adult Social Care was therefore unsighted on the full picture of issues between John and Susan.

GP Practice - Clinical Commissioning Group

- 6.19 John was a patient at the practice since his arrival in Somerset and throughout the relevant period, treating him for his substance misuse issues and attendant physical health problems. The practice worked with John's mother to try and provide stability and support to John and during consultations.
- 6.20 John's suicidal ideation and self-harming was apparent in his clinical history and intermittently during the relevant period and was subject to appropriate assessment and treatment. Suicide risk assessments were not considered by Panel Members to be consistently reliable, and a compassionate response (as given) was appropriate.
- 6.21 John's difficulties in his relationship were known to the practice and there was a presumption through conversations with Somerset Drugs and Alcohol service who are co-located, that he was working with a specialist advocacy service because John was being discussed at a multi-agency forum the 'One Team. Hence DASH checklists were not contemplated by the GP practice.
- 6.22 Cross referencing this with MARAC records show that (a) GP's do not appear to be directly or indirectly represented and (b) a request was never made for information from the GP as an action at the MARAC

Somerset Drugs and Alcohol Service

- 6.23 This service is co-located with the GP, affording ready exchange of information and sharing of records. They had extensive contact with John, with over 400 contacts since 2008 and 60 during the relevant period.
- 6.24 The service was aware of John's relationship difficulties through his own disclosure to them, their engagement with John's mother and attending hospital after he had been assaulted. Notwithstanding awareness of the difficulties, on only one occasion was a DASH checklist considered. It seems, there was a misunderstanding that the checklist is a referral mechanism always requiring consent.
- 6.25 The service made observations in respect of his health and well-being on a number of occasions, resulting in one referral to adult social care. A further observation was made in respect of his mental capacity that was not acted upon.

Somerset Integrated Domestic Abuse Services (SIDAS) - Live West

- 6.26 SIDAS is Somerset's main specialist service to support those who are affected by Domestic Abuse.
- 6.27 There are a number of referrals for both individuals and only two contacts made with Susan. Of the four referrals for John, none resulted in direct contact. A policy standard has subsequently been introduced regarding required efforts to contact victims.

Somerset Partnership NHS Foundation Trust (Sompar)

- 6.28 Sompar had contact with John and Susan on a number of occasions during the relevant period and attended three MARAC meetings where John and Susan were discussed.

- 6.29 One of the services provided is Community Mental Healthcare Team (CMHT) services. They received two referrals from SDAS in respect of Mental Health (17th August 2015 and 26th November 2015). Effective practice was noted in that professionals contacted SDAS and the GP when John did not engage.
- 6.30 John's interactions with Sompar show one of the contacts took place whilst in custody on the 29th September 2016 when John had been arrested. The IMR author notes that there was an opportunity to consider John as a victim and complete a DASH risk assessment.
- 6.31 Sompar had three contacts close together just prior to John's death. Only the one on the 13th April 2017 was in person. On exploring this event and learned, the panel learned he did not present as suicidal on assessment and was referred back to his GP for ongoing support. He declared no intent of self-harm at that moment in time. John did disclose that his girlfriend had moved back in and that this had heightened his anxiety. This was considered an opportunity to ask further screening and/or safety questions in respect of domestic abuse.
- 6.32 The second two contacts the day before his death relate to contact from John's pastor and paramedics seeking advice regarding John's mental state. The Mental Health team felt that a Mental Health intervention was not appropriate as it was apparent John was using crack cocaine and that the focus needed to be on substance misuse. The panel explored the belief expressed by the pastor that John had not been admitted owing to a lack of beds. On examination of the records shared by the coroner, they showed the question of admission to hospital did not arise.

Yeovil District Hospital NHS Foundation Trust

- 6.33 There is only one entry regarding John's attendance at the hospital on 29th September 2016, in the company of police. John was treated in respect of self-harm injuries. He voluntarily disclosed issues with regards to his relationship with Susan and frustration at having been arrested, having been the one to call police.

Taunton and Somerset NHS Foundation Trust – Musgrove Hospital

- 6.34 There were seventeen contacts during the relevant period, of which thirteen relate to long term health conditions or incidents relating to misuse of drugs and/or alcohol, reinforcing the issues John was suffering from regarding substance misuse.
- 6.35 John attended the hospital on a number of other occasions when domestic abuse had been apparent, which were not followed by further exploration as to the circumstances or completion of a DASH checklist.

Yarlington Housing

- 6.36 John had been a tenant of Yarlington Housing (YH) since April 2001. The chronology contains over ninety entries during the relevant period. A significant volume of these relate to resident diary sheet entries from neighbours noting down times and dates of incidents of ASB. Twelve incidents of arguments, shouting and screaming occurred between 21st December 2015 and 21st January 2016 not resulting in any calls to police.
- 6.37 YH were shown as attending the three MARAC meetings that took place that would have provided an opportunity to share the details contained within the diary sheets.
- 6.38 YH are also a regular attendee at 'One Team' meetings, where on one occasion it was reported that SDAS had mentioned Susan had tried to strangle him with a carrier bag.

This incident was not recorded on SDAS or police chronologies and this disclosure of abuse was not acted upon.

Events leading up to John Taking his own life

- 6.39 In the days leading up to John's death, he had been seen by the psychiatric liaison team and not deemed requiring a mental health input and he was referred back to primary care.
- 6.40 On the evening before his death, medical services had been alerted by the local pastor fearing his suicidal ideation. Ambulance services and police attended to John and determined involvement of the mental health teams was not required and that he was not suicidal.
- 6.41 After agency engagement, John went to his mother that evening and saw her again the following day.
- 6.42 The next day police were called by the ambulance service to John's home address where John had been found hanging by Susan. Police attended the scene and commenced an investigation into the circumstances of his death, determining that John had taken his own life.

7. CONCLUSIONS AND KEY ISSUES ARISING FROM THE REVIEW

7.1 Overview

- 7.1.1 John had suffered from substance misuse issues including alcohol and class A drugs since his early teens. He also suffered from diagnosed mental health issues, depression and suicidal ideation. These factors made him more susceptible to coercion and control from those who would seek to take advantage of him, including his online friend [REDACTED] and drug dealers.
- 7.1.2 Considering the government definition of Domestic Abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, it is clear he was a victim of Domestic Abuse in what was a mutually abusive relationship. It is a matter of recorded fact that John featured as a victim more frequently than Susan. He was assaulted and beaten on a number of occasions and he was subject to other facets of coercive and controlling behaviour, including his medication being stolen, her unwanted attendance at his and his mother's address and reports of being poisoned.

7.2 Care Needs, Safeguarding and Mental Capacity

- 7.2.1 John was in frequent contact with several agencies, notably the police, SDAS and his GP. There were frequent references to matters related to his needs, well-being and also comment about his vulnerability. However, he rarely featured for discussion or support by SIDAS or Adult Social Care.
- 7.2.2 The panel agreed that assessments of care needs are not binary choices, but are based upon consideration of facts known or discovered through information sharing and/or professional curiosity. Even if in possession of all the facts, it was clear that opinions are textured, neither black or white.

- 7.2.3 John presented a contradictory picture. Assaulted and abused by his partner and yet appearing happy and content with her, seeking help to keep her away and yet capable of excluding her from his flat. Such conflicting signals would be difficult to interpret in isolation. These factors demonstrate the complexity of his relationship with Susan, with abuse on both sides and one may argue their behaviour was mutually dependent and validating. It may therefore not have been possible to conclude definitively issues of Care Needs, Safeguarding or Mental Capacity.
- 7.2.4 However, in order to make that professional judgement on support / safeguarding needs or capacity at a point in time, requires professional curiosity, a decision either individually or collectively at a meeting such as MARAC to 'ask the questions' in respect of such matters and/or a decision to share information through a relevant alert or notification.

7.3 Information Sharing/Seeking

- 7.3.1 There were opportunities for more effective sharing of information and co-ordination of information 'known' to single agencies and therefore 'knowable' through a forum like the MARAC, such as information held by Yarlinton Housing regarding complaints of crying and shouting being held on neighbour's incident logs. The frequent discussions at One Team meetings are acknowledged, as are absence of actions that may have been afforded at a bespoke strategy meeting.
- 7.3.2 Whilst there is excellent information sharing across medical professionals, there were opportunities to improve the flow of information such as; the MARAC seeking information from John's GP; acting upon a disclosure of strangulation by a carrier bag and by more frequent consideration of John's health and well-being meriting a referral to Social Care.

7.4 Police Investigation and Operating Procedures

- 7.4.1 Over the relevant period there is evidence of improving investigative practice such as the introduction of Body Worn Video and listening to emergency calls. However, the police work to standard investigative templates for all crime and there were missed opportunities to investigate crimes such as cross allegations. Whilst it could be contended that the investigation of domestic abuse allegations could be improved further by introducing a minimum standard for Domestic Abuse Investigation, the panel learned about an evolving quality assurance programme including; supervisory review of DA investigations every 7 days and by an Inspector rank every 28 days; quarterly Directorate performance meetings; quarterly assurance meetings; further quality assurance at the Police Crime Board by the Police and Crime Commissioner. The response to Domestic Abuse was subject of a scrutiny and an assurance report in February 2020 at the Police Crime Board.

7.5 Recognising and Responding to Domestic Abuse

- 7.5.1 There were a number of missed opportunities to recognise Domestic Abuse across the partnership such as; not recognising allegations of administering drugs as a potential crime or abuse; not recognising Susan taking his prescribed medication as being a crime and evidence of controlling behaviour; entries on the chronologies of assault that were not

subject to corresponding police records such as being beaten by girlfriend and a disclosure of strangulation by a carrier bag; disclosures of overt abuse or coercive behaviour in healthcare settings that were either not recognised and/or not acted upon.

7.6 Risk Identification and Assessment

- 7.6.1 Whilst the DASH is routinely used by the police, and completion rates have improved over time for Avon and Somerset police, there appears to be an opportunity to improve the ability of agencies to recognise risk, assess that risk and refer accordingly. Missed opportunities in relation to DASH completion include not completing where there are cross allegations, misunderstanding of its use as a referral tool requiring consent as well as linking to the points made at 7.5 above.
- 7.6.2 The panel also noted that the DASH poses questions in respect of an abusers use of alcohol, drugs and mental health, whilst not prompting similar questions of the victim. It seems that when considering John, his situation as a victim and these factors ought to be reflected within any professional assessment.

7.7 Risk Management and MARAC

- 7.7.1 Discussion around the Marac raised a number of observation points including, representation at the meeting, information sharing, discussion around safeguarding/mental capacity, missed opportunities to refer into the MARAC and opportunities to improve the range of tactical options in addition to overall governance.

7.8 Risk Management and Vulnerability

- 7.8.1 John was an individual with complex needs, having substance misuse issues, suffering from mental health issues and presenting suicidal ideation. These issues were fluid in nature but nevertheless exaggerated his vulnerability to exploitation and abuse. He was a victim of domestic abuse and also criminally exploited.
- 7.8.2 Recognising him as not being atypical, it was apparent that John may have been one of a number of individuals who are caught in the 'gap' who don't meet the threshold for statutory assistance or intervention. He was rarely discussed at MARAC, but frequently discussed at a 'One Team' meeting, a forum without a statutory footing.
- 7.8.3 Local practices have evolved with a new 'Missing and Vulnerable to Exploitation Panel' and guidance 'What to do if its not Safeguarding', that may have 'plugged' the gap. And yet the One Team meetings that had discussed John, without documenting positive actions, still take place.

7.9 Barriers to Accessing Support

- 7.9.1 There were a number of potential obstacles to support, that included; agencies not completing DASH checklists; repeat incidents not resulting in automatic referral to MARAC; John's confidence in the authorities; Specialist domestic abuse services making limited attempts to contact him.

7.9.1 A broad issue of Gender bias was also raised by the author of the police IMR, owing to a cross allegation not having been investigated and no DASH having been completed. The panel explored this and noted the specialist domestic abuse provider had provided proportionately low levels of support to male victims, a matter now subject of recommendations by the local Somerset Domestic Abuse Board.

7.11 Safety Net of Community Organisations

7.11.1 The chair learned at his first meeting with John's mother and community advocate [REDACTED] that there was a lack of awareness of where to go for support in respect of Domestic Abuse.

7.11.2 The chair was able to track down John's former employer who referred to their own Employee Assistance Programme but was unaware of local support agencies and acknowledged that the business did not have a Domestic Abuse policy.

7.12. Learning and Development

7.12.1 The panel agree that many of the themes provide learning and development opportunities that requires addressing through awareness raising and/or an assessment by agencies of training need.

8. LESSONS TO BE LEARNED

This review of a suicide following extensive engagement with several agencies has identified several learning points that build upon agency IMRs.

8.1 The opportunity for professionals to reflect upon Care Needs, Safeguarding and Mental Capacity when considering abusive relationships.

8.2 The review showed opportunities to improve effective information sharing, that is the sharing of information known to single agencies to a wider professional audience to inform actions to mitigate risk.

8.3 The review shows an improvement of the standards of investigation over time and that opportunities to ensure the consistency of high standards is now being driven by a rigorous compliance regime.

8.4 The review showed missed opportunities to identify DA and improve professional curiosity through an investigative mindset in dealing with complex individuals with multiple vulnerability factors to ensure reporting and appropriate referral

8.5 The review showed there is an opportunity to strengthen understanding of how substance misuse and mental health may act as an aggravating factor in an abusive relationship.

8.6 The review revealed missed opportunities at various points to identify abuse and complete a DASH risk assessment, including where there are cross allegations.

8.7 The review revealed the opportunity to improve the risk management and safety planning via the MARAC process This includes, opportunities to share or seek information from

trusted professionals and opportunities to consider a range of tactical actions to mitigate risk including the recognition and response to suicide risk. The feedback from the partnership regarding inconsistent chairing and changes in Governance suggest an opportunity for a fundamental review of its efficacy.

- 8.8 To seek assurance that revised guidance 'What to do if it's not Safeguarding' and the new Missing and Exploitation panel plug the potential gap in respect of adults who present multiple vulnerability factors who may not meet the threshold for MARAC and/or Safeguarding, and in so doing reflect on the place of 'One Team' forums.
- 8.9 There were a number of barriers for John in seeking support from agencies that included; MARAC policy in respect of repeat victims, John's confidence in the authorities, potential Gender bias that affected decision making and community awareness of where to access help.
- 8.10 To ensure that support networks for victims of Domestic Abuse are more widely known and expanded in the locality.
- 8.11 To seek assurance that the breadth of learning and development opportunities are adequately provided for by agencies, including: Social Care Needs, Adult Safeguarding, Mental Capacity and decision making, Domestic Abuse Professional curiosity and investigative mindset, and DASH

9. SINGLE AGENCY RECOMMENDATIONS FROM THE REVIEW – FROM IMR'S

9.1 Avon and Somerset Police

- 9.1.1 Whilst no new recommendations arose from the police analysis, two others from DHR's are noted as active.
- 9.1.2 Guidance on 'Situational violence' to be added to current DA procedural guidance; to include information on screening techniques (February 2018)
- 9.1.3 The Force should take further steps to raise awareness of male victims of DA and also make officers aware of their own possible unconscious biases in circumstances involving male victims. The force should also undertake checking and testing to see whether male victims of DA are currently receiving expected standards of service by the Force. (April 2018)

9.2 Adult Safeguarding Services – Somerset County Council

- 9.2.1 Enhanced Information sharing by auditing referral routes and ensuring Social Care Representation at MARAC
- 9.2.2 Disseminate learning from DHR across Adult Social Care.
- 9.2.3 Understand the availability of domestic abuse support resources for males in Somerset and disseminate this to Safeguarding and locality teams

9.3 Somerset Partnership Clinical Commissioning Group

- 9.3.1 Whilst no new recommendations arose from CCG analysis, it notes Adult safeguarding training for Primary Care has been developed (2018 onwards)

9.4 Somerset Integrated Domestic Abuse Service - Live West

- 9.4.1 Ensure that staff complete fuller case notes to fully demonstrate the action they are taking and why.

9.5 Somerset Partnership NHS Foundation Trust (Sompar)

- 9.5.1 When CMHT's receive referrals from SDAS, to contact referrer to discuss whether joint assessment with SDAS could be offered.
- 9.5.2 During Court Assessment and Advice Service (CAAS) assessment when it becomes apparent that there is a victim of domestic abuse perpetrated by the client they are assessing, for CAAS to check with Police that the victim (who CAAS would not have contact with) has had an ACPO DASH completed and been referred to domestic abuse support services as applicable.
- 9.5.3 Reiterate to CAAS in all instances where domestic abuse is suspected during CAAS assessment/contact, and/or Minor Injuries Unit (MIU) contact, staff to offer to undertake DASH with patient if patient is suspected victim of domestic abuse. If DASH declined by patient, CAAS/MIU to give contact details for domestic abuse support services.
- 9.5.4 Encourage all staff working in acute settings to be familiar with the Dual Diagnosis Policy and to attend Dual Diagnosis training as applicable.

9.6 Somerset Drugs and Alcohol Service

- 9.6.1 SDAS staff to consider using the DASH form as a risk assessment tool as well as a referral tool and to explain to clients that completion of a DASH form does not have to automatically trigger a referral into SIDAS but can be used simply to indicate risk level and for further discussion with the client.

9.7 Yeovil District Hospital NHS Foundation Trust

- 9.7.1 No recommendations arose from the Trusts analysis.

9.8 Taunton and Somerset Foundation NHS Trust (TST) Musgrove Hospital

- 9.8.1 Reiterate message within Emergency Department (ED) regarding substance misuse as indicator of increase risk of vulnerability alongside recognising victims of domestic abuse in male patients and following correct processes associated with this.
- 9.8.2 Re-emphasize need for professional curiosity particularly when patient flagged as domestic abuse victim and presents with assault injuries to ED.
- 9.8.3 Think family approach to be embedded in ED and safeguarding training across TST, professional curiosity when aggressive behaviour demonstrated and flag on system re MARAC.
- 9.8.4 Review how MARAC related information is recorded by safeguarding service on MAXIMS /EPRO to be most useful / available to staff to access.

9.9 Yarlington Housing

- 9.9.1 Diary sheets will be reviewed in conjunction with other diary sheets/ incidents to enable a holistic view of the case.

10. OVERVIEW REPORT RECOMMENDATIONS

Recommendation 1: Reinforce the need for professionals to proactively consider Care Needs, Safeguarding and Mental Capacity in their deliberations in respect of abusive relationships.

Recommendation 2: Improve the effectiveness of information sharing across the partnership.

Recommendation 3: Empower professionals to recognize, respond and report Domestic Abuse, encouraging professional curiosity through an 'open mind' and 'investigative mindset'.

Recommendation 4: Reinforce the need for effective use of the DASH risk assessment tool

Recommendation 5: Strengthen professionals understanding of the effect on risk of victims who suffer from substance misuse and mental health issues.

Recommendation 6: To strengthen the Partnership approach to Domestic Abuse risk management. Including a review of the local Marac, ensuring GP involvement, policies in respect of repeat occurrences and enhancing the application of tactical options to combat multiple risks, including suicidal ideation.

Recommendation 7: To systemise the approach to vulnerable adults who don't meet the threshold for MARAC and/or Safeguarding when dealing with complex individuals who present multiple vulnerability factors, taking into account guidance in respect of "What to do if it's not Safeguarding", the "Missing and Vulnerable to Exploitation Panel" and in so doing determine the role of 'One Teams'.

Recommendation 8: To address the potential barriers identified in this review to victims of Domestic Abuse face in seeking support from agencies. This includes training to reduce gender bias by professionals.

Recommendation 9: To raise awareness across the 'Safety Net' of community organisations of where to seek support in respect of Domestic Abuse.

Recommendation 10: To address the learning and development opportunities provided by the review.